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A State Mental Health Division
Office of Consumer Affairs Program Evaluation:
Stakeholder Views, Efficacy and Desired Directions

by

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A dissertation submitted in partial fulfillment
of the requirements for the degree of

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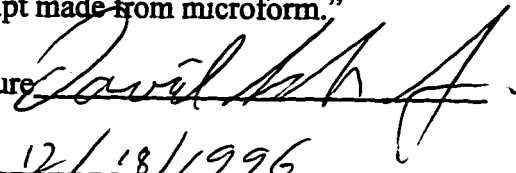
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Abstract

A State Mental Health Division
Office of Consumer Affairs Program Evaluation:
Stakeholder Views, Efficacy and Desired Directions

by David Schantz

Chairperson of the Supervisory Committee: Professor Lewayne Gilchrist
School of Social Work

This dissertation presents the results of a comprehensive stakeholder survey regarding a consumer staffed, State Mental Health Division (MHD) Office of Consumer Affairs (OCA). Part of a larger comprehensive 3 year program evaluation of the OCA, the investigation collected and analyzed both qualitative and quantitative field data from mental health consumers, family members and service providers about the office. Twelve stakeholder subgroups, represented by 345 individuals, were interviewed utilizing a quantitative-qualitative protocol. The range of stakeholder opinion and level of stakeholder knowledge were established regarding the OCA and its activities. Low levels of state-wide stakeholder knowledge and awareness of the OCA were found as was significant, broad based support regarding the mission of the office. Significant differences were found between the expectations and desires of mental health consumers and providers regarding extent of knowledge of the OCA and opinions concerning, among other issues, advocacy activities on the part of the OCA. Stakeholder observations of the successful OCA sponsored Consumer Ad-Hoc Committee are presented. Information from the wider evaluation provides background and explanation to illustrate survey findings. Lessons drawn are applicable to other similar offices across states and systems. Data based recommendations are made to address significant outcomes and process deficits revealed by the evaluation. The national and historical context of the OCA and other offices of consumer affairs are also briefly described.

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GLOSSARY

The following will assist the reader in defining and understanding acronyms mentioned within this study.

- AHCAC** Ad-Hoc Consumer Affairs Advisory Committee: Known as the Ad-Hoc Consumer Affairs Advisory Committee during data collection for this study, the name has since been changed to the Consumer Sub-Committee of the Mental Health Advisory Board (Washington State). This is the consumer committee sponsored by the Office of Consumer Affairs. Comprised of consumer advocates from around Washington, this group met every other month for training and to provide policy feedback to the Mental Health Division.
- AMI** Alliance for the Mentally Ill - Washington State Chapter - A family advocacy group.
- CAO** Consumer Affairs Office - Original name of the Office of Consumer Affairs.
- CAMO** Community Action for Mentally Ill Offenders - An advocacy group.
- CSP** Community Support Program - Federal mental health development program.
- MHD** Mental Health Division - Washington State.
- MHP** Mental Health Professional - Qualified professional designated by the state to do placement decision making for persons experiencing a mental health crisis.
- NIMH** National Institute of Mental Health.
- OCA** Office of Consumer Affairs - Washington State Mental Health Division.
- RSN** Regional Support Network - Regional mental health administrative body charged with coordinating services within a designated geographic area. Each area has a board of directors and contracts with the Mental Health Division to insure public mental health services are provided in their area. Each Regional Support Network in turn contracts with local service providers who provide direct mental health services.
- WAMI** Washington Alliance for the Mentally Ill.

WANA We Are Not Alone - Original 1940s name of self help group founded in Rockland State Hospital, New York. Later developed into Fountain House following deinstitutionalization of members.

WE-CAN Washington Education-Consumer Action Network - Consumer advocacy group.

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A major study such as this is can never be attributed to the sole efforts of one person. Many have played key roles in its development and shepherding through many stages to completion. Thank you all.

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Mom and Dad, your help came at a critical time in many ways. It is not stretching it to say that if the help hadn't happened when it did, you would still be wondering "if he will ever get that **/!!?# thing done." Sherry, your patience, interviews, data entry, and the million other things you have done have not been lost on your husband. I owe you a lot more than "1" and am looking forward to the process of repayment. Chris you even helped with some office and computer work (not bad for an ten year old), and Jarred, I appreciate your helping out in the office too. I am looking forward to the three of us celebrating.

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hope that the impact of this dissertation will lead to more effective services and improved representation of consumer interests within the mental health community.

DEDICATION

**To Sharon, Christopher, and Jarred,
with whom love is beyond measure.**

CHAPTER I

PROGRAM SIGNIFICANCE, BACKGROUND, AND RESEARCH NEEDS

Introduction

This dissertation presents the results of a comprehensive stakeholder¹ survey of a State Mental Health Division (MHD) Office of Consumer Affairs (OCA). Part of a larger comprehensive program evaluation of the OCA, the investigation collected and analyzed both qualitative and quantitative field data from mental health consumers, family members and service providers about the office. Twelve stakeholder subgroups, represented by 345 individuals, were interviewed utilizing an open and closed question protocol. The range of stakeholder opinion and level of stakeholder knowledge were established regarding the OCA and its activities. Significant differences were found between the expectations and desires of mental health consumers versus providers regarding extent of knowledge of the OCA and opinions concerning advocacy activities on the part of the OCA. The national and historical context of the OCA and other offices of consumer affairs are briefly described. Recommendations are made for improvements that will make this office and others more effective.

Significant Mental Health Consumer Empowerment Development

Brief Description of Offices of Consumer Affairs

The existence of offices of consumer affairs within state mental health divisions is a

¹ Stakeholders are defined as “people who have a stake - a vested interest - in evaluation findings” (Patton, 1986 pg. 43)

relatively new phenomenon. The first state level office in the United States was created in 1990. Six years later the number has grown to 20 offices. The primary intent of this growing movement is to enhance mental health consumer empowerment. Offices of consumer affairs place consumers' voices within mental health division offices to serve as advocates, resource persons, and liaisons to the wider consumer community.

State of Formal Communication and Research

Research regarding offices of consumer affairs is primitive or nonexistent. The first published listing of 16 offices of consumer affairs was printed in 1994 (Rogers, 1993-94). The information was limited. This list, contained in a newsletter, neglected the inclusion of addresses or contact persons. As of July 1, 1996 a non published current listing of all 20 offices was available by request through the Alabama Mental Health Office of Consumer Relations. Additional published information on these offices and related developments has also been difficult to find, and when found, highly limited in both breadth and depth. In general, the movement continues to rely upon informal personal and professional networks for dissemination of information and news. Thus far, these developments have not achieved the level of recognition that would bring formal mention in academic and professional journals.

Paralleling the state of published information, inquiry into mental health offices of consumer affairs is also extremely formative. As of March, 1995, key informants at the National Institute of Mental Health (NIMH) and national level consultants revealed that no formal program evaluation of a state mental health office of consumer affairs had yet been carried out. This was confirmed by national consultants as well as a literature

review in August, 1996. Research on state level offices of consumer affairs is needed to expand professional knowledge about their functioning and value.

Washington OCA Program Evaluation Plan

In 1991 the State of Washington Mental Health Division received a Consumer Family Partnership Grant from the National Institute of Mental Health to fund an office of consumer affairs and related activities. A full evaluation of the OCA was mandated under the federal grant used to establish the office. The evaluation was to be primarily focused on the impact of the office around the state with some focus on developmental process.

The evaluation of the OCA employed triangulation methods (use of multiple data streams for comparison purposes) to assist in the establishment of both the reliability and validity of collected data (Greene & McClintock, 1985; Kimchi, Polivaka, & Stevenson, 1991; Mitchell, 1986; Morse, 1991; Murphy, 1989). Three primary streams of data were incorporated in the triangulation methods. Records and documents generated by the office were collected along with non-random interviews with key stakeholders, limited participant observation was also incorporated. Finally, a comprehensive stakeholder survey was included to assess broader impact and stakeholder opinion.

The survey of stakeholder views was needed to complement evaluation data from other sources incorporated in the triangulation method to provide information on the overall impact of OCA activities. Strong, unidirectional survey findings would provide opportunity to draw stronger evaluation conclusions than could be reached on the strength of OCA internal documentation and non-random interviews alone. The study reported

herein is primarily from the stakeholder sub-component of the overall evaluation. The origins of the Washington State Mental Health Division Office of Consumer Affairs, its mission and the details of the evaluation plan will be further detailed on pages 6-11 and in chapter two. First, some background will provide the rationale for the importance of the present study.

Background and Setting

General History and National Trends

Empowerment

Over the last decades within the public mental health system there has been a movement toward strengthening the basic conceptualization of the client as an individual free entity who deserves respect, dignity, and a voice in shaping programs and service related decisions. This mental health movement finds support in the construct of empowerment as expressed in the social and behavioral sciences. Gutierrez (1990) for example, defines empowerment as a "process of increasing personal, interpersonal, or political power so that individuals can take action to improve their life situations". Not only confined to mental health, empowerment strategies have been implemented in many systems in this country on individual, organizational and societal levels (Rapp, Shera & Kisthardt, 1993; Segal, Silverman & Temkin, 1993; Tobias, 1990).

As part of "empowerment," efforts have been made to lesson the stigma of mental illness (Rapp, et al. 1993). For example, one development stemming from this effort has been the re-naming of mental patients and ex mental patients as "consumers". Originally

the term was concurrently identified with both family members of mental health patients (Battaglino, 1987; Hatfield, 1981, 1987; Sommer, 1990) and patients (Colom, 1981; Stephens & Belisle, 1993). The literature has noted this definitional dualism as problematic and has begun to differentiate by adding the designation of primary (patient or ex-patient) and secondary (family member or relative of primary consumer) (Emerick, 1989; Mowbray, Wellwood & Chamberlain 1989). In the last few years, the concept of consumer has become increasingly identified with primary consumer (Tower, 1994). In keeping with the national trends but also to clarify meanings, this dissertation research uses the term consumer defined as “a person who is or has been the recipient of mental health services from the public mental health system” (primary consumer). The term “secondary consumer” is not utilized. Instead for clarity, the term “family member” will be used rather than “secondary consumer” when referring to the family members of consumers.

Changing Mental Health Policy and Environment Since 1950

The above developments regarding consumer empowerment have coincided with a changing philosophy and approach to mental health service provision in the United States since the 1950s. As the original 19th century movement toward institutionalization of the chronically mentally ill was a move of compassion meant to improve quality of life and provide better treatment (Lamb, 1994) so too, was the advent of deinstitutionalization beginning in the 1950s. Made possible by the development of psychopharmacological medications which greatly reduced the risk of psychotic relapse and rehospitalization, individuals with no hope of living outside of an institution began to be discharged from

massive state hospitals to receive care in local communities (Davis, 1975).

The deinstitutionalization of the chronically mentally ill led in 1963 to the Community Mental Health Centers Act. This act was to provide for the care of chronically mentally ill persons within their communities. In spite of expenditures for the chronically mentally ill within local communities, the needs of those discharged from hospitals were not adequately met. Communities faced the prospect of increased fiscal and service burdens while observing increasing numbers of homeless mentally ill and further strains on established institutions such as schools who found themselves addressing the needs of severely emotionally disturbed children (Havel, 1992).

Accompanying the shift in the location of treatment for chronically mentally ill persons was also a shift in philosophy that continues through the present. The psychiatric rehabilitation philosophy shifted the focus from a pathology paradigm to a focus of working with the well part of the person from a strengths based approach. This model attempts to strike a balance between too little social stimulation and demand, and too much. The emphasis is on developing within the mentally ill person a sense of mastery over their lives and internal drives (Lamb, 1994). Inherent in this philosophy of developing mastery and self direction, is the assumption that the consumer has a voice in the determination of treatment directions. This philosophy of 'self-determination' was formalized in 1984 as a guiding principle within the Community Support Program (CSP) of National Institute of Mental Health (NIMH). NIMH had started the CSP in 1977 as a response to the problems that had developed out of the inadequately planned deinstitutionalization of the previous decade (McLean, 1995).

One further significant development in the mental health arena has been the explosion of costs to the public system and the accompanying efforts at fiscal control through the migration of mental health services to managed care models (DeLeon, VandenBos, & Bulatao, 1991; Kerrey & Hofschire, 1993). Managed care organizations have been observed to inherently present three key problems closely related to the original reasons for the development of advocacy groups. The first issue is obtaining access. Managed care gatekeepers determine who will receive services and what types of services will be accessed. Often the gatekeeper is not the primary care provider. Quality is the second issue. Problems develop in this area due to the determination of what is 'medically' necessary and lack of a range of services within one managed care organization. Consumer-provider awareness, the third issue, is related to the lack of consumer knowledge and a failure to communicate fully by providers what established 'best practice' options are and what is available to the consumer (DeLeon, VandenBos, & Bulatao, 1991). In an environment where such issues exist there is a continuing incentive for advocacy groups to be engaged with the mental health system.

Development of Advocacy and Self Help Organizations

Concurrent with, and predating the development of the consumer movement mentioned above, has been the advent of self help/advocacy organizations comprised primarily of family members of the mentally ill (Battaglino, 1987; Hatfield, 1981; Pfeiffer & Mostek, 1991; Sommer, 1990). Among others the National Mental Health Association and the National Alliance for the Mentally Ill were groups that lobbied for expanded services and more humane treatment of individuals with chronic mental illness.

They also developed local support groups and other services at local levels to address the immediate needs of their constituencies (Havel, 1992). These groups grew in strength with the advent of deinstitutionalization. Also coinciding with the above developments, consumers have independently become involved in the development of consumer run alternative mental health services and self help groups (Emerick, 1989; Stephens & Belisle, 1993). Both family member and consumer organizations have developed largely in response to unmet needs and expectations, and unsatisfactory experiences that have been encountered while interacting with the mental health system.

One of the original models of consumer run alternatives was the Fountain House model of New York. Fountain House, originally known as WANA (We Are Not Alone), was founded as a self help group in Rockland State Hospital by several patients in the late 1940s. Continuing to meet as a group in New York following discharge, the group continued to operate independently of professionals for a time. Beginning with the help of some volunteer workers, the model became increasingly involved with mental health professionals until by the early 1950s it was dominated by professionals in primary decision making roles (Chamberlin, 1978). This particular model has been widely imitated as a club house, day treatment support model. However, with the involvement of professional staff, this program departed from one that is exclusively controlled by consumer - ex-patient members (Beard, Propst, Malamud, 1982; Chamberlin, 1978).

Finally, due to changing philosophy within the mental health system and arising from pressure from family and consumer groups, there is growing recognition that consumers are in a position to inform care givers as to the efficacy, desirability and

impact of the services they receive (Carscaddon, George, & Wells, 1990; Polcin, 1990).

To enhance the impact of consumers on the mental health system, recommendations have been made in national literature for the inclusion of consumers on governing boards (Colom, 1981; Michael, 1985; Pinto & Fiester, 1979; Polcin, 1990; Tower, 1994).

Advent of Offices of Consumer Affairs

A logical extension of this changing philosophy of treatment and resulting strengths based, empowerment approach to consumers has been the development of offices of consumer affairs at state level mental health departments. The Alabama Department of Mental Health, Office of Consumer and Ex-Patient Affairs created in 1990 was the first in the United States. The idea for the creation of the Alabama office was credited by the originators to be the result of lobbying for consumer representation from family advocacy groups and a receptive director of Mental Health. The specifics of the creation were traced to a national conference and a discussion between a provider, Emmit Poundstone, the Alabama Associate Commissioner for Mental Illness, Rogene Parris, an advocate group member, and Joel Slack, a consumer who was running a human service evaluation consulting company in Georgia. Joel Slack was hired as a consultant to provide input to the Alabama Mental Health Department and the idea for the first management level consumer representative was created. Joel Slack applied for the position and was hired.

All of the above developments have been antecedents to the creation of offices of consumer affairs across the nation.

Local State Background

State developments have reflected the above national trends. Accompanying

deinstitutionalization, patients have been becoming known as consumers. Consumers have been running some mental health services. Consumers and family members have been increasing participation on mental health boards. The family advocate movement in the state has been developing and there have been trends toward organized consumer advocacy groups as well.

In 1989 Washington State implemented a mental health reform act designed, in part, to streamline and strengthen services to the chronically mentally ill adult population (WA, PL 5400) (Brown, Thomas, Allen & Gilchrist, 1994). One core philosophy has been the empowerment of individual clients to take further control of their lives and to provide increased input into the state mental health system. This has included the seating of consumer representatives on the state mental health advisory board, requirements for consumers to be represented on Regional Support Network (RSN) boards, and boards for lower service levels. (RSNs are the administrative organizations for regional/county level services. Contracting directly with the state they distribute money to local providers).

Coinciding with the legislative mandates, the Washington State Mental Health Division has also been engaged in additional efforts to promote consumer concerns within the system and around the state. Efforts to develop consumer networks and family advocacy groups have met with some success. Currently at least three groups exist: 1) the Alliance for the Mentally Ill (AMI), 2) the Washington Alliance for the Mentally Ill (WAMI), and 3) the Washington Education - Consumer Action Network (WE-CAN). Both AMI and WAMI are family advocacy groups that include consumer support groups among their activities. Both groups are controlled and run by family members. WE-

CAN is a state wide alliance of mental health consumers that was developed and governed by consumers. This organization has been functioning with limited activities.

In Washington there has been friction and competition between family groups and consumer groups, as well as, among various family groups. Similar friction between client and family interests has been documented to exist nationally (Sommer, 1990). Finally, the Washington movement resulted in consumer led and operated mental health services and businesses. Various consumer run support groups exist. There have also been three consumer run club houses in the state.

Office of Consumer Affairs

History. The Consumer Family Partnership Grant received in 1991 from the National Institute of Mental Health was developed by one primary author with the assistance of other Mental Health Division staff, and in consultation with consumers and family advocacy group members. Implementation of the three year, \$430,000.00 grant, began in the summer of 1992 and the project was fully staffed by that October. The primary grant focus was the establishment of the Mental Health Division Office of Consumer Affairs (originally referred to as the Consumer Affairs Office).

When investigating the genesis of offices of consumer affairs, it became apparent that the idea developed simultaneously across the country in a move that was largely independent of the federal government. Interviews with key persons among the family movement, providers, and consumers reveal roots for the Washington State office in the family advocacy and early consumer movements. These developments were also encouraged by individuals within the provider system at regional and state level

bureaucracies. Discussions relating to incorporating consumer representation into local and regional service providing agencies and at the state level were taking place between family advocates and providers as early as the mid 1980's. Cross fertilization of ideas was also taking place at national conferences. Stakeholders recalled in interviews discussions at national conferences regarding the need for representation of consumers in the decision making process of all levels of mental health services.

Environmental Context. The environment in which the OCA was created was one of change. Within the first year the Mental Health Division was engaged in Administrative Code revisions and by the third year the state mental health system was also undergoing a transition to managed care at the RSN level. Combined with shifts in practice, the Mental Health Division staff experienced ongoing staff level reductions, three changes in director, internal reorganization and persistent demands on staff time from the redistribution of the duties of those no longer with the division. The changes in administrative code and the movement to managed care, which required the development and approval of a federal Medicaid waiver, generated ongoing external pressure from providers, consumers, and family members.

Purpose. Consumer and Family Partnership Grant purposes were three fold:

- 1) place a voice for consumers in the day to day operation of the Mental Health Division;
- 2) promote communication, coalition building, and advocacy efforts around the state among consumers and promote mutual respect, understanding and cooperation between consumer and family groups, and 3) promote the placement of a consumer voice and representation at all levels of the state mental health system. The ultimate end goal was

that consumers and family members, working cooperatively with each other in state-wide coalitions, would have a positive impact upon the responsiveness of the mental health service system and its informed ability to meet consumer needs.

Spheres of Activity. Under the tenure of the NIMH funded grant, three general spheres of activity were established to accomplish the above goals. The first activity was the **establishment of a state Office of Consumer Affairs (OCA) within the MHD.** The OCA has been staffed by as many as four full time and part time grant funded employees and is located in the MHD offices in the state capital. The office was responsible under the grant for establishing, among other things, a 1-800 communication line, a computer bulletin board system, a technical assistance library, the development of video newsletters, and the provision of technical assistance to consumers and family groups around the state.

The second sphere of activity was the **establishment and training of an Ad-Hoc Consumer Affairs Advisory Committee (AHCAC).** The intent of this committee was to establish an organized state wide consumer leadership network and advocacy system within the mental health consumer community. It was also meant to impact local communities through projects initiated by AHCAC members. The AHCAC has been comprised of a group of about 15 consumers who have achieved some level of independence and advocacy activity levels at the local level. Members gathered together from around the state for a two day training and networking meeting every other month throughout the life of the grant beginning in the spring of 1993. In addition to receiving training designed to enhance their effectiveness as networkers and advocates in their local

communities, the MHD has utilized this group as a forum for consumers to provide policy input. Recently, the name of the AHCAC has been changed to the 'Consumer Sub-Committee of the Mental Health Division Advisory Board'. In this document it is referred to exclusively as the AHCAC. The OCA and the AHCAC have been the center of focus for the evaluation with the primary attention being given to the OCA.

OCA's final sphere of activity was to contract with each of the two state family advocacy groups (AMI and WAMI) for projects meant to promote positive mental health services around the state. Proposed projects have been, to one extent or another, developed in conjunction with and endorsed by consumers. The projects were to be planned and carried out in cooperation with consumers. As part of their contract, each family advocacy group was responsible for evaluating their own project. These evaluations were to be turned in directly to the OCA.

OCA Program Evaluation

Funding and Auspices

Limited funds were included within the NIMH Consumer and Family Partnership Grant to provide for an evaluation of OCA activities. Under the auspices of the MHD, a contract was let to this author for an independent program evaluation of the OCA. The NIMH stipulated that this evaluation focus primarily on outcomes questions. The writers of the grant also wished that the evaluation give some attention to the process of development. This dissertation is part of the overall contracted evaluation and primarily reports the results of the stakeholder survey component.

General OCA Evaluation Plan

As mentioned earlier, the overall program evaluation plan called for the use of triangulation techniques. Triangulation seeks pertinent information through multiple sources or streams (Greene & McClintock, 1985; Kimchi, Polivka, & Stevenson, 1991; Mitchell, 1986; Morse, 1991; Murphy 1989). Data collection was planned to come from documents/records, participant observation, ongoing key stakeholder interviews, and a comprehensive stakeholder survey. The following briefly describes the types of data actually collected. Archival data were planned to be collected, from among other sources: tracking of 1-800 calls, requests for technical assistance, computer bulletin board communication, and the collection of staff meeting minutes. In this stream, the actual archival data produced was very limited due to incomplete record keeping on the part of the OCA. Information was also collected through key stakeholder interviews with key persons throughout the three year life of the grant. Participant observation was planned throughout the evaluation, but primarily occurred during the first two and one half years. This participation took place through OCA staff and AHCAC meeting attendance, working with staff in planning, data base development and computer acquisition consultation. The above data streams combined with wide ranging interviews with advocates, consumers, and providers served as the groundwork for a formal stakeholder survey that forms the larger part of this dissertation. Taken together this information provides insight into the impact that the OCA and the AHCAC have had upon state wide communication, organization, and advocacy efforts of consumers and family members.

The overall OCA evaluation, incorporating the above mentioned data streams, has

also utilized methods providing for ongoing feedback to the OCA and MHD over the course of the evaluation (Patton, 1986). This open exchange of information has allowed for mid-course adjustments in OCA activities, and in the evaluation. This approach also insures maximum usability of research products.

Dissertation Research Purpose

This dissertation provides a general assessment of stakeholder knowledge and views regarding the activities of the Washington State Mental Health Division Office of Consumer Affairs and the Ad Hoc Consumer Affairs Advisory Committee. The study is timely and necessary for three reasons: 1) the newness of the Washington State Office of Consumer Affairs and other similar offices, 2) the OCA goal to be responsive to its constituency and, 3) the need to develop appropriate questions for further research.

Timeliness

When the dissertation proposal was written, the Consumer and Family Partnership Grant had entered the two thirds point of its three year life. OCA staff had been employed effective 10/92 and multiple activities had been undertaken. Preliminary data from various consumers, providers and family members indicated a general lack of knowledge and mixed opinions regarding the OCA, the AHCAC, and their activities.

While still relatively new, the OCA was three years old when primary stakeholder survey data collection was carried out. The primary months for conducting interviews for this study were from late August through December of 1995. These interviews update and expand information already available through preliminary reports based on data

gathering from other aspects of the triangulation method described earlier. Findings also provide some insight as to the levels of knowledge found among stakeholders and describe differences between stakeholder groups regarding controversial issues such as the role of the OCA in direct consumer advocacy.

Responsiveness

At the end of the grant life, in October 1995, a decision was made to continue the Office of Consumer Affairs in a limited capacity with state money. Consistent with the program evaluation utilization theory described by Patton (1986), comprehensive feedback to the project continues to be needed as course corrections and continuation decisions continue to be made. This dissertation meets two needs in the area of continuing feedback to the OCA. The first need is to use stakeholder opinions and levels of knowledge to assess what impact the efforts of the OCA and AHCAC are having around the state. The second need (based on the OCA and AHCAC expressed goal to be responsive to consumers) is to assess different stakeholder views as to the most desirable and useful aspect of OCA and AHCAC activities.

On the national level, there remains a widespread lack of information relating to the impact that similar offices of consumer affairs are having upon their constituencies and how such offices fit into efforts to empower consumers. This feedback will be important at the national level by enlightening efforts to strengthen the mental health consumer empowerment movement and enhance research efforts in the same area.

Foundation for Further Research

Due to the formative nature of research with respect to mental health consumer

affairs offices, empirical knowledge of emergent issues is needed. Researchers and policy makers lack even basic information as to appropriate program-specific questions for policy making and research. The organized descriptive information presented here on differences, similarities, range of stakeholder views, and existence of controversies will help meet this need and provide the basis for broader, more representative research at both state and national levels. The information presented herein will also allow for some initial conclusions about how close a mental health division office of consumer affairs can come to meeting its goal of empowering consumers.

Research Questions

The following are the general research questions that will address the research and informational needs previously outlined:

- I. What are the views of different stakeholder groups with respect to Office of Consumer Affairs and Ad-Hoc Consumer Affairs Advisory Committee activities? What is the range of opinion? Are there differences or similarities between groups?
- II. What do different stakeholder groups view to be the most appropriate and useful roles for the AHCAC and OCA? What is the range of opinion? How do these views fit with actual activities of the OCA?
- III. After nearly three years of operation, what level of awareness exists regarding the activities of the OCA and AHCAC within the key stakeholder groups of the State Mental Health System? How widespread and how extensive is this knowledge?

CHAPTER II

RESEARCH DESIGN

The goal of this dissertation has been to provide a general assessment of stakeholder knowledge and views regarding the Washington State Office of Consumer Affairs and its activities. The primary method utilized in this research incorporated qualitative and quantitative question formats into individual stakeholder interviews.

To accomplish the dissertation goal, two major challenges impacting research design for the entire evaluation of the Office of Consumer Affairs had to be overcome. The first challenge related to the newness of the OCA and the national movement. Newness resulted in a lack of previous research upon which to base evaluation questions. The second challenge related to the credibility of evaluation findings with stakeholder groups not sophisticated in research methods or processes. The stakeholder survey presented in this dissertation study was designed to address these two key challenges. It was also, in part, a solution to the above challenges faced by the overall evaluation.

Chapter two details the solutions utilized to address the challenges of newness and credibility and describes the place of the stakeholder survey in the solution. Overall, the program evaluation dealt with the issues in two phases. Phase I included idea gathering activities that led to, and included survey instrument construction. The data streams that were incorporated in phase I were described earlier on page 15 under the heading "General Program Evaluation Plan". Briefly, information sources were as follows: data that originated from record gathering, including meeting minutes, reports, letters, 1-800 phone call records, computer bulletin board system records and others. Ongoing

interviews with key stakeholders and numbers of consumers, providers, and advocacy group members were also utilized in generating ideas during Phase I. Participant observation activities were included. Some of this data from Phase I will be reported and used in interpreting the results of the comprehensive stakeholder survey that is described in the following material. Phase II constituted the process of full sample interviewing for the comprehensive stakeholder survey previously mentioned.

Included here in the second chapter is a description of the comprehensive stakeholder survey design and the program evaluation theory that underlies the method developed for this study. Beginning with a discussion of the research issues, both phases of the research process are described. Also provided is a listing of stakeholder groups selected for interview. Interviewer selection and training is described. The method of gaining access to stakeholders and confidentiality procedures are subsequently detailed. A description of the data processing method follows. The sampling plan, because of its complicated nature, follows in chapter three. Serving as a segue into further data analysis, chapter three, on sampling, presents the original sampling plan for stakeholder groups. This plan is described, discussed, and compared with the resulting details of actual stakeholder group samples.

Research Issues

The new, unresearched nature of the OCA and the national phenomenon presented its own set of issues. In these issues the first major research methods challenge was found. Gathering information to accurately assess consumer views where there is little

previous research and a potentially wide range of stakeholder positions necessitated an exploratory methodological approach. There were no pre-existing evaluation tools that provided easy access to consumer opinions about key issues. To develop a useful new evaluation tool, this dissertation study combined program evaluation methods proposed by Guba and Lincoln (1989), and Patton (1986). Elements of both methodologies were helpful in addressing the problems associated with this unresearched area. The relevant points of these theorists will be discussed shortly.

The second major methods challenge arose from the political realities of the Washington State Mental Health Division and its stakeholder environment. To maintain credibility, the evaluation needed to provide the resulting findings in a believable manner to non-statistically sophisticated research consumers. During evaluation planning with MHD stakeholders, it became apparent that standard statistically derived methods of sampling would not be adequate to establish the credibility of findings with key MHD staff and other stakeholders. MHD staff comments about a recent experience with another evaluation of local mental health services raised concerns related to sampling issues.

The issue of concern was the sample size. In the previous evaluation, the methods used to obtain information from consumers were considered by the academic community to be scientifically valid. However, they were not similarly credited by the MHD decision makers. This lack of confidence was due to what was perceived by MHD staff to be sample sizes too small to be truly representative of the whole population of consumers. Clearly, to achieve credibility with these same stakeholders this issue needed

to be addressed in the present evaluation effort. The program evaluation methods of Guba and Lincoln (1989) and Patton (1986) were of assistance in addressing the problems presented by both of the above issues.

Incorporated Method Theories

The primary focus of Guba and Lincoln (1989) is the use of the “Hermeneutic Dialectic Circle” (1989, p.174). This circle emphasizes a process oriented method of evaluation that places importance on including all points of view related to an issue. The method is achieved through a series of chain interviews that asks the opinion of a stakeholder and then also asks them who they know would disagree with their point of view. The person who disagrees is then interviewed and the process is repeated.

Guba and Lincoln (1989, pp. 174-176) outline their “methodology of constructivist inquiry” by making four points. First, the study must be pursued in a natural setting. It is recognized that the viewpoints of different individuals stem from and are dependent on the “time and context” of the person who holds the viewpoint. Second, the constructionist evaluator is not willing to assume that he/she knows enough about different individual contexts in the beginning of the study to accurately frame the most appropriate questions to ask. This calls for a flexible instrument that allows relevant constructs to assert themselves. The third point places the emphasis for information gathering on the qualitative side of inquiry. While not ruling out quantitative methods, the authors point out that methods “that come most readily to hand...are, clearly, qualitative” (p. 175). The fourth, final, point is that the “constructivist insists on the right to incorporate and use tacit knowledge”. This knowledge may be best understood as a

researchers 'sixth sense' or intuition about what is going on.

Patton (1986) focuses on providing program evaluation that is utilized by stakeholders for decision making. Three points are made, relevant to this study, that overlap in their practical implications for evaluation with the points made by Guba and Lincoln (1989). The first point is that stakeholders know best what questions to ask. When doing an evaluation, Patton recommends that a range of stakeholders be engaged closely with the evaluator in developing research questions. This point parallels both the first and second elements of Guba and Lincoln's (1989) method. The second point made by Patton (1986) is that for findings to be utilized the evaluator must identify and incorporate stakeholders in the development of the evaluation. A third point, is that to attain maximum utilization of an evaluation continuing feedback loops need to be built into the process. This feedback facilitates ongoing program adjustments by stakeholders. This last point finds parallels in the negotiating process of Guba and Lincoln and their Hermeneutic Dialectic process.

Research Issues Concluded

To be successful, this evaluation needed to overcome the methods barriers presented by both the general lack of knowledge of appropriate issues to address with stakeholders, and the need to establish a broad enough range and size of sampling to achieve credibility with MHD staff and other influential stakeholders. To be useful, it was necessary that this staff be convinced that the assessment of stakeholder views was indeed representative across a wide array of interested - or potentially interested - groups. This required both breadth and depth of sampling. Individually these two problems are

easily solvable. Taken together these issues presented major methods difficulties because of the time and financial resources which needed to be committed. Elements of both Guba and Lincoln (1989) and Patton (1986) were incorporated into the solution developed for this dissertation study.

The first problem, lack of knowledge, would easily be solvable by using an open ended qualitative interview that allowed subjects to easily state any thoughts or concerns they may have. The problem presented is that this traditional qualitative approach does not lend itself well to implementation within the larger sample size needed to gain credibility with MHD. The second issue, representativeness, is also easily solvable by using a quantitatively based survey instrument with large numbers of people. This method, however, would not lend itself to achieving credibility in the face of concerns that such a quantitative instrument would limit and prematurely focus stakeholders in their range of answers.

Both Guba and Lincoln (1989) and Patton (1986) allow for qualitative and quantitative data collection as defined by Strauss and Corbin (1990). By utilizing both types of measurement, random subject selection and “snowball²” techniques (similar to the Hermeneutic Dialectic) and by utilizing stakeholders in the identification of issues and questions for the survey instrument, the evaluation was able to establish the range of stakeholder views and determine the experiences of larger numbers of individuals. The

² “Snowball” refers to the practice of building a series of interviews based upon the referrals of people already interviewed. This referral may take the form of a name given by an interview subject or may come from deduction based upon other information presented in the interview.

combined approach used for this study made it possible to obtain greater depth and breadth of information than if only one of the above methods was employed.

Phase I: Idea Gathering and Instrument Construction

The development of appropriate questions and the selection of appropriate stakeholder groups for survey inclusion was a primary issue in constructing the stakeholder survey. This was complicated by the lack of previous research outlining issues. Relying on the wisdom of both evaluation methods theorists, (Guba and Lincoln, 1989; Patton, 1986) stakeholders were closely engaged in the development of survey questions.

A continuing primary concern, for reasons outlined in the theories above, was that stakeholders have a “voice” in shaping questions and determining those who should be surveyed. To insure that stakeholders had direct involvement in the formulation of the survey instrument, specific requests were made of OCA staff, MHD staff, and other stakeholders in the consumer and family advocacy groups for information regarding issues and specific questions to be asked in the stakeholder survey. These persons were also asked for input as to appropriate groups to include in the survey. A side benefit of this method of stakeholder involvement was that it helped generate ongoing interest on the part of key stakeholders. This interest increases the likelihood that evaluation results will be utilized. Combining this information as to stakeholder issues with data from the other facets of the overall evaluation, including the ongoing non-random key stakeholder interviews, a series of questions were developed that covered the concerns and

informational needs of the different stakeholders. Also stakeholder groups were selected for interview with this input serving in advisement.

To further address the first challenge of the general lack of research in this area, an interview format was selected that combined both qualitative and quantitative questions. Subject age, educational status, stakeholder group affiliation, importance of OCA mission and 'should the office of consumer affairs be closed?' are examples of categorical/quantitative questions that were asked. Where appropriate, qualitative questions accompanied related quantitative questions. Two examples of qualitative questions are; "How was your job impacted by the work of the Office of Consumer Affairs?" and, "What is your evaluation of the training you received as a member of the AHCAC?"

Paired open and closed-ended questions alternated throughout the interview in that order. Open, qualitative, questions were used for two reasons. The first reason for using open questions, mentioned previously, is lack of enough knowledge of expected responses. This prevented good close-ended, quantitative question design. Asking open questions allowed for the researcher to obtain fuller responses, thus shedding light on a broader range of issues than would have been otherwise possible. Secondly by keeping pre-formulated closed ended response patterns to a minimum and in a secondary position to open questions, respondents' open ended responses were not shaped by pre-structuring of their thinking by hinting at possible researcher thinking throughout the questionnaire.

The interviews were structured to take less than one hour. Within the hour, interviewers were able to provide follow up questions to pursue points and allow for

elaboration. The use of closed questions allowed for quick sample description and a few overall measures (quantitative in nature) of stakeholder opinion and knowledge. The use of qualitative methods prevented a narrow focus from developing that would have limited stakeholder input.

To address the issue of sample size credibility, an overall targeted sample size of 350 individual stakeholders was selected to adequately cover the base of stakeholder groups and subgroups that had been identified for survey. In this case, the use of qualitative questions with the large number of stakeholders ultimately interviewed also produced large amounts of data. The volume of this material presented analysis problems which are discussed in the data analysis section.

Interviews with stakeholders from dissimilar groups necessitated different and additional questions. General knowledge of OCA and AHCAC activities were assessed for all stakeholder groups. Groups such as computer bulletin board system users were provided with specific questions that were not relevant to others who were not computer bulletin board system users. Likewise Regional Support Network administrative staff and Mental Health Division staff were asked questions relevant to their positions that consumers who were receiving day treatment services would have found meaningless. Interview schedules for all groups contained a core set of questions that were supplemented by questions relevant to each specific stakeholder group. Interview schedules are included in appendix A.

Five initial research interviewers recruited for this study were enlisted in instrument testing. Revisions were made based on role play interviews and also initial test

interviews with actual stakeholders. Following both role play and stakeholder phases of testing, the group met to discuss problems with the survey instrument and any logistical difficulties that were encountered. Based on this input, questionnaires and interview procedures were altered as necessary. These revisions were submitted to the DSHS Human Subjects Review Committee and were part of the final approval process (appendix A). All stakeholder test interviews produced valuable data that were equivalent to other interviews conducted later by the group. These interviews were included as part of the data set.

Groups

As stated above, one key survey goal was to achieve overall stakeholder population representation. To do so, it was necessary to insure that members of the key OCA stakeholder groups be included in any sampling plan devised. The full range of stakeholder groups was first identified. Briefly, the range covered three primary general categories of stakeholders: consumers, family members, and providers. These groups needed further division to insure the intended representativeness. Using input from a variety of sources, including MHD staff, consumers, and other key informants, the following 14 stakeholder subgroups were identified: 1) Consumers from day treatment programs, consumer run club houses and the advocacy groups AMI, WAMI, and WE-CAN; 2) line staff from the day treatment programs; 3) administrators within the mental health system; 4) board members from mental health service providing agencies; 5) Regional Support Network (RSN) staff members and administrators; 6) RSN board members; 7) Policy and program level Mental Health Division staff; 8) family members

from AMI and WAMI; 9) consumer members of the AHCAC; 10) users of the 1-800 phone line; and 11) users of the computer bulletin board system. The plan also called for the inclusion of the leadership of 12) CAMIO (Community Action for Mentally Ill Offenders), and 13) RSN board members. Finally after interviews had already commenced, the (14) MHD advisory board was added as a stakeholder group at the request of the MHD. Every sample taken attempted to achieve representativeness through random selection or by inclusion of the total group population, as with the AHCAC.

An explanation of the rationale for the selection of mental health consumers is in order. Random samples of chronically mentally ill consumer stakeholders were selected from the attendance of four randomly selected day treatment programs, the three consumer run clubhouses within the state, and the advocacy groups: AMI, WAMI, and WE-CAN. This method of selection was chosen to insure access to those who would be considered to be the primary target population of the Office of Consumer Affairs. "Worried well", as less severe clients are often referred to in mental health centers, were intentionally excluded by this method. The goal of the OCA is to serve both populations, however, the emphasis is decidedly on the former.

Regional and Vertical Sampling

In addition to the stakeholder groups outlined above, two other factors were included in the sampling stratagem. Stakeholder representation from different state regions was targeted, as was representation of the vertical mental health system bureaucratic hierarchy linked to each of the day treatment programs selected.

To achieve the above two goals, two urban and two rural day treatment programs were selected from the group of agencies providing adult day treatment services in the state. One rural and one urban program was located in each of Washington's eastern and western regions. Line staff, administrators, agency board members, RSN staff/administrators and RSN board members were interviewed from the vertical administrative levels linked to each of the four selected day treatment programs. To complete the vertical nature of the sampling process, Community Support staff from the Mental Health Division, MHD administrators and others within the Washington State Mental Health Division who work with RSNs and local agencies were also interviewed.

Candidate day treatment programs were selected with the assistance of MHD staff. Staff help was elicited to identify those agencies with programs sufficiently large enough to have adequate numbers of consumers attending. With this information, and including the east-west, rural-urban criteria outlined above, a random selection was made.

Phase II: Full Sample Interviewing

Interview Session Format

Consumers attending day treatment programs and consumer run clubhouses, line staff, on site program administrators, and several MHD staff were interviewed face to face by a research assistant or the researcher. For the vast majority of the remaining interviews, telephone interviews were arranged. Face to face interviews were recorded by hand on an interview schedule/questionnaire (appendix A) and also audio taped. Telephone interviews were recorded by hand but not audio taped.

A visual stop signal was arranged with the subject prior to taping a face to face interview. This signal allowed an interviewee to indicate that they would like to say something that they did not want recorded. This procedure allowed a subject the freedom to provide further information for hand recording that they did not want taped. The vast majority of subjects consented to interview with the audio tape recording their comments. In general subjects were also very interested and verbal. Rarely did a subject request that a tape not be used or that it be shut off during an interview. Although no formal frequency data on such stoppages were recorded, this happened only 1 or 2 times in the entire process. There was also no apparent relationship between knowledge of the office and consent to be taped. Those most uncomfortable with the tape were consumers.

An interviewer brought to an interview the applicable stakeholder schedule containing both qualitative and quantitative/categorical questions (see appendix A). All subject responses for all interviews were recorded by hand on the schedule. Interviewers placed a star by written responses that they felt merited the transcribing of the audio recording. Rarely did an interviewer record these stars on a schedule. Each schedule was printed on one-sided copy to provide adequate room to record a stakeholder's response in its entirety. After listening to a sample of the audio taped interviews following the survey sessions, it was discovered that the hand written format of data recording was more than adequate to accurately record the general message that was being conveyed by the stakeholders. It was decided to not transcribe the tapes and to rely only on the hand written record that was created during each interview because of the accuracy of hand recording, the few recorded stars, and the expense involved in transcribing. This method

was able to sufficiently identify the major interview themes, which was the goal of analysis.

Interviewer Recruiting and Training

A core group of five interviewers was identified including the author. This group of five conducted 324 of 345 interviews. Six others were also involved in interviewing. Between them, these six individuals interviewed 21 stakeholders. Scheduling problems and illness caused some interviewee turnover and unavailability.

All interviewers were hired through the academic, personal and professional associations of the author. None had prior knowledge of the Office of Consumer Affairs or issues/controversies stemming from its existence. This selection process differed from the research plan which called for advertisement through consumer and family networks as well as local colleges. The decision to recruit only those not associated with the consumer movement or mental health system was made because of developing controversies concerning the OCA. Not including stakeholders as interviewers in the research process was meant to help maintain the integrity and credibility of survey findings. None of the interviewers was associated with the mental health system in Washington. All fit the qualification of being neutral. None had any apparent agenda from a particular stakeholder group.

Interviewers were selected based upon their training and observed skills (verbal and written communication skills) in an interview setting. Part of the selection process included the training described below and required a demonstrated ability to adequately complete a practice interview schedule. All but one interviewer had a B.A. or higher.

The other was an upper division college student. All were trained in human/social interaction disciplines.

The training received by each interviewer focused on a careful review of the interview schedule and a brief introduction to the mental health system, including background on the stakeholder groups that would be interviewed. Specific training in the meaning of acronyms that might be encountered such as RSN, MHP (Mental Health Professional), etc. was also provided. Role play practice interviews followed for all. Initial training lasted approximately four hours. Each interviewer also engaged in home study of the research instrument prior to stakeholder interviews. Finally, as a last phase of training, each interviewer conducted practice interviews with two subjects.

One key feature of the interviewer training that developed out of initial interviews was the specific instruction received by interviewers to claim neutrality and lack of knowledge in the face of detailed questions from interview subjects about the OCA or AHCAC. It was quickly apparent that neutrality and ignorance on the part of the interviewer would be advantageous to the integrity of the research. In the face of the wide scale lack of knowledge encountered by interviewers, neutrality and the lack of detailed editorial material from the interviewer allowed the team to accurately measure without influencing the opinions of subjects beyond whatever shaping occurred as a consequence of the interview schedule itself.

As discussed in the research plan, the core group of interviewers and the researcher worked together to identify how many additional research assistants were needed to complete interviews in a timely manner. These persons (comprising the remainder of the

11 interviewers previously mentioned) were recruited and trained in the same fashion as described above.

Each interviewer was paid \$5.00 for an interview lasting 30 minutes or less.

Interviews lasting longer than 30 minutes were paid at the rate of \$10.00. Miscellaneous expenses such as phone bills and photo copies were paid. Time for making phone calls, tracking down phone numbers, and other research related activities were reimbursed at the rate of \$10.00 per hour. Compensation was made after interviews were completed, handed in to the researcher, and completeness verified.

Agency Entry, Stakeholder Access, Consent

RSN's and provider agencies were contacted through the auspices of the MHD. Permission to interview clients, staff, or organization members was secured from the executive director of each agency and organization. At the request of the WAMI executive director, the researcher made a presentation concerning the proposed research to the board of directors. For all others, a conversation with the Executive Director and letter verification from the MHD was adequate.

Prior notification of all stakeholders who were candidates for possible interview was required by the Washington DSHS Human Subjects Review Committee. To meet this requirement, agency administrators posted announcements in advance of a site visit and also made announcements in client meetings and staff meetings. Memos were also used to notify staff. Some boards were notified in advance through a memo from the agency administrator, others were notified through a board meeting announcement. The membership of WAMI and WECAN were notified through each group's newsletter. The

sample of AMI members were notified through a letter from their Executive Director. MHD staff were notified by e-mail from the director.

Announcements provided a brief description of the evaluation and emphasized the voluntary nature of the interview. Examples of a letter from the Mental Health Division, a memo to an agency board, and the text of a staff/client meeting announcement are included in appendixes B, C, and D respectively.

On the day of an agency site visit, another announcement was made to both staff and consumers. Consumers randomly selected from those in attendance were individually asked for an interview by a program staff member. Those expressing interest were then introduced to the interviewer and another informed consent was reviewed by the interviewer with the stakeholder. Staff members randomly selected were asked in advance by the program administrator. Protocol examples are included in appendix D.

Day treatment and consumer run club house members were all contacted at their agency site. Most members of other stakeholder groups were contacted using the phone. For phone contacts, the interviewer contacted those selected. Once contacted, informed consent was reviewed with the individual over the phone.

To contact persons who had used the 1-800 number of the OCA, the Washington DSHS Human Subjects Committee required initial contact to be made by a person from the OCA. In this case, only the names of persons providing advance consent were provided to the researcher. The protocol for contact by the OCA staff member is included in appendix E. Once the name of the 1-800 phone line using stakeholder was received, they were contacted by an interviewer and the informed consent was reviewed.

Further details related to this contact procedure are provided in the discussion of samples.

AHCAC members were also notified of the intent to interview in advance during an AHCAC meeting. Finally, persons using the Computer BBS were notified in advance through a posting on the board. The informed consent format used for phone interviews is included in appendix F.

Confidentiality Procedures

A possibility existed that individual interview subjects would be inadvertently selected more than once. While there was some overlap between lists of consumer members of family groups and between these groups and the AHCAC, the overlap was relatively minor. In the nomination process there were multiple nominations to interview the same persons. Many people who were nominated were also persons who had already been sampled or identified for interview through the random or population sample process. To prevent persons from being contacted for interview multiple times, while also addressing confidentiality concerns, the following procedures were utilized:

1. Each questionnaire was numbered and coded with the date, interviewer, number of interview for the day, agency, and stakeholder group. This made each questionnaire individually identifiable. The name of the stakeholder was not recorded on the interview schedule. Audio tapes of interviews also have the date, the interviewer, and interview number recorded on the tape.
2. Each interviewer maintained a separate tally sheet for each day they conducted interviews. On the tally sheet, names of interviewed stakeholders were listed and numbered consecutively in the order conducted. The name of the stakeholder group

was also entered on the tally sheet. This tally sheet information corresponded to the number and information recorded on the survey instrument.

3. Each interview began with a reassurance of the voluntary nature of the process and of confidentiality (see appendix G for informed consent). In addition, the interviewee was asked if they had already been interviewed by a member of the OCA evaluation team. If the response to this question was affirmative, the interview was discontinued.

4. As sets of interviews were completed, the questionnaires, audio tapes, and code sheets were turned in. No interviewer kept copies. When the code sheets were received, the researcher cross-checked names against those of others already interviewed to insure there were no duplicates. The plan for duplicate interviews conducted by mistake from specific targeted populations was to use all information collected from all questionnaires for the subject so that all stakeholder group specific questions were completed. If a duplicate was found between a random sample and a population, the population questionnaire was to be chosen. For duplicate interviews in random samples, the earliest interview was to be kept.

5. In the event duplicate interviews were found in random samples, additional interviews were to be collected on a random basis at the respective interview sites or from the respective population or sample list.

6. As of this point in the research process, all interviews and questionnaires are completed. Once the issue of duplicates has been addressed to the satisfaction of the dissertation committee, and when the final draft of the dissertation is accepted by the

graduate school, all names connected with the questionnaires will be destroyed.

7. Audio tapes will also be erased based upon final acceptance of the dissertation.

8. Data have been stored on a restricted access computer. Questionnaires have been stored in a locked file. Data have been and will be made available to MHD in aggregate composites so no individuals are identifiable.

Two additional notes concerning duplications and confidentiality are in order. First, no duplicate interviews were conducted. Only one subject, from an RSN staff, reported that they had already been interviewed. They were adamant about this with the interviewer even though the interviewer *knew* they had not been interviewed. This case was counted as a refusal. Secondly, throughout the interview process, multiple subjects volunteered that they would like to have their names used. Statements such as “and you can tell them that I said that” were made repeatedly. To avoid errors and breaches of confidentiality, names have not been used.

Data Processing

Miles and Huberman (1984) discuss one method of handling qualitative data through the use of a series of wall maps. This method is to help highlight connections between different concepts and groups. These approaches, well suited to the small data sets that traditionally accompany qualitative data collection, begin to have difficulties in the face of larger amounts of data. One of the analysis methods outlined in the dissertation plan called for this form of handling data.

Compared to many qualitative studies, this evaluation produced much larger sample sizes and volumes of qualitative data. This volume was due to two key issues outlined earlier; the exploratory nature, which called for qualitative approaches, and the political need for large sample sizes. Also, large numbers of those interviewed were very invested in the concepts being discussed. Consequently, they were much more verbal than anticipated. The sample size of 345 stakeholders was needed to gain credibility with key stakeholders. This sample size combined with the relatively large amount of data generated in each interview, made the use of manual wall mapping impractical. Such methods would likely have lead to missing key points made by stakeholders. Different approaches were needed.

Computerized methods using Paradox 5.0 for Windows (1994) and SPSS 6.1.2 (1994) were developed to parallel Miles and Huberman (1984) on a larger scale. These methods enhanced the researcher's ability to identify themes and relationships in the collected qualitative data. Computer methods also assisted in insuring the accuracy of coded data. Briefly, the basic method consisted of recording quantitative and qualitative data into the Paradox program, converting the qualitative data into single thought quantifiable points and then moving all of the quantitative and short string alpha numeric data into SPSS for analysis. A more detailed explanation of this process follows.

Data Base Description and Computer Data Entry

Paradox 5.0 for Windows (1994) is a state of the art commercially available data base program. It is capable of handling a wide variety of variable types including short and long numeric codes, dates, times, memos, bitmaps, sound, and other fields. In

industry and business this program is widely used for inventory tracking, reservation systems, and company wide data bases. Capable of handling very large data sets, Paradox is flexible in its design format. Custom applications are possible that can ease data entry, report generation, and enhance the ease of use by novice computer users. The simplicity of use increases accuracy of data entry. Data can be entered directly through spread sheet like tables or through custom designed data entry forms. Some reporting and analysis of data is also possible through a query system. This query system does not adequately or easily generate many major statistics. To produce statistical analysis, this dissertation used SPSS 6.1.2 for Windows (1994).

As a first step to computerizing study data, five tables were created in Paradox (1994). The tables contained all of the data recorded by hand on the survey instruments by interviewers. Each table contained different parts of the hand recorded data. For example: the first table "SUBJID" (a DOS name standing for subject identification) contained information that identified each individual respondent. This primary table was the "key" for all other tables created for this study. This "key" consisted of a variable that identified the case number for each individual stakeholder respondent. This key prevented a mix up of cases in different tables. Another table, "AHCACMHD" contained data from questions exclusively asked of persons working in the Mental Health Division or who were members of the Ad-Hoc Consumer Affairs Advisory Committee. Two more tables contained data common to all questionnaires. The last table contained personal data such as age, education level, etc. One advantage to using the Paradox tables format is that validity checks, including data type and answer range can be established. These

validity checks help prevent the entry operator from entering invalid data.

To enhance accuracy of data entry, a Paradox computer form was created that mirrored each different stakeholder group questionnaire. The appearance of each data entry form was similar to the interview questionnaire it represented. The correspondence enabled the data entry person to easily follow the appropriate sequence of data recording. This in turn reduced the possibility of inaccurate data entry (such as data being entered into the wrong field). As quantitative and qualitative responses were distributed throughout the questionnaire, data entry was easy to follow and no confusion resulted on the part of the data entry persons. Check off boxes and check lists were utilized in the computer form design to limit entry error. Further information regarding the use of Paradox and the design of custom programs is available in the Paradox for Windows (1994) users guide.

Conversion of Qualitative into Quantitative Data

Once data entry was completed, all quantitative and qualitative data collected in the stakeholder survey were contained in the five Paradox tables described above. Numerical and categorical data could be easily quantitatively processed but qualitative data, contained in multiple memo fields, was still relatively unavailable for analysis. To make the qualitative data available for analysis it needed to be turned into categorical data.

The first step in this process involved recording a list of individual thoughts expressed by stakeholders for each qualitative question. Once a thought was recorded for a question, it was not recorded again for that particular question regardless of how many times it might be expressed by the same subject or others. Thus, if a subject expressed

the same thought multiple times in an answer to one question it was recorded only once. If another subject produced the same or similar thought to the question mentioned in the last sentence, this expression was not recorded on the list, thus preventing duplicate responses. This process was repeated for each qualitative question.

Once all concepts had been listed for each qualitative question, the list of responses for each question was reexamined and like responses were combined. Duplicates were eliminated as they were not to have been recorded in the first place. The coding process produced 2146 individual thoughts from across all qualitative questions. No effort was made to eliminate duplicate or similar responses between interview schedule questions during this or the following step.

Utilizing the Paradox tool again, 14 new keyed tables were formed to contain single dichotomous variables for each of the 2146 response categories. Response categories were; 1 (meaning yes), and no response. The original computerized data entry forms used to enter data from the paper survey instruments were then converted into qualitative data coding forms. This was accomplished in a series of steps by keeping the 2146 response categories matched on the computer data entry form with the corresponding qualitative questions (memo fields) from which they were created.

Once complete, it was then possible to read an individual subject's qualitative responses in a memo field and simultaneously enter a "1" in each categorical response field representing the thought contained in the qualitative data being read immediately above. This process insured that the coded data being entered was accurately matched to each subject. While time consuming to set up and execute, the coding process was

relatively easy. This reduced the possibility of error.

The above process made it possible to convert all of the qualitative data provided by each stakeholder into quantifiable individual thoughts. For example; if a subject shared 10 different thoughts in response to the interview question, "What would you most like to see the Office of Consumer Affairs doing?", these 10 thoughts were recorded in a series of 10 responses that were checked off from the list of all categorical responses matched with the question. To record each individual thought, a "1" was entered in the blank representing each thought. This procedure was completed for each qualitative question for all subjects. Once completed, it was possible to count the number of subjects that shared the same thoughts about each question. Multiple identical responses by the same person were not recorded multiple times, but only once for each question where it was present. Therefore there is no easy measure of intensity contained in the coded data.

In summary, the use of the Paradox program enabled the researcher to handle all quantitative data and the great amount of qualitative data collected with relative ease and accuracy. It also made possible the easy, accurate conversion of qualitative data into quantifiable, categorical format. The use of this program increased the assurance that the steps involved did not corrupt the original data provided by the interviewers. The use of Paradox permitted ease of coding, however handling of data through Paradox (1994), presented one primary disadvantage. From a research standpoint Paradox does not provide for ease of statistical analysis. To conduct statistical analysis all quantitative and converted qualitative material was moved into SPSS.

Moving Paradox Data into SPSS

To accomplish the data move into SPSS, all Paradox fields (except memo fields) from the 19 tables described above were downloaded in free field ASCII format. Each table created its own independent ASCII file. A command program for SPSS was constructed within Word Perfect (1994) and run as a syntax file in SPSS (1994) to translate the ASCII data into a SPSS file format. The transferred fields included the categorically converted qualitative data. Once converted to SPSS format, file contents were checked against the Paradox output using frequencies. Variables were spot-checked against the original data and the Paradox table data. The addition of a dummy variable holding a response for each case at the end of each Paradox table allowed the data to transfer without flaw. All SPSS files were then combined within SPSS creating a complete data file including all quantitative and numerically coded qualitative data. Frequencies were once again run to cross check the data.

Error Description

A total of twelve very minor errors were found in the converted data. A series of eight upper case "Y's" and "N's" had been recorded during data entry rather than lower case. The Paradox program had not been coded to convert all cases of a letter for the variable in question into lower case and SPSS recognized them as different response categories. In addition, four of the 2146 qualitative variables (hereafter referred to as Q Variables) had a double "1" recorded rather than a single. These were changed to "1". For the Q Variables, Paradox had not been set up to prevent double entries for each case. This programming task would have been very time consuming and since the only valid

values were 1 or blank it was easier to use SPSS frequencies to identify and subsequently repair any entry other than 1. To complete the transformation of the data into SPSS usable format, a "0" was added to each non-response (SPSS missing value) on all of the Q Variables. The value label of "Statement Not Made" was added to these "0" responses. Finally the dummy variables created in Paradox to facilitate data transfer were dropped from the SPSS file.

The advantages of using a data base program such as Paradox for Windows (1994) for data entry on a large data set becomes apparent when the ease of converting the qualitative data into numerical codes and the accuracy of data entry and transfer is considered. The current disadvantage to this method is that without the ability to directly read a file from a particular data base program, SPSS requires two independent programs to be written; one for Paradox and one for SPSS. This process is time consuming. As software development continues at its present rapid pace this problem of translation will likely disappear as did the 500 variable limitation that existed in SPSS PC for DOS prior to the redesign of the program for Windows.

Identification of Central Themes Within Qualitative Data Variables

The transformation of qualitative answers into individual quantifiable categorical thoughts generated large numbers of variables. The production of so many individual variables presented unique difficulties for the identification of common themes across different question responses. Identifying themes by using different variables with high scoring frequencies was not workable for two reasons.

First, respondents often did not provide the answer to any one question solely

within that question's place in the interview. Answers to multiple questions were often provided together in the stream of thoughts elicited in response to any one of the number of interview questions. This format was part of the design. Interviewers had been instructed to record any information provided that was focused on the Office of Consumer Affairs or the Ad-hoc Consumer Affairs Advisory Committee regardless of whether the respondent seemed to be directly answering the question that had been asked. Therefore, answers to any one particular question might be found within a respondent's answer to a different question. In a related issue, as previously mentioned, a respondent might say the same thing twice or more in response to a question, or say it differently - multiple times - across the interview. For example, a respondent may at one point say that they "know the staff members." At a different point the same respondent may discuss a conversation or interaction that they had with one staff member in particular. Both of these would be coded within the Q data, and both answers indicate the stakeholder knows at least one staff member. However, the ability of SPSS or other programs to adequately identify the commonality of these variables is highly limited and the frequencies statistic would be totally inadequate to the task.

The second reason for not using Q variable frequencies to identify themes was the predominance of extremely low frequencies for most of the Q variables. The highest response rate by the 345 respondents to any one Q variable was 103, but the vast majority of the 2146 Q variables had a response rate of 1 (858 Q variables) or 2 (374 Q variables). The mode of distribution was 1 and the mean 4.212.

To identify common themes that appeared in the data, methods related to those of

Miles and Huberman (1984) were utilized. In addition to wall mapping, Miles and Huberman (1984) suggest other ways for 'living with the data' until themes begin to present themselves. In the several steps and layers involved with data collection, coding, and conversion into categorical format, this researcher has become intimately acquainted with the study data. A series of themes presented themselves in the types of responses that could be seen across questions. As these themes were identified, a series of representative aggregate variables were created in the SPSS data file.

Once the thematic variables had been defined for SPSS, individual subjects were assigned a score on these variables through the COUNT command. If a stakeholder had responded affirmatively to one or more of the Q Variables which were components of a new aggregate variable, affirmative responses were counted and this count became the value for the new composite theme variable. These theme variables were then recoded into a second dichotomous variable with values "0" and "1". The score of zero (0) meant a subject did not make any statement that corresponded to any of the Q Variables comprising a particular theme. A score of one (1) meant the respondent had made one or more statements reflecting the same view identified by the theme variable. Thus, for each identified theme there were two variables created. The scores of the first theme variable reflected the number of times a subject made comments that were related to the variable theme. The value of the second dichotomous theme variable represented whether a subject had expressed any thoughts in the entire interview related to the theme. The results that are presented in this study are based on the second dichotomous variable. This second variable is used because the first score of multiple theme responses is not

truly representative of the number of times a stakeholder repeated a thought in an interview. The reader will recall that multiple similar comments made by a stakeholder to any one question were not recorded during coding. Identified themes are listed in the next chapter where they will be presented along with other study findings.

CHAPTER III

SAMPLES

Sampling Procedures, Process and Results

The following material outlines the sampling process for different subject groups, the planned sample sizes, and the sizes of the actual samples gathered. The unique configuration of each program and organization necessitated the use of different approaches to obtaining the desired sample. These approaches, while essentially similar for similar groups and sample types, were diverse enough to warrant mention for each group. Often the procedures used were negotiated on-site with the specific agency the day the interview team arrived or during the visit that the researcher made to an organization to obtain stakeholder names. Tables I, II and III provide more detail concerning samples.

Tables

Table I

Table I contains all information on sample breakdown from each vertical level of the four selected regional day treatment programs beginning with consumers. To help the reader understand the vertical sampling method, Table I then lists stakeholder samples of the staff, agency administration, board, and the connected RSN staff and board for each agency. Overall, the samples drawn from these groups, with the exception of the agency boards, were the most complete and easiest of all samples to obtain. Table I also provides information on the consumer run club houses that were sampled.

Table I: Distribution of 345 Person Stakeholder Sample Part One: Day Treatment Agencies, Associated RSNs, and Consumer Run Clubhouses.					
AGENCY	PLANNED	REFUSAL	MULTIPLE CALLS	COMPLETED	% OF PLANNED
SPOKANE RSN AREA DAY TREATMENT					
consumers	18	3		20	111%
line staff	5	0		5	100%
administrators	2	0		2	100%
board of directors	14	2	4	8	57%
SPOKANE RSN					
administrative staff	6	1		5	83%
board of directors	5	0	2	3	60%
GREATER COLUMBIA RSN AREA DAY TREATMENT					
consumers	18	8		19	105%
line staff	5	0		5	100%
administrators	3	0		3	100%
board of directors	10	6		4	40%
GREATER COLUMBIA RSN					
administrative staff	5	0		5	100%
support staff	0	0		3	N/A
ombuds persons	0	0		2	N/A
board of directors	10	1	1	8	80%
KING COUNTY RSN AREA DAY TREATMENT					
consumers	18	8		18	100%
line staff	5	0		5	100%
administrators	1	0		1	100%
board of directors	10	1		9	90%
KING COUNTY RSN					
administrative staff	14	0	2	12	86%
board of directors	8	0	2	6	75%
TOTAL:	157	30	11	143	-

Table I (continued)					
AGENCY	PLANNED	REFUSAL	MULTIPLE CALLS	COMPLETED	% OF PLANNED
NORTH SOUND RSN AREA DAY TREATMENT					
consumers	18	8		18	100%
line staff	5	0		5	100%
administrators	2	0		2	100%
board of directors	11	all ^a		0	0%
NORTH SOUND RSN					
administrative staff	5	1		4	80%
support staff	0	0		1	N/A
board of directors	9	2		7	78%
ABERDEEN CONSUMER RUN CLUB HOUSE					
consumers	15	2		4 ^b	27%
administrators	1			1	100%
CHEHALIS CONSUMER RUN CLUB HOUSE					
consumers	15	2		15	100%
line staff	0	0		1	N/A
administrators	1	0		1	100%
OLYMPIA CONSUMER RUN CLUB HOUSE					
consumers	15	4		14	93%
line staff	0	0		2	N/A
administrators	1	0		1	100%
total this page	100	30		76	-
total previous page	157	30	11	143	-
TOTAL TABLE I:	257	60	11	219	85%

The order in which Table I day treatment programs are listed is as follows: Eastern-Urban (Spokane RSN area), Eastern Rural (Greater Columbia RSN area), Western-Urban

^aBoard chair refused access, communicating the board was too busy with other matters.

^bThe researcher was informed by program administrator that the program experienced the typical average daily attendance on the day of the site visit.

(King County RSN area), Western- Rural (North Sound RSN area). Following the samples from the day treatment providing agencies, the three consumer run club house samples are listed in alphabetical order.

Table I provides the agency and target sample group in the far left column. Columns two and three list the number of interviews planned and the refusals respectively. The fourth column numbers those persons to whom multiple calls were made in an attempt to secure an interview. In this first table and the second, in all cases, noted multiple calls represent an interview that was planned but did not take place because contact could not be made with the stakeholder. The column also represents a minimum of 5 calls made. These attempts to contact the identified stakeholder were made at different times of the day and days of the week. The fifth column provides the raw number of interviews completed and finally the sixth column gives the numbers of interviews as a percentage of those originally planned.

Table II

Table II presents information on all remaining stakeholder groups that were not connected to the day treatment programs or consumer run clubhouses. The organization and target stakeholder group are listed in the far left column. The sample size for groups follows the planned sample size originally proposed. Sample size represents the number of names drawn from the population of names contained in the membership, user, or mailing list provided by each respective organization. From this larger list, the number of planned interviews was to be obtained. Before further describing the function of the remaining columns in Table II, a note about the samples drawn is appropriate.

Table II: Distribution of 345 Person Stakeholder Sample Part Two: Advocacy Groups, AHCAC, Mental Health Division, and 1-800, BBS Users.							
AGENCY	PLANNED	SAMPLE SIZE	REFUSED	COULD NOT LOCATE	MULTIPLE CALLS	COMPLETE	% OF PLANNED
AMI							
consumers	15	45	2	11	6	12 see text	80%
administrators	1					1	100%
family	15	45	5	12	12	16	107%
WAMI							
consumers	15	40	5	11	14	8 see text	53%
administrators	1					1	100%
family	15	40	5	8	11	16	107%
WECAN	15	58	3	36	10	9	60%
AHCAC	32	32	1		7	24	75%
MHD							
professional staff	15	16	2		1	12	80%
support staff	3	3				3	100%
advisory board	18	18			5	5 ^a	72%
BBS	15	45	3	27	11	4	27%
1-800 ^b	15	45 / 14	8 / 1	13	10	5	73%
Others ^c		10				10	NA
Total table II	175	397	35	118	87	126	72%
Total table I	257	NA	60	NA	11	219	85%
Total tables I and II	432	NA	95	118	98	345	80%

^a8 of 18 already interviewed for other categories.

^bOf total population of 636 and sample size of 45, 14 names were provided to research team. Of these 6 had already been interviewed and 2 were state employees. 5 were interviewed in this round. Refusals reported by OCA equal 8. There was 1 direct refusal to an interviewer. The numbers reported for "could not locate" and "multiple calls" are those reported by OCA.

^cThis group constitutes 7 randomly selected consumers and three others.

The list from which each random sample was drawn was problematic. List information was not always current or accurate and many persons could not be located. Several times an entire sample list was exhausted while the desired number of interviews was not attained. This was very different than results drawn from day treatment agencies and their connected RSNs. There are at least two possible explanations of this problem. First, many of the individuals represented on these lists may be more distant from the respective organizations than employees, consumers, or board members of day treatment agencies or club houses. Distance would lead to difficulties in keeping membership lists and mailing lists current. A second possibility is that the tight budgets of non-profit voluntary organizations may prevent resources from being invested in maintaining the accuracy of membership and mailing lists. Problems with stakeholder group samples will be detailed with the presentation of sample results.

Column four of Table II represents refusals made by persons asked to consent to an interview. The fifth column of Table II indicates the number of persons for whom a phone number could not be located. This list includes persons whose numbers had been disconnected or were wrong numbers. Occasionally the person who answered the phone stated that the person sought had never lived there or the name was not recognized. These experiences further reinforce the conclusion that organizations are having trouble maintaining accurate information on members. The remaining columns of Table II represent the same categories as outlined for Table I.

The concluding division of this chapter names each group targeted for sample in the dissertation research proposal and describes the sampling process. Differences between

the resulting sample and the proposed sample size are discussed, as are resulting sample highlights and other details of interest related to representativeness. For a breakdown of sample results by group without agency, please consult Table III.

Total Sample Plan

Sample Plan Total: N = minimum 350 subjects distributed among groups.

Consumers of Mental Health Services in Day Treatment Programs and

Consumer Run Clubhouses

Sample Plan: 117 stakeholders.

Spokane RSN Area Day Treatment	18 stakeholders
Greater Columbia RSN Area Day Treatment	18 stakeholders
King County RSN Area Day Treatment	18 stakeholders
North Sound RSN Area Day Treatment	18 stakeholders
Capital Club House	15 stakeholders
Chehalis Avenue Club House	15 stakeholders
Coastal Club House	15 stakeholders

Spokane Area Day Treatment

Sample process. Clients attending the Spokane RSN area day treatment program reported to three different activity/treatment program areas. As consumers came into a program area, the area coordinator recorded each consumer's name on a yellow sticky note that had been folded in half. The coordinator placed this name into a paper bag that had been supplied by the research team. When interview team member was ready to begin an interview, the researcher checked with each program area coordinator to verify

that all new names had been placed in the bags. When all names had been recorded and were in the bag, each of the three bags was emptied into a central collection bag. The paper slips were then mixed and one randomly withdrawn by the researcher. The case manager or coordinator for the consumer whose name had been chosen was identified and this professional person privately made a specific request for an interview to the consumer. If consent was given the consumer selected was introduced to the interviewer. This research team member then gave the informed consent form to the consumer and reviewed the form with the consumer. If a name was drawn of a consumer who had left the agency, the name was destroyed and another selected. This process continued until a sufficient number of interviews had been conducted.

Sample results. The planned consumer sample size for this agency was 18.

Twenty (20) interviews were conducted with consumers. The number completed was intentional. The Spokane RSN area day treatment program was the first program visited following survey instrument testing and approval. The researcher felt that the two additional interviews would help compensate for any unforeseen interview problems. There were no difficulties with the instruments and all interviews were used.

Greater Columbia Area Day Treatment

Sample process. The process for sampling in the Greater Columbia RSN area day treatment program was essentially similar to the process utilized for the Spokane RSN area program. Differences were due to program structure variances. In the Greater Columbia area program, each consumer member signed in on a note pad at the entrance. Program staff were not available to record names. The researcher personally recorded the

names from the sign in sheet on a yellow sticky note and placed it in a single bag for selection. All other procedures were the same.

Sample results. Nineteen (19) interviews were conducted rather than the planned 18. The last interview had been started before an updated count of interviews was completed.

King County Area Day Treatment

Sample process and results. The day treatment program selected for King County RSN area did not have a sign-in process for its clients suitable to sampling selection. To obtain the sample from this program the researcher visually tracked the consumers coming to the program with the assistance of one of the staff members. The staff member then recorded names of newcomers on yellow slips of paper and placed them in the paper sack for selection. There were 18 planned interviews and 18 interviews conducted.

North Sound Area Day Treatment

Sample and results. The procedures for North Sound RSN area day treatment were the same as those from the King County area program. Due to the limited time that the program was open during any one day (2 hours), the interview team visited this agency twice to obtain the planned interviews. On the second trip those subjects who had already been interviewed or had refused were not asked again. As planned the number of interviews attained were 18.

Consumer Run Club Houses: Capital Club House, Chehalis Avenue Club House, and Coastal Club House

Sampling process. Sampling procedures for the Capital Club House and Coastal

Club House were the same as those used in the Greater Columbia RSN area program except that a club house member assisted the researcher in recording the names of members coming into the program. The coordinator of both programs made the individual requests for the interviews. At the Chehalis Avenue Club House, the researcher recorded the names off of the sign-in sheet as had been done in the Greater Columbia area program.

Sampling results. Two notes about sample size are in order. In the Capital Club House, the number of interviews completed was one short of the planned 15. This number resulted from a miscount by an interview team member of the number of interviews they had conducted. At the Coastal Club House the plan of 15 interviews turned out to be totally unrealistic. Upon contacting the program director to arrange an interview visit, the director related that the average daily attendance at this club house was in the range of eight persons, including the director. On the day of the interview visit, attendance was average. Two in attendance were persons from other stakeholder group population samples. Attendance of these two persons was normal and expected by the researcher and was not an attempt to influence the sample.

Refusals From Day Treatment Programs and Consumer Run Club Houses

Of the four day treatment programs, three (3) had eight (8) interview refusals. One program returned 3 refusals. All four programs were approximately the same size with respect to numbers of consumers in attendance on the day of interviewing. Some noted differences between programs may have attributed to the differences in refusal rates. It was apparent to the interview team that on the day of visit the one program returning the

least number of refusals was the most prepared and expectant of the visit. In this same program, the interview team shared the subjective observation that there seemed to be more order, energy, a sense of consumer connection to the program, and a collegiality among consumers. No other differences were readily discernable between the day treatment programs.

Of the three consumer run club houses, the two larger had approximately the same number of consumers attending on the day of the interview visit. These numbers were, however, markedly fewer than the day treatment programs mentioned above. Between the three club houses, there were no discernable differences in program ambiance, collegiality, or openness to the interview team visit. These two groups returned 2 and 4 refusals, both of which are lower numbers than were generally found in the day treatment programs. It should be noted that, as the club house programs had noticeably fewer people attending than did the day treatment programs, a much higher percentage of the club house attendees were interviewed. All programs reported that the attendance on interview day was roughly average. The third club house program reported average attendance but these numbers were much smaller than the other two club houses. This club house also returned a disproportionately higher number of refusals; 2 of 4 (50%) completed interviews. The two larger clubhouses returned 2 refusals of 15 (13%) completed and 4 of 14 (28%) completed.

When the total number of persons sampled from the smaller program are accounted for, the proportion changes to 2 refusals out of 6 (33%) completed. This is still higher than the other consumer run club houses and closer to the 42% to 44 % range of refusal

rates of the three day treatment programs with the higher number of refusals. It should be noted that the lowest refusal rate of the day treatment programs, 3 refusals of 20 completed, is also a low rate of 15%.

These numbers are too small and the study was not constructed to speculate statistically as to why the percentages vary and generally fall into two different groups. The only obvious differences between the day treatments have already been noted. As far as the club houses are concerned, one comment that was made by the two persons that refusing interview in the smaller club house may shed some light on the issue. These two persons accompanied each other to the program and were asked by the coordinator in the fashion outlined for advised consent procedures. Limited space led to a interviewer inadvertently overhearing one of the refusal responses. This response was quoted as “sounds like politics to me” accompanied by a “no thank you”. This program also proved to be the most difficult of all programs regarding gaining access by the research team. The director requested the assistance of a local RSN administrator to check out the nature of the study and also called a board meeting in which the matter was discussed. There was a marked measure of hesitancy at first contact that disappeared as the director was able to get satisfactory answers. It is possible that the internal club house discussion over the acceptableness of the interview visit may have influenced the decisions of the two persons who refused.

A point for further study, stemming from subjective observations made during interviews is a working hypothesis that the ambiance, openness, and connectedness of consumers to their program makes consumers more open and approachable by unfamiliar

persons who are requesting assistance. This, if true, would have important implications for program planning, clinical, and life skills implications and overall successful consumer reintroduction into the social arena.

Sample representativeness. The representativeness of the samples from day treatment programs and clubhouses is important. The evidence on hand points to the relative representativeness of the samples. The actual number of refusals, and the ratio of refusals to sample taken, was relatively low considering the fluid conditions from which the samples were drawn.

The day treatment programs and club houses were quite busy with activities. During interview visits, it became quickly apparent that many of the small number refusing were doing so because they were not inclined to take time away from program activities that they wished to engage in. Program attendance was reported as on par with non interview days. It is likely, therefore, that those who would refuse because of “politics” were not discouraged from attendance by prior announcement.

There were also large numbers of subjects that were not aware of the OCA (reported in the next chapter). Any motivation on the part of stakeholders to influence the outcome of the survey would have resulted in those with an agenda being in higher attendance. The study found many who didn't have knowledge of the OCA. In that attendance was reported as normal, the distribution of consumers being interviewed were most likely the same as normal within the general population or, weighted in the direction of more people having knowledge. Assuming that attendance ratios are influenced in the direction of those with an agenda being present for interview, then one of the main

findings of this study - lack of knowledge - is further reinforced.

In general, it is reasonable to find that the random samples outlined above are indeed representative of the programs from which they were drawn. If some stakeholders did stay away because of “politics” and others attended with an agenda, these differences were not enough to impact this study to the extent the exploratory goals were jeopardized. In that the programs and agencies were randomly selected and none had any particular negative issues visa-vi the OCA, it is reasonable to find that they are generally representative of these programs around the state.

Service Providers - Line Staff

Sample Plan: 20 stakeholders.

Line staff were interviewed from the same day treatment programs listed above. These professional staff were randomly selected by placing the name of each staff person who was working on the day of the interview visit on a yellow slip of paper in a bag and selecting names randomly. Qualified staff were considered to be those that worked directly with clients as program treatment staff. Support, maintenance, and housekeeping personnel were not included. The goal was to attain 5 random interviews from each agency. There were no refusals and the goal was met. There was no evidence of any schedules being shifted in an attempt to influence interviews. People were generally working their regular shifts. Based on the lack of refusals and the randomness of selection, it is reasonable to find that the sample is representative.

Service Providers - Administrative/Policy Staff

Sample Plan: 4 stakeholders.

Administrative staff were interviewed from the same day treatment agencies as above. There were no refusals by administrators from any of the 4 agencies. The specific numerical goal of administrative interviews was further refined following the approval of the proposal. This was done after initial and administrative interviews were held and it was possible to determine those who had direct administrative responsibility for the day treatment program of the agency. These persons were also sought for interview. The goals are listed for each agency in Table I.

Administrators of the club houses and advocacy groups were also interviewed. As with the day treatment program agencies, the CEO or program director was interviewed and these interviews helped determine other persons, if any, to interview. In the case of WE-CAN, the director was a member of another population group and is not listed twice in the tables. Once again, there were no refusals from this group of administrators. With two exceptions, this was the case for all RSN level staff/administrators as well.

Day Treatment Agency Board Members

Sample Plan: open.

Of all the agency linked stakeholder groups in this study, the interview of board members from different day treatment agencies was most difficult. The intent of the research plan was to interview the entire board for each day treatment agency and for each RSN. This did not happen. The chair for one agency board, from the North Sound RSN area, refused for the whole board when the request was raised by the agency

director. As a result, none of the 11 board members were interviewed. The agency director related to the researcher the response of the chair. The board chair stated that the agency board had “too many issues taking too much member time [as it was, and that] the board had never heard of the OCA anyway”. All things considered, the board did not wish to take time for any interviews. This statement of lack of knowledge and time pressure was born out in board interviews and refusals from other agencies.

Of the three remaining agencies, 34 interviews were planned totaling 45 board members for all 4 agencies. The 45 planned board interviews represent the entirety of the boards (as nearly as could be determined) of all agencies. Twenty-one (21) interviews were completed (46%) of 45, there were 20 refusals (44%) and 4 (8%) could not be contacted. In addition to the North Sound RSN area day treatment program, two other agencies presented high refusal and failure to contact rates. The Greater Columbia RSN area agency returned a refusal rate of 6 or (60%) of the board. Between multiple calls and refusals, the Spokane RSN area program board refusal rate was 6 or 43%.

To obtain the samples, the executive director was contacted by the researcher following the arrival of the letter from the director of the MHD. A request for interview was forwarded to the board members through the executive director. The executive director then related the responses of the board members to the researcher. The King County area day treatment program forwarded the entire list of board members with no prior refusals. The Greater Columbia RSN area, and Spokane RSN area day treatment program agencies forwarded a list of board members with notations as to which members had refused interview. These refusals were included in the agency board refusal rates

listed in Table I. The high rate of failure to contact, 29%, provides further confirmatory evidence of the busyness and possible disinterestedness of the agency boards. The level of knowledge that these boards have of the OCA may also shed light on the amount of investment by board members in being interviewed. More on this in the next chapter.

RSN Members and Board Members

Sample Plan: 18 stakeholders.

Regional Support Network staff were interviewed from the same regions as the day treatment programs from which clients were sampled. RSN staffs tended to be relatively small. The goal was to interview all RSN administrative and decision making staff. To meet this goal with RSN administrative/decision making staff, the numbers of planned interviews was increased to 30, including four executive officers, from the planned 18. This allowed the researcher to cover all key policy making staff working in all four RSNs. There were only 2 refusals in this group representing (6%) of the planned 30 and only 2 individuals to whom multiple calls were made.

King County RSN was the agency that was most difficult to achieve contact and interview stakeholders. It is the impression of this researcher that all staff were extremely busy but wished to be helpful. That only two of 14 individuals targeted for interview in this agency were not reachable can be interpreted as an overall staff investment in being helpful with this evaluation. The low refusal and failure to contact rates support the representativeness of findings.

Samples for each agency were selected by obtaining a listing of all RSN employees and their job titles from the RSN. Appropriate candidates were identified and contact

initiated. In addition to the planned interviews, there were some support staff and two ombuds persons interviewed, a total of 3 persons, who had not been included in the original study plan. Ombuds persons are consumers that have been hired on a part time basis by the RSN to handle complaints from individual consumers in the local agencies. Serving as advocates for the consumers they are responsible with assisting in insuring the consumers rights are respected and needs met. The ombuds persons and support staff are listed in their own categories under the agencies they were interviewed in. At the time of the survey, the ombuds positions were new and not all RSNs had equivalents at the time. When this was discovered, further ombuds person interviews were not sought out through the interview process.

All Board members of the above RSNs were targeted for interview. One problem that became apparent in targeting RSN board level stakeholders for interview was that for all but one RSN, these boards were in a state of flux. There was some uncertainty as to current membership. To obtain a list of board members to interview the director of each RSN was contacted following the letter from the MHD and a request made. All directors were helpful and facilitated contact with board members. Spokane RSN provided the names and phone numbers of all board members as did Greater Columbia, King County and North Sound RSN. North Sound RSN also provided the names of board members who had expressly stated they did not wish to be interviewed. For reporting in tables and text, these refusals provided from RSNs were added with refusals resulting from direct interviewer contact to equal the total board refusals for each RSN. Once again it was the direct impression of the researcher that these persons were very busy and many had little

knowledge of the OCA. Many were human service professionals, county government commissioners or employees, and business persons. A commitment of time for an interview represented a commitment to assist. Of 32 planned interviews 24 (75%) were completed, there were 3 (9%) refusals and 5 (16%) could not be reached. It was the impression of the interviewer, that refusals were based on board members having other priorities and not wanting to take time. That such a high percentage of these stakeholders would take time for an interview indicates the strength of investment in this community in the OCA concept, even though many had no or only cursory knowledge of the Office of Consumer Affairs or its mission.

Mental Health Division Staff

Sample Plan: 20 staff.

When the dissertation plan was approved, the Washington State Mental Health Division employed approximately 40 personnel. These people were administratively divided as follows: the director, the management team, community support team, management information team (computer support etc), accounting staff, clerical support, project employees (OCA staff), volunteers (two), and the Mental Health Information Project (one person). The plan was to interview the population of the MHD with the exception of the clerical, management information, accounting teams and director who had already been interviewed. After closer examination of the MHD staff listing, it was decided that rather than the original 20 targeted subjects, a more appropriate number of stakeholders was 15. Twelve (12) out of the intended 15 interviews (80%) were completed. There were 2 refusals (13%) and one unsuccessful game of phone tag. Three

(3) support staff that work closely with the clinical staff were included in interviews.

A request was made by the MHD that MHD advisory board members be included in the sampling. Of 18 individuals, 8 (44%) had already been interviewed for other populations at the time of the request. Five more, (27%) were interviewed following the request and 5 were not reached prior to the discontinuation of interviews.

Consumers and Family Members Involved With Formal Advocacy Groups

Sample Plan: 75 members.

AMI:	family	15 stakeholders
	consumers	15 stakeholders
WAMI:	family	15 stakeholders
	consumers	15 stakeholders
WE-CAN:	consumers	15 stakeholders

Three statewide advocacy groups in Washington are identified as having consumer members. The Alliance for the Mentally Ill (AMI Washington Chapter), the Washington Alliance for the Mentally Ill (WAMI), and Washington Education - Consumer Action Network (WE-CAN) comprise this list. Two of these groups, AMI and WAMI, are predominantly family member oriented groups with consumer members. The sample of consumers and family members were drawn from these groups. The sampling method for each group differed because of organizational dynamics. The differences are described below.

Alliance for the Mentally Ill

The consumer sample from AMI was taken with the assistance of a list of random numbers by drawing a group of 45 names from an alphabetized consumer member

mailing list. The mailing list was a computer print out with the same number of names on each page. This made the identification of consumers selected by random number relatively easy. The plan was to attain 15 random interviews from this group of consumers. Twelve (12) interviews of the intended 15 (80%) were completed. Of the 45 names selected for the sample, there was one duplicate name. Only two consumers refused (4% of the total sample of 45). However, there was a high degree of inaccuracy in the names selected regarding phone numbers and addresses of consumers. Eleven (11) individuals could not be located and 12 stakeholders could not be contacted through multiple calls. Also 13 members from the selected random list of 45 were members or former members of the AHCAC. The completed list of interviews represents consumers from the sample list who were not part of another population sample and who could be found. To attain the 12 interviews the entire sample of 45 names was required.

The family member sample from AMI was obtained in the same fashion as the consumer list except that the names were taken from the list of AMI family members. Unlike the consumer sample, there were no overlapping names with another sample or population list. Sixteen (16) interviews were completed. This represents 107% of the 15 intended stakeholders. The extra interview was inadvertently obtained because two interviewers were simultaneously working on different portions of the list. One provider who was neither a family member or consumer was interviewed from the family list. This person was not counted as a family or consumer member. Once again there were relatively high numbers of persons that could not be located (12, 27% of the 45 person sample) or contacted (12, 27%). The refusal rate was 5 (11%) of the 45 person sample.

Washington Alliance for the Mentally Ill

The consumer and family member samples from WAMI were drawn from the mailing lists of this organization. Permission to sample was obtained from the board following a presentation by the researcher. As with AMI, the sample was also obtained randomly but used a different approach. To select this sample, a zip code number was randomly selected from a list that had been generated from the membership data base. Starting with this number, the next 40 consumer and 40 family member names were taken from the list in consecutive order by zip code. This different approach was used because the support staff assisting the researcher was uncomfortable making available the entire mailing list to the researcher from which to draw the 2 random samples. The smaller sample size number was also a result of negotiation with the support staff. Both the list of consumers and family members ended up being primarily located in the Seattle area. This is consistent with a report from WAMI that the vast majority of members reside in the greater Seattle area.

The refusal rate for both consumer and family members of WAMI was 5, or 13% of the 40 person sample. Once again there were many who could not be located; 11 consumers and 8 family members. Fourteen (14) consumers and 11 family members could not be reached after multiple calls.

One noticeable difference between the AMI and WAMI consumer samples was the lack of WAMI overlap with the AHCAC group. Thirteen (13) of the AMI members were members of the AHCAC sample. Only two (2) members of the WAMI sample were members of the AHCAC.

Washington Education-Consumer Action Network

The final consumer sample was obtained from the WE-CAN group. As stated before, the organization was experiencing functional problems. Also, the leadership was in the process of change. Nevertheless, organizational leadership was most helpful and extended themselves to the researcher in obtaining a sample. Because of the WE-CAN organizational functional status, the sample plan called for the use of both former and current active members. Randomly selected members were to be contacted by the researcher.

WE-CAN, whose membership is composed exclusively of consumers, made available the addresses of members as well as others that were on their mailing list. Because of inadequate records WE-CAN was not able to determine who organization members were. Because of the inability to determine membership, it was decided to select from the mailing list of consumers. Most of these individuals, if not all, were considered by the leadership to be members in one form or another. The list came in multiple unconnected parts primarily without phone numbers. In some cases incomplete addresses existed and the list included duplicates. The researcher composed a list of names and address for the group from which to draw a sample. Once completed, the list comprised 58 names, excluding AHCAC members and known providers who were not consumers. Most names remaining were without phone numbers. Because of the prior difficulties contacting enough members from both AMI and WAMI, both of whom had better organized membership and mailing lists, it was decided to keep the entire mailing list from WAMI as a working sample with the goal of attaining 15 completed interviews.

Interviewers were then given the task of tracking down phone numbers through information.

Thirty-six (36) of the 58 (62%) consumers on the list could not be located. Ten (10) individuals (17%) could not be contacted after multiple calls, and 3 (5%) refused. This left 9 persons interviewed from the intended number of 15. Of the 9 interviewed individuals, 2 identified themselves as family members.

Advocacy Group Representativeness

The total number of refusals across all three advocacy groups was 20 of 228 persons (9%). This refusal rate is very low and can be considered relatively representative of the groups. It will also be noted when examining Table II that one major issue encountered in doing this survey was difficulty in contacting persons that had been identified for interview. Many could not be located (78 stakeholders) and many others could not be contacted (53 stakeholders). Many of the persons to whom multiple calls were made also may not be at the numbers identified for them. Only a few of these individuals had answering services, but because of expressed state concerns for confidentiality, no messages were left for those that did. Overall, those who were contacted were most happy to assist by providing an interview.

AHCAC Members and Former Members

Sample Plan: 25 stakeholders (population).

The survey was able to interview 24 (75%) of the estimated 32 members and former members of the AHCAC. This population was estimated due to incomplete record keeping on the part of the OCA. Among those interviewed were 12 current and 12

former members. There was one refusal (3% of the population total) and 6 persons could not be contacted after repeated phone calls. One was not completed because of interruption and inability to reconnect before the decision was made to discontinue interviewing.

There is some doubt as to the correct number of former members. This doubt results from incomplete maintenance of records on the part of the OCA. The lack of any comprehensive files or member list, required the use of different sources to determine the base population size estimate, and the persons to interview. Lists found with the help of OCA support staff were used. Copies of old minutes were also used, as were interviews with the OCA original staff. Generally, members were very eager to assist and interviews took much longer than the average.

Interviewing 75% the population may be considered representative of the group. It may also be likely that those who considered their opinions to be controversial avoided interview in order to avoid potential trouble. This would argue that the findings from AHCAC interviews that were preformed would be less extreme than those of the population as a whole.

OCA 1-800 Information and Referral Line and Computer BBS Users

Sample plan: 15 stakeholders each.

The final two groups sampled for this evaluation were users of the computer bulletin board system (BBS) and persons who had called the 1-800 phone line of the OCA. Both samples were drawn from OCA records. Obtaining both samples was problematic. The first group sampling process detailed here will be that of the computer

BBS users.

Computer Bulletin Board System Sample

The original plan was to select a random sample from all persons connecting with the computer BBS over the life of the project. In the end, the sample population was only a fraction of the envisioned population. A brief history of the BBS will assist the reader in understanding the resulting actual sample, and the numbers of individuals actually interviewed.

The OCA computer BBS did not become operational until the second year of the OCA grant. For several months there were ongoing problems with usability and the ability of the system to stay up and running. It would occasionally go for a period of weeks without running, and at one point the consumer systems operator reported that the BBS had been down for a period of 9 months. There were verbal reports of as many as 360 users on the system. When the system operator left the employ of the MHD in the fall of 1994 the system was not operating. He also reported the high probability that all computer data that had been recorded from the system had been destroyed. A new consumer system operator was hired. This new operator was able to get the system operating again and began working on converting the system to a world wide web page for the OCA.

The researcher made a request for a sample of users for the evaluation in July, 1995 following the approval of the evaluation plan. After several delays beginning in July, the researcher was informed that indeed all the records from the 360 users had been destroyed and that this had also happened to the back up copy that had been kept in the

archives. The destruction of the backup copy had occurred during the later part of the summer or fall, 1995, several months after the OCA became aware that a sample of these users would be requested for the evaluation. When pressed, OCA staff attributed delays to the stated confidentiality concerns of the consumer director. The expression of these same concerns had also delayed the DSHS expedited approval process as well.

Because of this data loss, the population list of contacts that were used for the sample were primarily from persons who had logged on to the BBS during the spring and summer of 1995, during the period when the BBS was under the care of the new systems operator and functioning. After extended delay, the sample was finally drawn by the MHD chief of research and the OCA consumer director during December, 1995. The sample was then forwarded to the researcher and interviews from this list were completed during January, 1996.

Access to the BBS users list was given only after the current BBS operator lobbied to make it available. He clarified that no one using the BBS had been told that their name would be kept restricted exclusively to the immediate OCA staff and not released to the division or for evaluation purposes. This was the opposite of what was being maintained by the OCA consumer director.

The sample for the evaluation was drawn from a list of non duplicate users that had been condensed from the user list of the current operating BBS. The population size was estimated to be 57 at the time. Once again, this population number is an estimate because many names on the user list were incomplete. A table of random numbers was used to draw the sample. Three draws were taken, one primary and 2 replacements of 15 for a

total of 45 possible contacts.

To attain the interviews that were completed it was necessary to cover the entire sample list. Of the 45 names drawn, 3 refused an interview (6%). Twenty-seven (27) individuals from this list could not be found based on the information that they had provided. Multiple calls failed to contact an additional 11. Four (4) persons (8% of the population and 27% of the intended sample size of 15) were actually interviewed from this list. There was no overlap between this sample and others drawn for this evaluation.

1-800 Sample

Securing the names of the 1-800 phone line user sample was also problematic. The issue was confidentiality. The consumer director stated that all persons who had ever contacted the OCA through the 800 line had been promised strict confidentiality and that no one outside of the OCA would ever have access to their name or anything that had been shared. A negotiated solution with the consumer director of the office was arrived at after several months. Access was finally given beginning in December 1995. Names continued to arrive from the office through January, 1996. An explanation of the process follows.

In compliance with the stipulation by the WA DSHS Human Subjects Committee, the first person to contact the stakeholder for interview was an OCA staff member. This stipulation was imposed after members of the committee were informed by the OCA consumer director of the promise made to callers of the 800 number. The solution to meeting this stipulation while attempting to obtain a representative unbiased sample, encompassed two steps.

The first step to obtaining this sample was as follows. The consumer director, the MHD research chief, and the evaluator, met to select the names of 45 stakeholder candidates for interview. As with the other samples a decision was made to draw 45 names to insure that there would be at least 15 for interview. Selection was made using a list of random numbers. As the evaluator read each random number, the research director watched the OCA consumer director locate the name on the list of 1-800 caller and circle it. This insured that the evaluator did not see the list of population names on which the chosen names were being circled. At the same time the process insured that another party interested in a non biased sample would observe the process. Two duplicate names appeared in the sampling process so 47 numbers were selected. At this point, a few notes as to the population of names from which this sample was drawn are necessary.

The consumer director reported that she had a list of the 636 non-duplicate individuals representing the entire population of persons who had contacted the OCA. These names were reported to be taken from the OCA computer phone call data base. The consumer director also reports that this OCA computer data base contains all names and business of those contacting the OCA. As stated above there were duplicates. This may mean that the consumer director does not understand enough about the data base to generate unduplicated names, or it may indicate another problem with the data base.

These reported numbers contradict data reported at an earlier time by the OCA consumer director. On June 3, 1994, the consumer director stated that the OCA had experienced 5,000 individuals requesting assistance from the OCA on the 1-800 phone line. During mid September 1995 the stated number was 2,000. These discrepancies

combined with the refusal of the OCA consumer director to allow an independent examination of the records call into question the reported phone traffic and phone work-load experienced by the OCA. One goal of the MHD for this study was to establish these parameters. Without independent verification, which requires the full cooperation of the OCA regarding access, there will be no reliable or valid method of determining the actual population size from which the sample for the evaluation survey was taken. Also the MHD goal of determining the work-load and phone traffic of the OCA will remain unanswered.

The second step in obtaining the 1-800 line user sample was for the OCA support staff to call each person in the random sample to secure permission for a research interviewer to contact them. This support person was trained in a protocol (appendix E) developed by the researcher specifically for this purpose.

The consistency of the contact process by the OCA support staff was supervised by the MHD research director in the following manner. The OCA support person used a telephone in her MHD cubicle to make the initial contacts. This cubical was abutted by an empty cubical. Cubicles have 3/4 height walls and conversations can be easily overheard. Calls by the support staff were to be made only when the MHD research director was on the premises and could be free to supervise. The research director supervised by entering the empty cubicle on a random basis to listen in on the process during the time phone calls were made. While awkward, this was the most workable solution to insuring that the support staff person did not attempt to unduly influence persons through the initial contact.

Between the time of random selection and the beginning of calls, the consumer director kept the list of names for contact. The research director verified that the list being used for calling was the same as the original.

Clearly, with the resistance and inconsistencies from the OCA consumer director regarding the provision of stakeholder samples, the accuracy of the list of names obtained from the above process is suspect. However, there are similarities between the results of this sample with those from the AMI, WAMI, and WE-CAN samples. A comparison of these samples will help illustrate. Information that follows concerning stakeholder contacts whose names were not forward to the researcher was provided by the OCA support person making calls. This information may help to shed some light on the larger population of 1-800 users.

The researcher requested 15 random consenting names from the OCA. Only 14 were provided. Of the 45 names originally selected, 11 were wrong numbers or disconnected. The phone numbers of AMTRACK and the Capital Van Pool were represented by 2. Ten (10) persons could not be contacted after multiple calls. According to the support staff, the majority of persons that could not be reached were consumers. Eight (8) persons refused to be interviewed. No information was provided as to the identity of these persons. The 11 wrong numbers and 10 persons who could not be contacted are consistent with the corresponding numbers in advocacy groups. These numbers may be due to inaccurate reporting, recording, or the mobility of consumers. The higher refusal rate may be due to the awkwardness of the contact process or reluctance of persons to divulge names.

Of the 14 names provided to the researcher, 6 had already been interviewed. Of these 6, 4 were AHCAC members and 1 was the director of a WA advocacy organization. One person of the fourteen refused and two were state employees from different parts of the government. These two could not be reached in the time frames remaining for interviews. Two consumers and three family members were interviewed. If the list is accurate and representative of the population and assuming that the majority of persons who were not contacted were consumers, clearly a high percentage of the phone traffic to the OCA is not from the general consumer population, but from consumer advocates and government employees. Without permission to examine the original data this will remain unclear.

Community Action for Mentally Ill Offenders (CAMIO)

Sample Plan: 1 interview.

The leadership of CAMIO was to be contacted by the researcher or an assistant. Attempts to make contact were unsuccessful. It is understood that during the time contact was being attempted there was a leadership change underway. The director may not have been available.

Snow-Ball Interview Method

Sample Plan: 50 stakeholders.

The research plan called for 50 interviews to be conducted using snowball interview techniques. As the list of random and population interviews grew, it became apparent that only a limited number of persons had extensive knowledge of the OCA and that many of those persons who were being nominated had already been interviewed in

random or population samples. It was also apparent that the range of stakeholder opinion would be well established through the 345 interviews that are represented within this study. Because of these factors, this part of the stakeholder interview plan was not carried out. This method may have proven to be useful in a larger state with greater levels of stakeholder knowledge.

Groups

The views of consumer, provider, and family member stakeholder groups were of primary concern to the different persons being interviewed. Differences and a perceived gulf between providers and consumers and family members received repeated attention in interviews by members of all three of these stakeholder groups. MHD personnel and members of other organizations that have a direct interest in the findings of this study also express interest in comparison and contrast between the views of these stakeholder groups. The views of consumer, provider, and family stakeholder groups may also have the most potential impact upon the national scene with respect to the policy and program development implications of survey findings. This document primarily presents research findings with these groups in mind.

The above material outlines the wide variety of agencies and individuals included in survey samples. The purpose of this wide selection process was to insure adequate representation of the different stakeholder groups that have an interest in the Office of Consumer Affairs. This selection process makes it possible to divide the three groups into several sub-groups. Occasionally sub-group views provide the clearest framework

through which to view survey data. When helpful, the views of subgroups will be provided to better illustrate significant variation in the views of consumers, family members, and providers. The concluding few paragraphs of this chapter describe the composition of these three primary stakeholder groups.

The consumer stakeholder sample group has a total n of 173 subjects. This group is comprised primarily of the samples drawn from the different day treatment programs ($n = 75$), the consumer run clubhouses ($n = 35$), consumer members of AMI, WAMI, and WECAN ($n = 27$), and AHCAC members ($n = 24$). Consumer to Provider Training Program enrollees comprised 7 of this number, computer BBS, 1-800 phone line users and others complete this number ($n = 5$).

Family member stakeholder group subjects number 42. These stakeholders come primarily from both AMI and WAMI ($n = 34$). The remainder were found in the WECAN ($n = 2$), the 1-800 phone line user ($n = 3$), the BBS ($n = 2$), and consumer run club-house ($n = 1$) samples.

Providers represent 129 subjects. These individuals come primarily from day treatment providing agencies and their boards ($n = 49$), and the connected RSNs and their boards ($n = 54$). The remaining 26 individuals come from the Mental Health Division staff ($n = 20$), consumer run club house staff ($n = 3$), 1-800 phone line users ($n = 2$), and the AMI ($n = 1$), samples.

The following chapter describe the results of the stakeholder survey that has been detailed above.

CHAPTER IV

RESULTS

The following material is focused on data most likely to have an impact on national trends with respect to offices of consumer affairs. The chapter begins with a discussion of stakeholder support for the mission. Different stakeholder views regarding advocacy are described next. These first two sections are followed by a presentation of findings describing stakeholder knowledge of the OCA. This trio of findings consecutively address the first three dissertation research questions. Remaining chapter partitions are devoted to completing the picture of stakeholder views regarding OCA and AHCAC activities. Findings from the broader program evaluation are also included to help illustrate stakeholder views shared in the interview process. One primary purpose of the use of the triangulation methods described earlier was to look for dissonance or consonance between the different branches of investigation. The order in which the first three findings are presented is meant to help the reader develop an understanding of how data presented in the final chapter sections may have come to be.

When the description of study methods is read it becomes quickly apparent that there are thousands of possible combinations of groups, subgroups and data that could be made and presented in analysis. This is not possible nor would it be the most useful presentation of the central findings that have been generated by this evaluation. This chapter has been organized to answer the individual research questions and at the same time clarify for the reader the central points outstanding from the interviews. Findings are primarily presented as expressed by the three primary stakeholder groups of concern

in this study. These groups consisting of Consumers, Family Members, and Providers are described fully at the end of the preceding chapter. Occasionally, factors such as knowledge of the OCA and stakeholder subgroup are used to provide insight and clarity.

One final note before presenting findings. Whenever possible for chapter subheadings a direct quote has been selected from qualitative survey data that best illustrates the subsequently reported findings. Such headings can be easily identified as they are bracketed with quote marks.

“A Vital Mission”

The first significant finding of this study directly addresses the first research question: “What are the views of different stakeholder groups with respect to OCA and AHCAC and their activities?” There is broad support for the concept of the Office of Consumer Affairs. 74.5% (n = 239) of 321 subjects responding to the question responded that the *mission* of the OCA was “Very Important”. Another 15.6% of subjects (n = 50) responded that the mission was “Mostly Important”. Only 7.5% of interviewees (n = 24) responded that the mission was “Somewhat Important”, and 2.4% (n = 8) were evenly split in replying that the mission was either “Mostly Not Important” or “Not At All Important”. Those not responding to this question constituted 24 subjects or 7%. Figure 1, located on the following page, displays overall survey data and primary stakeholder group findings.

One can see by examining the figure below, that this broad support crosses all stakeholder groups. Support is most pronounced among family members. Mission

support by family members was closely followed by consumer and provider support. Eighty two percent (82%, n = 32) of family members responded that the mission was “Very Important” and another 10% (n = 4) responded that the mission was “Mostly Important”. These sentiments were closely seconded by consumers, 75% (n = 121) responding “Very Important”, another 13.1% (n = 21) replying the mission was “Mostly Important”. Providers responded “Very Important” 70.5% (n = 86) of the time and “Mostly Important” 20.5% (n = 25) of the time.

One further point of interest may be made concerning stakeholder support. Family members and consumers were respectively the strongest in their responses supporting the OCA mission. Both groups responded above the expected frequencies of 29 and 119.1 for “Very Important” and below expected frequencies of 6.1 and 24.9 for family members

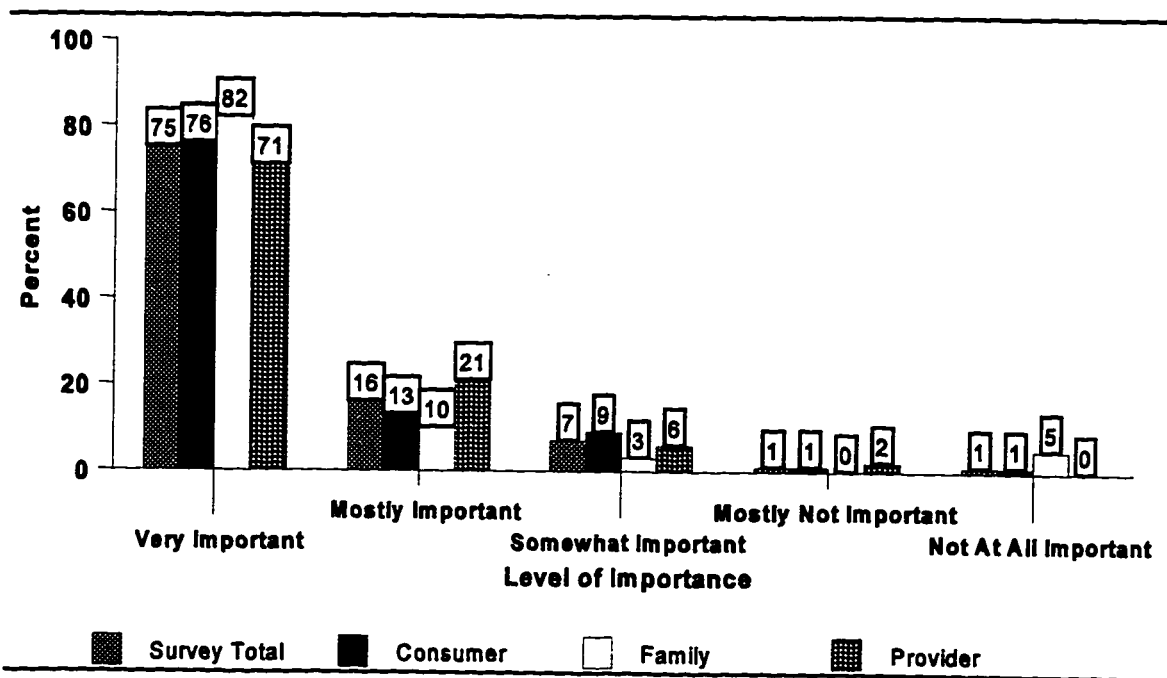


Figure 1: Stakeholder Views of Mission Importance
321 Respondents, By Percent

and consumers respectively (Pearson $p = .06667$). Providers while strong in support of the mission tended to be softer in their expression scoring below the expected frequency of 90.8 for “Very Important” and above an expected frequency of 19.0 for “Mostly Important”. These differences, while not significant statistically at the .05 level may lend insight into a different emphasis between Consumers, Family Members, and Providers.

To better assist the reader in judging the significance of these responses the remainder of this section describes how the above question was asked within the interview context. During an interview, after questioning stakeholders about their specific knowledge related to the OCA, the AHCAC, and their activities, a description of the general mission was provided. This summary statement of the mission was generated from the original grant goals and reduced to three points reads as follows.

“The Office of Consumer Affairs was created and placed in the state mental health division so that it could accomplish 3 things: 1) have a consumer ear and voice in the day to day workings of the mental health division; 2) promote consumer representation at the mental health division by communicating with other consumers, promoting placement of independent consumers and advocates on boards and policy making bodies at the state and local levels; and 3) help develop consumer communication, advocacy, and independence around [the state] by serving as an information, referral, and training resource. These are the purposes of the 1-800 information and referral phone line, the resource library, the computer bulletin board system and the Ad-hoc Committee.”

The question text was used as a guideline for interviewers to use in describing the goals and functions of the OCA. During interviews there was some variation to increase clarity. The primary clarification made by interviewers was the insertion of the words “... at the mental health division and at regional and local levels...” in point number 2 of the text (see appendix A for full questionnaire).

A follow up question about the importance of the mission was then asked. The response

options were contained on a likert scale of importance with 1 symbolizing “Not At All Important and 5 symbolizing “Very Important”.

To Advocate, or Not to Advocate is *NOT* the Question

But How to Be Most Effective.

Accompanying wide stakeholder support for the mission of the Office of Consumer Affairs are statistically significant differences in expectations as to the primary effort this mission implies. No stakeholder group is entirely of one opinion, however, there are distinct discernable differences in emphasis. These differences may have contributed to some of the issues arising out of office operations. Data on these issues will be presented later and serve as a basis for discussion in the next chapter.

Before describing the differences between stakeholder groups, a review of how composite variables were generated is in order. To adequately represent stakeholder views relating to research question number II, the survey developed several aggregate theme base variables that are composites of the Q variables described earlier. These aggregate variables reflect common themes identified among qualitative statements made by interview subjects. It is important to remember that all of these comments were volunteered by stakeholders in response to general questions. Specific themes that appear in the data were, by design, not elicited by the researcher but were presented in response to general, neutral, questions. The particular aggregate themes discussed here were identified through repeated review and analysis of the qualitative interview data provided by stakeholders. The following presents the data on stakeholder views regarding most

appropriate and useful roles for the OCA.

In short, while all stakeholder groups are interested in the OCA serving as a voice for consumers within the mental health system, differences exist between consumers, family members and providers as to how this mission should be accomplished. As a part of “voice”, all three groups wish to see advocacy taking place within the mental health system and community.

Groups also differ on how to get advocacy accomplished. Consumers tend to focus on *individual help and individual advocacy* being a desirable activity on the part of the OCA and AHCAC. Providers tend to focus on the need for the OCA to engage in *capacity development* for advocacy among consumer and family groups at the local level.

Definitions of advocacy also tend to differ between groups as do the methods proposed to accomplish it. Consumers and family members tend to define advocacy as engaging in **direct personalized intervention**, providing assistance to individual consumers needing help. Analysis of survey data revealed two distinct arenas of advocacy related to direct, one to one, interventions. Two different aggregate variables were generated from the data to separate comments that reflect these two different areas. These will be referred to as helping and advocacy. The first aggregate variable reflects comments relating to helping as a desirable activity on the part of the OCA. Helping in this case can be defined as insuring that a consumer receives food, clothing, housing, medication etc. The second aggregate variable separates stakeholder comments about advocacy. Advocacy is defined here as the OCA interfacing directly with an agency on the behalf of a consumer who is having difficulty with obtaining services (or respect) and

feels the need for outside intervention from a higher (more powerful) governmental entity on their behalf. To many consumers, this theme has overtones of aggressive action. Some providers also supported this form of activity but in no instances were there overtones of aggression. More commonly, when a provider calls for advocacy activities on the part of the OCA, this type of activity was to take place in an environment where a foundation of partnership and cooperation had already been laid and was being actively cultivated by the OCA.

The statistical data provide important insight into the distribution of these views as expressed by stakeholders. In the area of helping, 40.5% (n = 17) of family members supported this type of activity on the part of the OCA. Helping activities by the OCA were supported by 23.1% (n = 40) of consumers. Among providers, only 5.4% (n = 7) stated this type of activity as desirable on the part of the OCA ($\chi^2 (2) = 30.39, p < .01$).

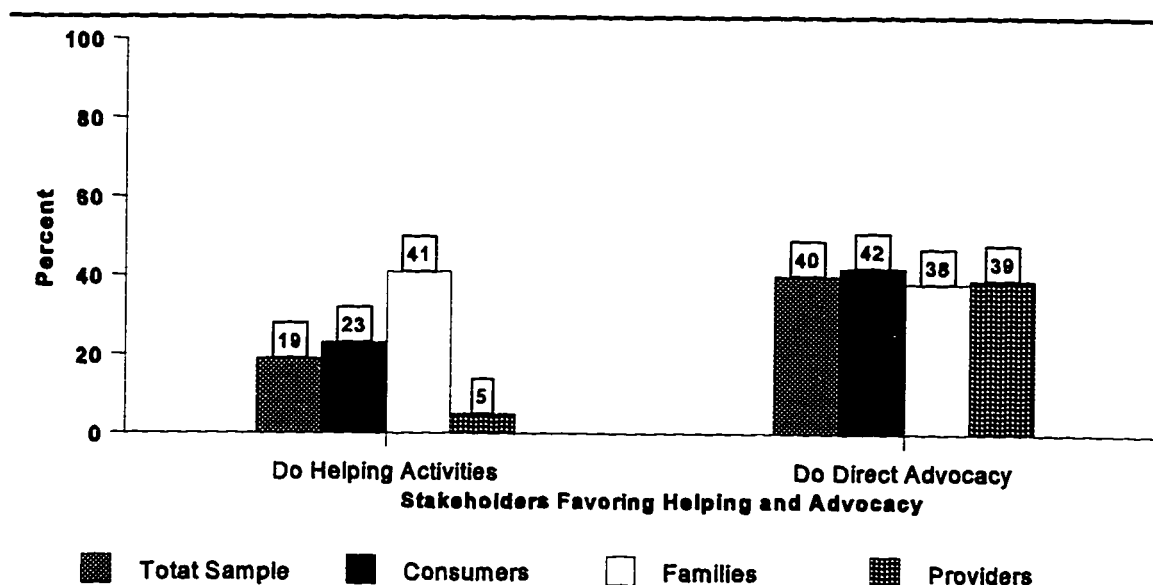


Figure 2: Stakeholders Supporting Helping and Direct Advocacy
344 Stakeholders, By Percent of Each Group Volunteering Support

Between the overall groups of consumers, family members, and providers, there was no significant difference in distribution between the 138 persons (40% of 345 stakeholders) who proposed that the OCA engage in individual advocacy. What leaps out of the data are those who did not mention advocacy as a desirable OCA activity. No Chief Executive Officer level administrators (N = 10) from agencies or RSNs proposed this activity. Also, only 3 (27.3%) of MHD policy level staff proposed individual advocacy as an activity that the OCA should be spending its time on. On the other hand there were significant differences between groups that stated overtly that the OCA should *not* do advocacy ($\chi^2 (2) = 19.37, p < .01$). Providers stated this desire 32.6% (n = 42) of the time, consumers so stated 13% (n = 24) of the time, and family members mentioned it

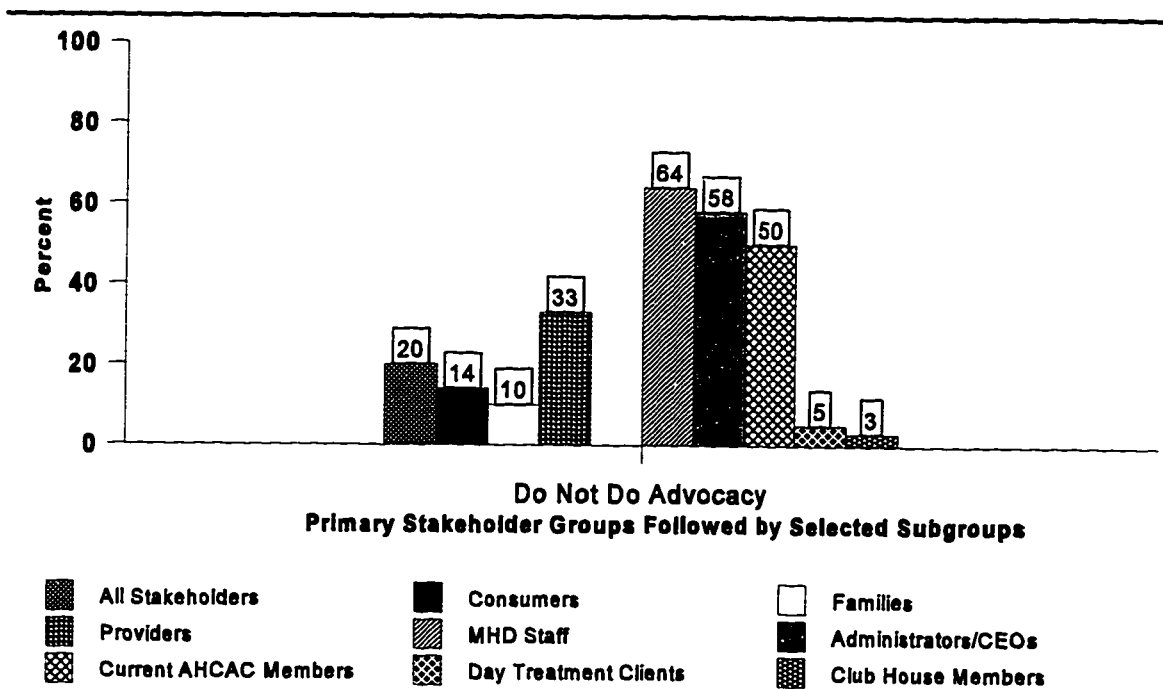


Figure 3: Stakeholders Against Direct Advocacy
344 Stakeholders, By Percentage of Groups Volunteering Statement

the least, only 9.5% (n = 4) of the time.

Subgroups that mentioned this most frequently were MHD policy staff 63% (n = 7), Administrator-CEOs of agencies and RSNs 58% (n = 7), and among consumers 50% (n = 6) current AHCAC members. Those least likely to state that the OCA should not engage in advocacy were day treatment clients (5.3%, n = 4) and consumer run club house clients (3.0%, n = 1), ($\chi^2 (17) = 80.81, p < .01$).

Providers tend to see the most appropriate mission for the OCA in a different light. While less inclined to have the OCA provide direct assistance to consumers, providers *are* significantly more interested in system **capacity development** at local levels to promote the ability of advocacy groups around the state to directly impact the lives of individual consumers needing assistance. This tendency can be seen in the results of the following aggregate variables that address advocacy capacity development themes.

A large percentage of providers (89%, n = 115) shared that they wished for the OCA to act as a voice to represent consumers in the mental health system. A significantly smaller percentage of consumers, (61.3%, n = 106) and family members (61.9%, n = 26) shared this same view $\chi^2 (2) = 30.67, p < .01$. Wide variation existed within consumer subgroups. The consumer subgroup with the highest percentage of individuals emphasizing that the OCA provide a voice, exceeded the overall percentage for providers expressing the same theme; 91.7% (n = 22) of AHCAC members and former members. Day treatment program consumers who are furthest from being involved with advocacy groups or policy development expressed this view the fewest number of times (48%, n = 36). It should also be noted that the theme of voice is stated

explicitly in the interview survey format.

Providers significantly favor OCA efforts being directed toward policy development 85% (n = 110), $\chi^2 (2) = 12.64, p < .01$, and education and training 83% (n = 108) $\chi^2 (2) = 10.38, p < .01$. Consumers were significantly lower in their expressions supporting these activities by the OCA, 69% (n = 120) and 68.2% (n = 118) respectively. Family members were lower than consumers in suggesting that the OCA engage in policy development 64% (n = 27) and higher than consumers in suggesting that the OCA be engaged in education and training 81% (n = 34).

Stakeholders recommended two further avenues for OCA activities: advocacy group development and information and referral activities. Significant differences were once again found in both of these areas. Family members recommended in 38% (n = 16) of their interviews that the OCA be engaged in starting advocacy groups around the state. Providers made this recommendation 37% of the time (n = 48) and consumers spoke of this as a desired OCA activity 25% of the time. With both family members and providers the number responding was greater than the expected frequency while consumers were significantly lower $\chi^2 (2) = 5.75, p < .01$.

The majority of providers 55.8% (n = 72) and one half of family members 50% (n = 21) recommended that the OCA be engaged in information and referral activities. Consumers recommended this course of action in 37% of interviews. These differences were significant $\chi^2 (2) = 10.91, p < .01$.

“Why Don’t I Know about this?”

Stakeholder Levels of Awareness of OCA, AHCAC

The third research question asks “What level of awareness exists regarding the activities of the OCA and AHCAC within Key stakeholder groups?” The following material addresses stakeholder knowledge of OCA and AHCAC activities through several measures. Included in these measures were direct answers to questions asked in interviews as well as composite variables that were assembled from qualitative data provided by stakeholders. It is important to note that the bulk of stakeholder interviews represented by this study were collected when the OCA was in the thirty-sixth month of its three year grant. The remaining were primarily collected in the two months following and later. The reason for this notation, already alluded to in the section title, will be apparent shortly.

One of the most pronounced findings from the stakeholder survey is the lack of stakeholder knowledge and the theme of astonishment, on the part of many, that they did not know of the OCA or AHCAC. Indeed, several agency individuals personally interviewed by this researcher revealed a sense of anger accompanying their astonishment that an “agency” or project with a key mission such as that of the OCA and AHCAC that had just been described to them could be created and function for a period of over three years in the state mental health system without their knowledge. “Why don’t I know about this?” is a direct quote from one administrator that was echoed by others. While many agency and RSN staff were in the dark regarding the OCA and AHCAC the stakeholder groups least likely to have heard of the OCA and AHCAC or to have any

knowledge beyond having heard of their existence were the groups the project was meant to empower the most. These individuals were represented by consumers interviewed in day treatment programs and consumer run club houses. Consumers members of advocacy groups ran a close second in their lack of knowledge.

The first two questions of an interview asked directly if stakeholders had heard of either the Office of Consumer Affairs or the AHCAC. If the subject responded that they had not heard of either the OCA or the AHCAC the subject was read a short summary of the project and then asked if the information “brought anything to mind” about what they may have heard concerning the Office of Consumer Affairs and the Ad-hoc consumer Affairs Advisory Committee (see questionnaires in appendix A).

At first prompting, providers were significantly more likely to have heard of the OCA than other groups: 69% (n = 89) as opposed to 54% (n = 96) of consumers and, 47% (n = 20) of family members, $\chi^2 (2) = 8.77$ $p < .01$. There were no significant differences between groups when asked if they had heard of the AHCAC but the percentages of people giving an affirmative response drops to 29.9% of providers, 31.8% of consumers and 19% of family members. Following the reading of the recognition memory prompt during the interview, the percentages of subjects responding affirmatively to one of the three questions increases to 77.5% of providers 63% of consumers and 61.9% of family members. The differences between each of these groups continue to be significant $\chi^2 (2) = 8.00$, $p < .05$. When those subjects who are either directly connected to the MHD or AHCAC (n = 51) are removed from the sample, the percentages remain roughly in the same range; 73.1% for providers, 55.6% for

consumers, family members remained with the same response rate as reported earlier. On their face, these numbers appear to support the idea that the OCA is widely known among state mental health system stakeholders, however a second measure which is likely to be more accurate provides conflicting information.

The reader will remember that pre interview announcements were required. These announcements made stakeholders aware of the OCA, the evaluation, and the intent to interview persons that were willing. It is reasonable to expect that these announcements would have generated discussion among subjects. It would also have been possible to generate one or two comments concerning knowledge of OCA and AHCAC purposes and activities as a result of many of the announcements and explanations provided to stakeholders in preparation for the interview. It was the impression of this researcher and research assistants that stakeholders attempted to impress the interviewer with their knowledge concerning the OCA and AHCAC even when such knowledge was lacking. This was often the case with consumers and occasionally providers.

With this in mind a second indicia was developed that measured the knowledge of stakeholders beyond an affirmation of having heard of the OCA or AHCAC. The second method of assessing stakeholder knowledge was to ask a respondent who indicated some knowledge of the OCA or AHCAC, what they knew about these two groups. Responses were subsequently counted and compiled into an aggregate variable. The aggregate variable is comprised of a count of responses to check off lists and qualitative descriptions of the OCA or AHCAC.

Included in the questionnaire were a series of check off lists of all grant related

activities that both the OCA and AHCAC groups were to be engaged in (see question 4 on the Ad-hoc questionnaire in appendix A). In addition, subject responses that did not correspond to the check lists were recorded as qualitative data. This information when converted to Q Variable data was combined with check off list responses and counted to determine the extent of the respondents knowledge. Each primary stakeholder group was then divided into three subgroups for analysis; those who could make no statement reflecting knowledge of OCA or AHCAC, those who made one or two statements, and those who made three or more statements.

The key issue needing to be addressed at this point in the analysis is the awareness levels of the primary OCA and AHCAC stakeholder constituencies which exist around the state. Of less interest is the awareness of those directly involved with the MHD. The following information relates primary stakeholder knowledge. Those directly associated with the MHD bureaucracy or the AHCAC have been removed from the overall sample (N=52).

No significant differences were found between consumer, family member, and provider groups based on their knowledge. Critically important data *are* found by examining the percentages of individuals within the various stakeholder groups who were disproportionately able to express knowledge of the OCA and AHCAC.

The percentages of persons having any ability to describe the OCA or AHCAC is much smaller than those described above who stated above they had heard of one or the other organization. In contrast to the 37.2% of respondents stating they had never heard of the OCA or AHCAC, almost double the number of respondents, 62.8%, n = 187

(including the 37%), were not able to respond with any specific statements describing the OCA, the AHCAC, or their mission, or purpose. Twenty-two percent of all respondents (22.9%, n = 67) related one or two comments. Fourteen percent of the all stakeholders (14.3%, n = 42) made three or more comments. When sub-groups are examined significant differences are found between groups $\chi^2 (22) = 57.99, p < .01$.

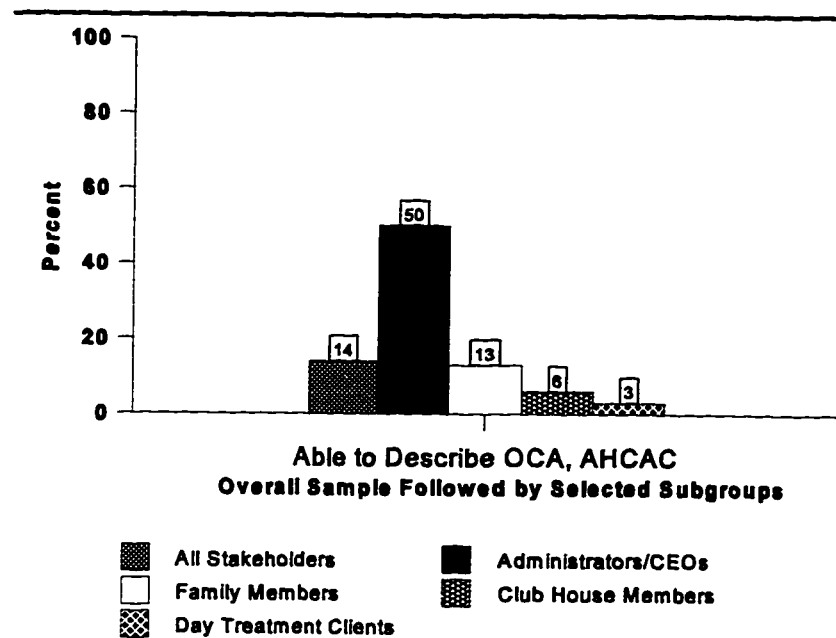


Figure 4: Stakeholders With Knowledge of OCA, AHCAC
293 Stakeholders, By Percentage With MHD and AHCAC Members Excluded

Of providers, chief administrators/CEOs were most likely to have acquaintance with the OCA. Chief administrators/CEOs made one or two statements 41.7% (n = 5) of the time. Fifty percent (50%, n = 6) of these individuals made three or more comments. Administrative employees in RSNs and agencies made no comment in 37% (n = 10) of interviews. For this same stakeholder group 33.3% (n = 9) made one or two comments, 29.6% (n = 8) made three or more. Of providers, board members were least likely to

have knowledge of the OCA and AHCAC. Board members expressed no knowledge in 71.1% (n = 32) of cases. Thirteen percent (13%, n = 6) made three or more statements. Family members expressed no knowledge in 61.5% (n = 24) of cases and only 12.8% (n = 5) shared three or more comments (see figure 4).

Finally, 81% (n = 27) and 78.7% (n = 59) of consumer run clubhouse members and day treatment clients respectively made *no* statements describing knowledge of the OCA or AHCAC. Only 2.7% (n = 2) of day treatment clients and 6.1% (n = 2) of consumer run clubhouse members were able to make three or more statements expressing knowledge of the OCA or AHCAC. Of consumers, consumer members of advocacy groups were most likely to express knowledge of the OCA or AHCAC with 23.3% (n = 7) making three or more comments and 33.3% (n = 10) making one or two statements. It may also be important to note that among day treatment clients expressing knowledge of the OCA and AHCAC, (n = 16) forty-three percent (43%, n = 7) of this subgroup made statements attributing to the OCA or AHCAC responsibility for activities or accomplishments that were rightfully credited to other organizations or groups such as AMI or WAMI.

Stakeholder Observations of OCA, AHCAC Awareness on the Part of Others

Clearly there is a marked lack of general stakeholder information regarding any knowledge of OCA and AHCAC activities. It is also probable that awareness of OCA and AHCAC existence is minimal. Awareness was certainly raised by the process of the interviews. This lack of knowledge has not escaped the attention of stakeholders who have knowledge of the OCA and AHCAC. The findings reported in the remainder of this

chapter section include all stakeholders who were able to make statements describing the OCA and AHCAC. Stakeholders from groups directly associated with the MHD and AHCAC are included. The total N of this sample is 156 individuals.

Eighty-two percent (82.6%, n = 57) of all providers who expressed one or more statements reflecting knowledge of the OCA and AHCAC volunteered that generally people were not aware of the OCA or AHCAC. Significantly different at the .01 level, 61.4% of consumers who knew and 64.7% of the family members who knew about the OCA and AHCAC expressed that people were not aware $\chi^2 (2) = 7.98, p < .01$. These same groups also considered the lack of public knowledge one of the primary failures of the OCA and AHCAC. Thirty-one percent of providers (31.9%, n = 22), fourteen percent of consumers (14.3%, n = 10), and 11 percent of family members (11.8%, n = 2) expressed this view. These differences were significant, $\chi^2 (2) = 7.43, p < .05$.

“Those That Don’t Know Don’t Know They Don’t Know.”

The above material related to support for the OCA, expectations of different stakeholder groups, and levels of awareness help set the stage for the remaining findings. The following findings primarily return to answering the first research question that asks what the views are of stakeholder groups regarding the OCA and its activities. Stakeholder group differences in primary expectations as to the office mission may have also contributed to internal conflict, perceived lack of direction and perceived ineffectiveness observed by many who know of the OCA. These observations are reinforced by other data streams that were generated in the overall OCA program

evaluation. The following chapter section relates information applicable to these issues and others.

Stakeholder observations of an ineffective OCA, are predominantly described by those closest to its operations as being unhelpfully overly assertive in its direct advocacy activities, generally unavailable, disorganized, generally unprepared, not focused on grant activities and in need of a defined focus centered in the original grant objectives and tasks. There is also a recognized pattern of continuing internal and external conflicted relationships related to power and control issues. This conflict is viewed by stakeholders to have negatively impacted OCA effectiveness.

Of the entire stakeholder sample, including those directly associated with the MHD and AHCAC, 84 stakeholders exhibited demonstrable knowledge of the OCA and/or the AHCAC. This group was identified by selecting from the total population of 345 respondents those who provided three or more descriptive statements regarding the OCA or AHCAC. This 84 member subgroup was comprised of 38 consumers including 24 associated with the AHCAC, 7 family members, and 39 providers (Table III). Of the providers, 15 were associated with the MHD. The following survey material for this finding has been developed from interviews with these 84 persons.

- ▶ Thirty-one percent (31%) of consumers, 28% of family members, and 41% of providers volunteered that they did not feel the OCA was carrying out the tasks of the grant. There were no significant differences between the three primary groups.
- ▶ Thirty-four percent (34%) of consumers 14.3% of family members and 12.8 percent of providers discussed conflicted relationships between OCA staff and between

OCA staff and others outside of the OCA. These same individuals considered these conflicted relationships to be one of the greatest failings of the OCA. Once again there were no significant differences between primary groups.

Administrators/CEOs	14
Ad-Hoc Consumer Affairs Advisory Committee current and former members	23
Board Members	8
Day Treatment Clients & Consumer Run Clubhouse Members	4
Other Consumers	9
Mental Health Division Staff	12
Family Members	5
Other Providers	9
TOTAL:	84

The above two themes can be contrasted with the fact that no one in this same group volunteered information that the OCA was doing its job, or as the job is defined by the grant. No one shared a view that the OCA had been able to resolve conflict either internally within itself or the MHD, or externally with stakeholders outside of the MHD. No one shared that the OCA either was or had begun to work in partnership with both consumers and providers.

- ▶ Fortyfive percent (45%) of the 84 persons discussed access problems. These stakeholders observe that persons outside of the OCA have difficulty contacting the OCA or getting them to return calls or respond to requests.
- ▶ Thirty-five percent (35.7%, n = 30) of this overall 84 person sample considered that the OCA was doing a poor job considering the resources that had been provided.

There were no significant differences between consumer, family member or provider groups on this point. Seventy-two percent (72%) of those associated with the MHD volunteered this information. On the other hand 9.5% of the sample shared that the OCA was doing a positive job. These persons were exclusively consumers comprising 21.1% (N=8) of the 38 consumers in the 84 person sample of those who know the OCA.

The above information is consistent with findings reported to the MHD at the mid-point report of the overall program evaluation. Data generated by the non-survey method of this evaluation research also support the observations of the above stakeholders. Key grant described activities of the OCA have been left undone or partially completed. OCA staff continue to be involved in direct committee work and other peripheral activities in the MHD and elsewhere. Staff have been described by stakeholders as an additional “MHD labor pool” and that different agendas on the part of different MHD management personnel and OCA staff members have led to diffuse activity patterns that are not focused directly on performance of core grant defined activities. Activities such as ongoing involvement in national consumer efforts, and direct individual advocacy are not central to the OCA mission and defined activities. Interviews with central stakeholders relate that a great deal of OCA energy has gone into these activities. This has not been possible to quantify due to a complete apparent lack of any formal ongoing documented reporting system regarding staff activities, products produced or tasks preformed. The primary grant intended role of OCA staff can be seen to be that of a facilitative, developmental, technical assistance, and educational role. Throughout this evaluation,

stakeholders have reported that this has not been the primary focus of the OCA. This lack of grant focused direction and different MHD managerial and OCA staff agendas led the original grant director to request a transfer within the MHD away from responsibility for the grant or the OCA.

The following points are from the first, non survey phase of the overall evaluation which lasted throughout the 3 year life span of the grant and beyond. They assist in illustrating some of the internal OCA problems referenced by stakeholders in the survey described in this dissertation.

- There is no listing of consumers qualified to serve on a speakers bureau.
- There is no listing of consumers who can serve on state or local committees.
- There is no organized method of promoting consumers as speakers or committee members.
- Beyond taping of AHCAC meetings there have been no video newsletters produced.
- Stakeholders report there has been no appreciable compilation or dissemination of technical assistance materials other than those owned personally by the present consumer director.
- There was no brochure describing the OCA or its activities available to distribute to stakeholders for the survey phase of this program evaluation.
- The BBS was allowed to not function for months at a time.
- Computers that were promised to AHCAC members were not delivered, nor was there an explanation for why they had not been.
- Independent consumers and advocates have not been recruited to accomplish many of the tasks described for the OCA.
- The data base of consumer complaints and information and referral calls continues to be collected in paper form. There is no provision for quantitative, non-anecdotal feed back from these records to the rest of the MHD as to problem areas in the state.
- Additional general disorganization can be seen in the lack of an ability to generate a listing of AHCAC members and former members for the purposes of this evaluation.

This same evaluation process as well as the stakeholder survey highlight some areas of positive achievement as reported by stakeholders. The following activities were

either directly observed by this researcher or volunteered by stakeholders to be effective OCA activities and actions.

- Creation of the committee agenda and training was turned over to the AHCAC.
- Leadership of the AHCAC was turned over to the members.
- Reporting mechanisms were put in place for AHCAC members to provide feedback as to their community efforts.
- The computer bulletin board system was the first of its type set up in the national mental health arena.
- Continuing willingness to provide an assertive voice resulted is reported to be partially responsible in the redirection of mental health policy both at state, regional, and local levels.
- The Anti Stigma Campaign preformed in conjunction with AMI received very positive reviews by stakeholders that were knowledgeable about it. Materials continue to be distributed.

In the stakeholder survey, provider stakeholders who had experienced contact with OCA advocacy efforts at the regional or local level were very careful in their descriptions of these interactions. It was apparent that providers were being careful to not say anything that was overly negative regarding the OCA. It was occasionally shared that while the OCA had been of assistance to a consumer in need, the *nature* of the assistance was performed in an abrasive manner rather than one of partnership. One provider described the approach of the OCA staff as one that planted further distrust in the consumer as a result of the interaction between OCA staff and the consumer. The OCA was described to have failed to find out all of the problem background. The provider felt that the OCA automatically assumed that the consumer was completely correct in presenting the facts of the case. The approach to the provider and RSN was described as demanding, based on inaccurate information. This approach unnecessarily consumed a great deal of time mollifying the OCA while providing the OCA a fuller background on

the consumer dispute and related events. This mollification and education of the OCA was necessary before a resolution could be reached. It was felt that if the OCA staff had been, at minimum, ready to listen or at most, willing to refer the consumer to a local level problem solving process, the problem could have been solved much sooner. The focus could have been primarily on solving the problem of the consumer rather than meeting the needs of the OCA. This above approach was felt to generally have left the consumer in a continuing conflicted or resentful position with the provider. The provider was left reluctant to seek out the OCA for assistance.

These same providers shared that a different, non-adversarial approach would have made possible full conciliation with the consumer. Providers also repeatedly called for the availability of training opportunities for their boards and staffs to help facilitate a working partnership with the consumers they serve as well as the advocacy groups. They expressed, in some cases, reluctance to contact the OCA because of the abrasive, aloof nature of the staff and the potential problems with attempting to work with the office.

It was a stakeholder (not one of the principals) describing the above conditions in some detail who related the title of this chapter subheading: “those who don’t know, don’t know they don’t know”. This person was discussing the necessity of focusing on capacity development and positive relationship building in order to advance the cause of consumer empowerment within the mental health system. This stakeholder also observed that the consumer members of the OCA had no idea of the negative impact of overly assertive, aggressive advocacy efforts. In addition, the lack of focus on the development of capacity for local advocacy and partnership building was perceived as significantly

negatively impacting the consumer empowerment movement.

“Fix It, Good Grief.”

In spite of lack of knowledge of the OCA and perceived problems among those who were aware of operations, there is strong support for the actual office and a perception that this office can serve a valuable function. Often, when asked if the office should be kept open or closed, persons with specific knowledge of the OCA often responded that the OCA should remain open and that they wished for office operations to be revamped and brought back to original grant purposes. “Fix it good grief”, a direct quote from a lower echelon provider reflects the expressions of many consumers, family members and providers. Additionally, many of those who shared that the OCA should be closed stated that they felt this was because they did not feel that the OCA could be made to function within the parameters of the grant.

Of 84 persons demonstrating direct knowledge of the OCA or AHCAC 83.3% (n = 70) shared that the OCA should remain open. Another 8 or 9.5% shared that it should be closed. The remaining 6 or 7.1% did not provide a response. There were no significant differences in the response rates between groups.

In the overall sample of 345 subjects 8.1% (n = 28) individuals shared that the OCA should be closed. Those that shared the OCA should remain open constitute 75.7% of the sample (n = 261), and 16.2% of the sample (n = 56) made no comment. Significant differences exist between these groups, $\chi^2 (6) = 13.09, p < .05$. Consumers are less likely than expected to make no comment; 13.9% or 24 (expected value 28.1), or support

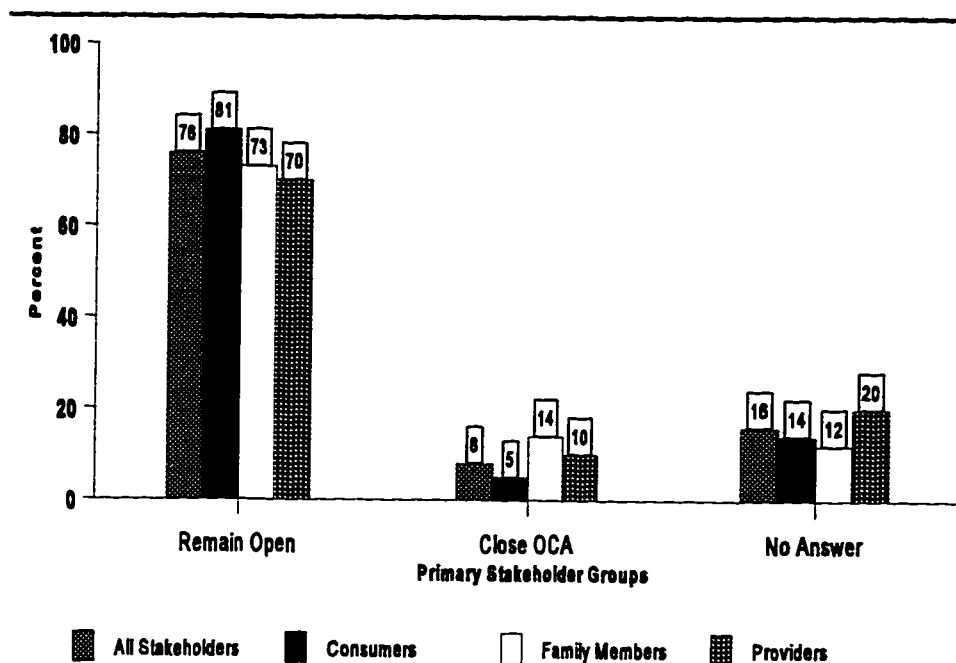


Figure 5: Stakeholders Wanting OCA to Remain Open
345 Stakeholders, By Percentage

closure 5.2% or 9 (expected value 14.0). Consumers were also more likely than expected to support the office remaining open 80.9% ($n = 140$, expected value 130.9), providers on the other hand are more likely than expected to support closure 10.1% ($n = 13$, expected value 10.5), more likely to make no comment 20.2% ($n = 26$, expected value 20.9), and less likely than expected to support the OCA remaining open 69% ($n = 90$, expected value 97.6). Family members were more likely than expected to support closure 14% ($n = 6$, expected value 3.4), and less likely than expected to support it remaining open, 71.8% ($n = 31$, expected value 31.8) less likely than expected to make no comment 11.9% ($n = 5$, expected value 6.8).

A few comments regarding stakeholders making no comment are in order. It was not unusual for a consumer run club house member or a day treatment client to not

complete the questionnaire and skip many questions. This particular question came toward the end of the interview. On the other hand it was highly unusual for providers to fail to complete an interview once begun. It was the impression of interviewers that many providers who would otherwise stated that they wished the OCA to be closed did not wish to directly state so. Even so, the lowest percentage of persons supporting the OCA remaining open are providers with 69.9% stating support.

Upon examining subgroups, it is of interest that although significant differences between groups disappear when primary groups are subdivided, there were no persons associated with the MHD stating that the OCA should be closed. In general, while many of these individuals felt there were problems with structure, direction, focus, and internal/external relationships, they also saw that the OCA was a valuable addition to the MHD and wished for it to be continued, all be it, with serious modifications.

“How Do You Measure Success?”

One natural question that lends some insight into overall views of the OCA and AHCAC are the responses and associated comments that were made by stakeholders regarding the success of the OCA and the AHCAC. Stakeholders were asked to respond to a global measure of success on a 1 to 5 likert scale for both the OCA and AHCAC. One meant “not at all successful”, two meant “mostly not successful”, three stood for “neutral”, four symbolized “mostly successful”, five symbolized “very successful”. On these measures the OCA was rated by 102 subjects responding from all 345 stakeholders to be successful or mostly successful 47.1% of the time with 35.3% (n = 36) responding

“mostly successful” and 11.8% (n = 12) responding “very successful”. The total number of stakeholders in the survey responding to this question was 102. Only those stakeholders who indicated that they knew of the OCA were asked this question.

Fifty three (53) persons of the 345 provided an opinion of AHCAC success. Once again only those who indicated they knew of the AHCAC were asked this question. Of those responding 62.3% felt the AHCAC had been “mostly successful (45.3%, n = 24). Those who felt the AHCAC was “very successful” comprised 17% (n = 9) of the group responding. Those who held a “Neutral” position were another 18.9% (n = 10).

A similar set of findings are found when the 84 stakeholders who were able to demonstrate knowledge of either the AHCAC or OCA. Overall 62.2% (n = 28) of the 45 individuals responding held the AHCAC to be “Mostly Successful” (42% n = 19) or “Very Successful” (20%, n = 9). Those responding “Neutral” comprised 17% (n = 8) of the sample. There were no significant differences between groups.

Of the 70 individuals from the sample of 84 mentioned above that responded regarding the success of the OCA, 48.6% (n = 34) held the opinion that the OCA was “Mostly Successful” (38.6%, n = 27), or “Very Successful” (10%, n = 7). There were significant differences between consumers, family members, and providers in their opinions of OCA success ($\chi^2(8) = 16.34, p < .05$). A full 70% of consumers felt that the OCA was “Mostly Successful” (50%, n = 17) and “Very Successful” (20.6%, n = 7).

No family members or providers regarded that the OCA was “Very Successful”. Family members were roughly split by thirds between “Mostly Successful” (33.3%, n = 2), “Neutral” (33.3%, n = 2), and “Not At All Successful” and “Mostly Not Successful”

(33.4%, n = 2). Providers registered below an expected frequency of 11.6 when reporting the OCA to be “Mostly Successful” (11%, n = 8). They were also above the expected frequencies for “Neutral” (e = 8.6, 43%, n = 13), “Mostly Not Successful” (e = 3.9, 16.7%, n = 5), and “Not At All Successful” (e = 3, 13.3%, n = 4). These numbers are consistent with qualitative data collection which found providers repeatedly declining to be critical of the OCA while at the same time expressing opaquely that they felt that the OCA had been performing far below its potential.

All persons who indicated knowledge of the OCA were asked what was the most successful characteristic of this office. Among the 84 who demonstrated reliable knowledge of the office, two answers appeared most often with no significant differences between groups. The most frequently volunteered response was that the “OCA managed to exist” (15%, n = 13). The second most frequently volunteered response is that the OCA was responsible for “getting some consumers involved” (14.3%, n = 12). This

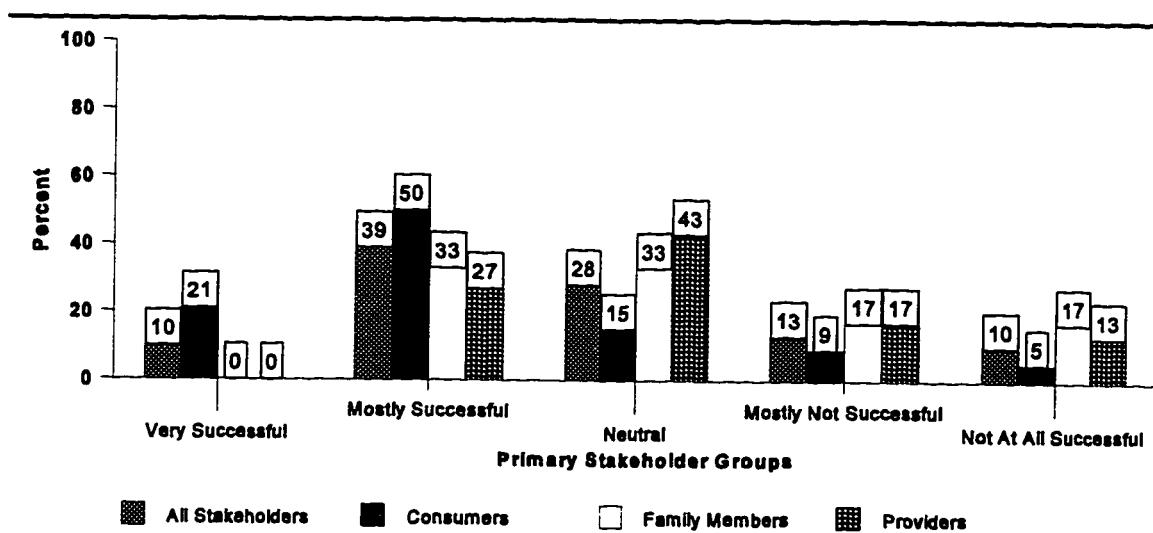


Figure 6: Stakeholder Views of OCA Success
70 of 84 Respondents, By Percentage From Group That Knows OCA, AHCAC

second statement was most often in reference to the fact that the OCA staff were consumers and also in reference to the involvement of the AHCAC.

The nature of the two opinions of success lend some insight into overall stakeholder opinion. Generally stakeholders, feeling that the OCA had not achieved its potential, wished that the office could actually achieve potential higher levels of performance. Consumers were more likely to state that it had been successful, many providers who clearly knew of performance, hesitated or declined to offer an opinion. On the other hand the AHCAC was given a 62.2% positive performance rating by those who knew of its performance. While stakeholders were not specifically asked in what way had the AHCAC been successful, the qualitative data gathered in the stakeholder survey as well as the experiences of interviewers may lend some insight into the source of the favorably reported opinions. The following material discusses some of this qualitative data.

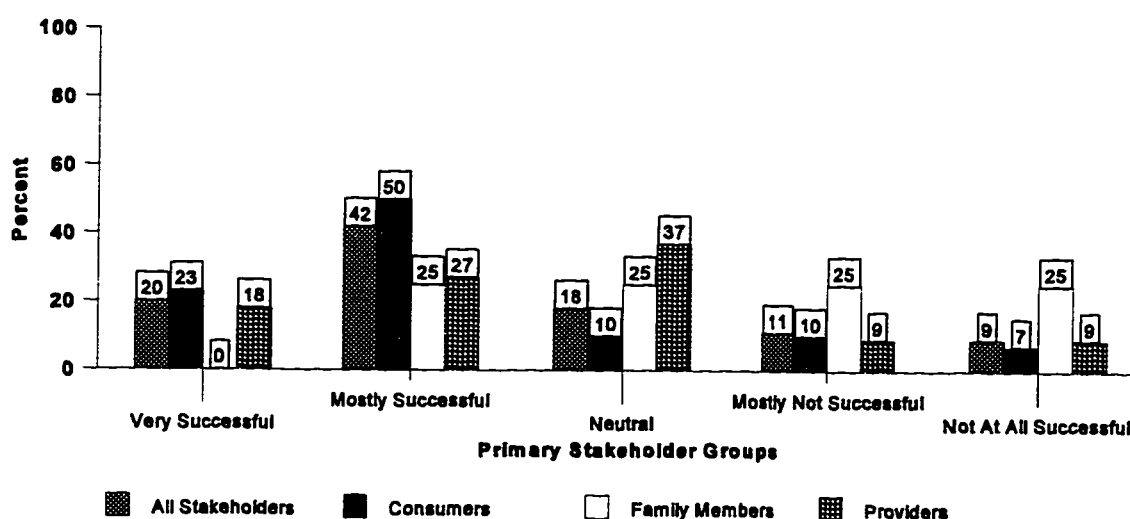


Figure 7: Stakeholder Views of AHCAC Success

45 of 84 Respondents, By Percentage From Group That Knows OCA, AHCAC

The AHCAC committee has been an overall positive force and has been a key to the impact that the grant has had on the state consumer movement. While the specific name of the AHCAC was generally not recognized, consumers and providers continually mentioned AHCAC members and former members as knowledgeable resources to the community. When stakeholders knowledgeable of the AHCAC were asked for improvement suggestions there were many; however, there was only one individual making negative comments about the overall mission concerning the AHCAC. AHCAC performance received 20 positive comments from the sample of 38 consumers (52%) in the sample of 84 stakeholders described above.

One specific case experienced by interviewers can best describe the indicated impact. In one agency one of the AHCAC members was reported repeatedly by stakeholders to be of great assistance to the consumer movement in their area, yet there was no recognition of the AHCAC. This AHCAC member was present at the time of the visit and it was apparent that this member frequented this consumer service. In agencies where AHCAC members were not present on an ongoing basis there was no mention of names or the AHCAC. AHCAC members repeatedly mentioned constraints on their roles due to the inability to pay for long distance telephone charges or to have "gas money" to get to different agencies and services in their area. The names of AHCAC members were very frequently recommended and spoken highly of by providers.

CHAPTER V

LESSONS LEARNED: ORGANIZATIONAL IMPLICATIONS FOR CONSUMER EMPOWERMENT PROGRAMS

The following chapter links the major findings of this study by describing how differing organizational goals, differing stakeholder expectations, consumer employment issues, and management structures have impacted the overall effectiveness of the Office of Consumer Affairs. Beginning with a discussion of the OCA empowerment mission, major findings and national literature will be presented that explain the observed overall impact of the OCA. Some background information from the overall stakeholder survey phase, as well as phase I, of the evaluation process will be used to assist the reader in coming to understand the stakeholder survey findings. Issues are tied to professional literature to provide a frame of reference through which to view OCA development and to illustrate the generalizable nature of the issues involved. In addition, study data will serve to confirm and advance some of the more tentative findings found in the literature. Findings from this evaluation study will also be used to propose alternative explanations to some hypotheses proposed in the professional literature.

Specific structural recommendations are made to address the observed limited impact (effectiveness) of the Office of Consumer Affairs. These recommendations have national significance and provide valuable information for policy makers and administrators considering the implementation of an office of consumer affairs or other consumer run programs, or who are attempting to improve the impact of existing similar offices. Implications of this study for consumer empowerment movements in general are

also discussed.

Empowerment Vision of the Office of Consumer Affairs

The Office of Consumer Affairs was designed to increase consumer representation in the State Mental Health System and to promote independent consumer services and networks located in local communities. The project was to accomplish its mission through two general arenas. The first arena included placing consumers in positions of influence in policy and decision making bodies at state, regional, and local levels. These efforts included generating an educated consumer base throughout the state in local agencies and communities. The purpose of educating consumers was to allow them to adequately represent themselves, or to be represented as more equal, proactive, participants in decisions regarding all aspects of treatment. The second arena of endeavor was to assist in the development of an advocacy base among consumers and families at local levels. This advocacy base, centered in independent consumer and family member organizations and networks, was envisioned to not only influence local, regional and state system agendas, but also to develop alternative diverse service options for mental health consumers. With input from this diverse, decentralized conglomerate of individuals and organized networks, it was felt that a wider variety of needs within the consumer community could be met. In short the Office of Consumer Affairs was meant to promote consumer empowerment.

Stakeholder Support of Mission

McLean (1995) relates the historical antecedents of consumer empowerment within the mental health arena. The term empowerment was originally meant to encompass all that was necessary to function *independently* from the mental health system. This term changed over the years in the mental health community to refer to individuals' power to exercise choice *within* the mental health system. In this process of changing definitions, the mental health industry has taken a politically challenging development and altered it through co-optation into a safely controllable "intervention" that attempts to encompass a movement. The differential use of this term may also mean that it has different meaning for various stakeholder groups. Regardless of the meaning, it is apparent that at least two co-existing attitudes exist about consumer interaction with the mental health system.

These co-existing attitudes regarding empowerment can be seen in OCA grant goals. In essence, the OCA, is intended to accomplish empowerment for consumers both within the mental health system, and independently of it. Regardless of differing root definitions of empowerment, or perhaps because of them, the tenor of the times and the broad based intention of OCA goals easily lead to the observed, general, wide support of this project by all stakeholder groups. This support can be seen in the 90.1% overall stakeholder rating of the OCA mission as "Very Important" or "Mostly Important".

Differential Stakeholder Expectations of the OCA

The research findings of this study describe significantly different expectations relating to the role of advocacy on the part of the OCA. Providers significantly more

often than consumers call for the OCA to be involved in information and referral, education, and general advocacy capacity development activities and to *not* be involved in advocacy. On the other hand, consumers significantly more often than providers call for the OCA *to* be involved in direct helping activities.

Consumers, as equally as often as providers and family members, call for direct individual advocacy activities. However, significant subgroup differences merit mention. Chief administrators and Mental Health Division staff were most likely to call for the OCA to *not* be involved in direct advocacy and were least likely to call for direct helping activities. These stakeholders are commonly perceived to have the most power within the mental health bureaucracy. Wide differences in expectations on the part of these groups have potentially serious implications for policy decisions.

It might be perceived in a cursory reading of this evidence that the gap in expectations is one between providers and consumers. There is, however, another group that significantly calls for the OCA to not be involved in direct advocacy. This group consists of the current members of the Ad-hoc Consumer Affairs Advisory Committee. Each member of this group is considered to be a consumer advocate. As previously mentioned AHCAC members have received a variety of training related to the mental health system and consumer advocacy efforts. Members have also been engaged in the implementation of a variety of community based projects.

Recognizing that significant numbers of these individuals also oppose OCA involvement in direct advocacy leads to the search for alternative explanations for a consumer, family member/provider split on the issue of direct advocacy. An assumption

that differences are based on high position within the mental health system is not supported by the data. One hypothesis is that AHCAC member opposition comes from enculturation (others have used the word co-optation) from providers through training. Another hypothesis is that these members realize that the OCA will not have its widest impact if it devotes its limited resources to the resolution of individual problems encountered by consumers around the state. The second hypothesis is supported by survey data from this study. In short, study data reveal that providers and systems savvy consumers saw the most effective impact that can be expected of the OCA is through capacity development for advocacy at local and regional levels. Many opposing direct help and advocacy activities on the part of the OCA indicated that such efforts would consume the bulk of limited staff time and thereby make the office unavailable as a training, information and development resource to advocates and providers around the state. Whether resulting from enculturation or reasoned logic, this observation is, on its face, valid.

Different expectations will lead to conflict. Similar issues in the consumer arena have been observed elsewhere. Hints of different expectations directed toward consumer employees and projects exist in the national literature. Qualitative studies (Dixon, Krauss, & Lehman, 1994; McLean³, 1995; Mowbray, et al., 1996) briefly discuss conflicts related to differing expectations of and by consumers hired as service providers

³McLean (1995) has written a qualitative study of a consumer run service that experienced many of the same issues encountered by the Office of Consumer Affairs. Because of its depth and adroit handling of many issues that are only touched upon in other literature, this chapter will refer to McLean several times throughout.

in mental health systems. Differing stakeholder expectations of project goals, leading to conflict have also been touched upon (McLean, 1995).

Permeable Boundaries and A Struggle for Ownership

The previous chapter relates that the staff were described by survey stakeholders close to the OCA operation as a 'labor pool' for the mental health division. Although this information takes little space to note and not much more to describe, its significance to the overall impact of the Office of Consumer Affairs is dramatic. At the root of this issue are differences in expectations.

Interviews with all OCA staff members revealed developing different expectations among OCA staff members and management as to appropriate activities that the OCA should engage in. These differences developed early in the life of the OCA. Early documented interviews and participant observation data reveal that OCA staff as a group initially recognized pressure from the broader mental health division to perform tasks that were described by OCA members as peripheral to the mission and possibly a threat to potential effectiveness. By the one year point, only 25% of OCA staff activities could be related directly to the tasks described in the grant. Consumer staff members were working far in excess of their allotted time (reported as much as 60 hours per week per person hired for 30 hours) in order to keep up. It was also impossible, due to the external demands of other MHD responsibilities, for the grant writer/office director to provide the administrative/supervisory and developmental input necessary to get the project adequately moving in the envisioned direction. A pattern of approximation was being

settled upon for the completion of grant described tasks by all involved directly with the office.

OCA staff eventually came to view what had been originally held to be peripheral activities as central to the OCA mission and identity. One example of this is the writing of “Blue Slips” that were responses of the MHD to a constituent on the behalf of a elected state level official. Another example can be seen in the participation of OCA staff on multiple policy committees of the MHD rather than completing the original grant intent of finding or training sophisticated consumers, not employed by the MHD, who could participate on these committees.

This process of OCA staff adaptation to conflicting expectations/demands from the MHD was pointed out to the MHD at the mid-point report on the evaluation of the OCA grant. By then a struggle for control had ensued between the OCA grant director and the consumer staff. This struggle was being exacerbated by higher levels of mental health administration who allowed the supervisor to be bypassed and who placed demands upon the consumer staff over the objections of the director. The demands were described by MH administration as opportunities and enhancements to the OCA mission. The evaluation found that these additional involvements were actually a process of consuming the advocacy capacity building ability of the office.

What happened in this demonstration project was that the immediate supervisor of the grant director gave tasks to OCA staff members which were not central to the mission. The staff became invested in these projects and resisted the direction of the grant director to focus on clearly defined grant goals. This resistance was supported by

the director's immediate supervisor to the point that the grant director felt she no longer had any control of the project and that the OCA was not carrying out the tasks of the grant. At this point the grant director removed herself and the OCA staff continued under the nominal supervision of the grant directors former supervisor with no functional lines of established accountability. With some additional staff attrition and administrative changes these circumstances continued through the end of the data collection period. Beyond the predictable personal conflict observed by the literature, and other variables already mentioned, the ongoing organizational pressures and turmoil of the MHD during this time worked against top level administrative attention to the OCA internal issues and exacerbated a situation that would have been difficult even in a stable environment.

Continuing differences in expectations on the part of influential MHD and OCA staff contributed to the ongoing conflict and dissatisfaction on the part of many stakeholders. The findings of the stakeholder survey indicate that these conflicts were not resolved in such a way as to promote focused coordinated efforts on the part of OCA to bring it recognition as a viable resource on the part of the vast majority of the consumer population and providers.

Conflict as a Normal Part of Program Development

As just mentioned, it was apparent from ongoing interviews, from phase I of the evaluation, that there was disagreement among non consumer MHD staff as to most appropriate roles for OCA staff as well as supervisory lines of communication. These problems, including external demands on OCA staff time, may have been exacerbated by

tight budgets, administrative regulatory reform, MHD staff cutbacks, and an ongoing environment of emergency and crisis management mode of operation on the part of the overall MHD. These pressures, different expectations, and the conflict associated with them is seen by this evaluator as contributing to diffuse efforts of the OCA and an inability on the part of the MHD to adequately supervise OCA staff and directions. At their root these are issues of ownership and expectation that have been observed in the national literature.

The professional literature observes that conflict is a natural occurrence in the formulating of new programs (Hage, & Aiken, 1970; Kantor, 1983). This was the case within the OCA and in the MHD management of it. The stakeholder survey shows that observed conflict, and an inability of the MHD to resolve it was felt by stakeholders to be a significant detriment to OCA effectiveness. Generated from different expectations, the literature has also observed that such conflict is often of a personal nature and viewed as a struggle for control (Hage, & Aiken, 1970; Kantor, 1983). Observable significant conflict continued throughout the OCA grant with less emphasis on open disagreement during the last third of the grant life. Even though overt conflict abated, there continued to be significant evidence of such within the OCA staff and between MHD staff and the OCA as well as between the OCA and various non MHD stakeholders through the end of the data collection process. While conflict in a new program is normal and expected, clearly the normal organizational mechanisms designed to address such conflict within the larger organization were not adequate to bring resolution in this case.

Advocacy Group Vestment In Ownership

The issue of ownership of consumer organizations sponsored by professional agencies is noted in the national literature. In the McLean (1995) study, conflict developed over ownership of the program. Different definitions of expectations from consumers and contracting providers led to paid consumers responding to the perceived expectations of providers and a struggle for decision making ownership on the part of consumers. Within the present survey results, these consumer stakeholders, whether or not dissatisfied, often called for consumer, non-employee, oversight of the OCA. The pressure from advocacy groups as well as general consumers voicing these opinions make the struggle for ownership of the current OCA office apparent.

The OCA was intended to be an egalitarian organization that coordinated and facilitated a variety of educational and empowerment initiatives throughout the state. In essence the OCA intended to look to the entire consumer community as its organizational and operational base. As can be seen above, issues of ownership quickly developed as the organization responded to external pressures from the MHD as well as the advocacy movement. As in the McLean (1995) study, without the direct presence of the OCA staff in the general consumer community around the state, there was a lack of direction related to OCA goals and an absence of knowledge, even though interest remains high. In the McLean (1995) study when the levels of frustration on the part of consumers reached high levels, consumers stopped using the service. The case of the OCA has been different. Those who were knowledgeable but frustrated with the function of the office, responded by voicing their opinions through advocacy group spokespersons such as AMI,

WAMI, WECAN, and the AHCAC to Mental Health Division employees.

There was overwhelming stakeholder support among all groups in this survey for consumers to have an active role in the supervision of the OCA and its activities. One proposal was that this happen through the AHCAC. Others called for an oversight committee of consumers and family members that monitored the OCA and reported to the MHD management. To be most responsive to the needs of the stakeholders the issue of ownership must be addressed for the OCA.

Technical Staff Qualifications

Another issue that is not directly addressed but, nevertheless, existing in literature discussions is related to professional qualifications of consumer staff and the relationship of these qualifications to implementing the mission of the particular consumer agency or project being studied. A related issue is appropriate provision of professional management/skill support to consumer staff and directors. The literature does mention complexities (difficulties) that have been observed with the employment of consumer staff (Dixon, Krauss, & Lehman, 1994; McLean, 1995; Mowbray, et al., 1996). McLean (1995) talks about the behavior of consumer directors of a project she studied. Implying that these persons were controlling, McLean (1995) states they were not able to function in an egalitarian environment that allowed consumers to voice their opinions and to allow for non-paid consumers to have control. The professional qualifications of employed consumer staff were that of a medical doctor, an educator, an administrator, and a provider of mental health services. No mention is made of the specific training in

professional values that would encourage unconditional positive regard, promote empowerment of the consumer base, and focus on giving up control which are the implied solutions to the observed organizational problems.

In the case of the OCA and possibly in the cases described by McLean (1995), the individuals hired lacked professional training in community organization, program development, and the promotion of self care on the part of individuals. They also lacked the specific technical expertise needed in the area of computer data base development, self evaluation and setting up a computer bulletin board system. Lack of professional training of consumer staff is viewed by this evaluator as having a significant impact on difficulties with grant implementation and perceived ineffectiveness.

Egalitarian Values of Consumer Staff and Focus of Energy

The final factor in the finding of OCA diffuse effectiveness also relates to the egalitarian values just mentioned, and the need to share control of process and outcomes. Professional boundary issues with consumer employees and between consumer employees and consumer constituents are beginning to be discussed in the newly emergent literature (Dixon, Krauss, & Lehman, 1994; Mowbray, et al., 1996; Solomon & Draine, 1996). These boundary issues are directly related to control. Determining professional behavior toward consumers and how to deal with relationships between consumers has been an issue for the OCA as can be seen in the internal control struggle and the described conflictive patterns between OCA staff and professionals and other consumers outside of the MHD.

McLean (1995) addresses the issue of relationships. The consumer staff were implied by the author to have lacked a sense of the value of mutual empowerment, support, and non-control. Observing that the consumer employees had not been associated with the consumer advocacy movement, McLean (1995) implies that the solution to consumer employee leadership problems can be found in selecting consumers who have been part of this movement.

McLean (1995) related that many of the observed organizational problems, related to relationships and performance, could be attributed the lack of enculturation of the consumer staff in the values and social dynamics of the consumer advocacy movement. In the case of the OCA, all internal staff and the grant director were intimately acquainted with these values. The consumers had indeed been drawn from the state consumer movement. In spite of these experiences, many of the consumer stakeholders that the OCA was meant to serve were alienated in ways very similar to those described by McLean (1995). Because of the continued performance and relationship difficulties with the OCA, it is apparent that the answer may not lie entirely in the associations from which a consumer is drawn.

It is possible that OCA staff directed their energy to activities that they knew best and were most comfortable with. Consumer employees in this study were observed by key stakeholders as individuals who enacted their own agendas in the face of overall organizational confusion and mixed messages emanating from the MHD and other stakeholders. Stakeholders also observed that consumers within the OCA, readily acted on the invitation/direction to become actively involved in service provision and decision

making within the MHD. Such activities were often the focus of effort rather than the role of facilitation intended to support the development of independent consumers to sit on these decision making bodies.

The professional literature also touches on possible reasons for this type of behavior. It is possible that OCA consumer motivation to recover and achieve professional credibility made it likely for them to become rapidly over-involved in activities of the larger MHD. Some of those in the consumer advocacy movement with whom the OCA consumer employees had been previously associated were moved to accuse OCA staff of being coopted and becoming "little bureaucrats". This opinion was shared by some providers who were acquainted with, or had observed OCA staff behavior in meetings. The above tendencies, while not entirely unidirectional, are consistent with observations of McLean (1995) who noted that consumer employees saw their positions as a means to recoup former status and a stepping stone for further promotion within the provider system.

Clearly for any OCA to be successful the above issues need to be addressed. The development of the Office of Consumer Affairs was basically a political act with specific aims and tasks to accomplish. It is reasonable that in the selection of consumer employees for such a project, the professional qualifications, values, and possible motivations of the staff are important considerations in the hiring and promotion within the project.

An End Result

Stakeholders in the currently reported survey observed a general lack of focus, conflict within the office and between office staff and other stakeholders. There is a perceived overall lack of effectiveness. These stakeholder observations are reinforced by the general overall program evaluation. It is the hypothesis of this researcher that a combination of the above variables led the OCA to these conditions. Any or all of the above circumstances can potentially impact a similar office and other consumer sponsored, run projects. Before making recommendations as to solutions, two other findings need to be discussed.

Ad-Hoc Consumer Affairs Advisory Committee Success

Beyond assessment by some that the OCA is successful only in that it survived in spite of problems, the AHCAC that was sponsored by the grant and coordinated by the OCA is viewed by many stakeholders and this evaluator to have been the most successful portion of the grant. It is an example of OCA efforts gone well. AHCAC members were all chronically mentally ill volunteers who were already viewed, prior to membership, as persons of some significant accomplishment within their community. This recognition came in spite of their recognized disability. While the name of the AHCAC was not widely recognized nor was knowledge of its activities extant, its members were repeatedly mentioned by other consumers and providers as persons of some influence and importance within the mental health system.

Overall the AHCAC group viewed membership as being helpful to them in

activities in which they were already inclined to be engaged, but also by widely expanding their relative horizons and broadening their understanding of the mental health system itself. Many attributed their membership as having been a great assistance to them personally and in their work. Several also attributed their movement to employed status as being partly attributable to membership. Overall this committee has been developing positive relationships with providers as well as consumers and are viewed by all stakeholder groups as knowledgeable assets to the system.

Various AHCAC members described OCA staff as controlling and demeaning. These descriptions are consistent with observations of McLean (1995) who described the conflictive relationship between the paid consumer staff and the volunteer members of the organization that she observed. Conversely, the OCA staff is credited by these same members with releasing control of AHCAC decision making to the volunteer member constituents. This control was in two areas, first the roles of leadership and facilitation were released to the group who then began to rotate this responsibility, secondly, the agenda and learning curriculum was given to the committee. This release is credited by many members as the turning point in the group, moving it from a non-useful exercise to one that empowered them to take control of the AHCAC within its defined mission. This move is also credited as enabling members to resolve conflicts and move toward accomplishment of tasks as a group and individually.

Issues still remain in the minds of AHCAC members related to AHCAC functioning and performance. Included are questions relating to how membership is chosen, how long the membership should last, how new members should be introduced,

and what oversight role should they have vis-a-vis the OCA. For those members choosing to move on, there are questions regarding continued engagement for members at state, regional, and local system levels with regard to policy and decision making and advocacy. In spite of such issues that need to be resolved, the AHCAC is described by those who are acquainted with it as an example of consumer involvement, education, and empowerment efforts - gone right. It could be viewed as a desirable, working example of consumer operated services. Central to the success is evidence of a continuing desire among members to provide egalitarian support of each other, a relatively clearly defined purposes, and a defined benefit to the members and larger community.

Continuing Stakeholder Support and Desire for Reform

The last finding is highly noteworthy: in spite of the observed ineffectiveness of much OCA effort, stakeholders wish it to continue, all be it, with revisions focusing on achieving the original mission. Any administrative decision making regarding the OCA and AHCAC should take into account the overwhelming support for the office and the desire to fix it. The following recommendations will assist the OCA in this task.

Recommendations

To achieve the original goals: to be most widely recognized, to promote effective building of independent consumer networks external to the mental health system, and advocacy within the mental health system, the OCA needs to redirect its efforts to its original plan focusing on capacity development through facilitation rather than

concentrating efforts at individual advocacy and helping, and personally sitting on policy making bodies in the MHD and attending national meetings. This refocus will require a single supervisory goal and support from the MHD to this end.

The problems of internal conflict and diffuse efforts of the OCA that are found within this evaluation are mentioned within the broader literature. The issue of conflicting organizational agendas has also been previously mentioned. Also issues related to training, values, and the motivation of consumer staff to recover or gain positions of professional credibility are mentioned in the literature (Zinman, 1987) and parallels are found in this study. To be maximally effective, each of these challenges will need to be addressed in future projects. A plausible explanation as to the course and effectiveness of the OCA in its initial stages can be found in the evidence that these factors are all operating within this Office of Consumer Affairs project.

Beyond the literature, in the public arena, interviews with national figures within the office of consumer affairs movement indicate OCAs set up with permeable boundaries are susceptible to peripheral demands from within their umbrella organization. These offices have had difficulty. Those offices who have a trained professional next to the MHD director have experienced the most success (J. Slack, personal communication, March 1996). These interviews, while anecdotal, also share that offices that are allowed to develop within protected administrative conditions and also exist at the highest levels of management are most successful in accomplishing their mission and being well received as an effective addition to the mental health system. Such assertions, while presenting face validity, need to be empirically investigated. This

study has also revealed additional factors that must be accounted for to insure success.

The recommendations are as follows.

- ▶ Continue the OCA. This may not be an obvious choice for some and is therefore best stated. The support is wide spread as is the desire for an effective OCA.

- ▶ Recommit to the original OCA mission emphasis on linking learning and changing. Place primary emphasis on; providing information and referral services; developing, gathering and disseminating technical assistance materials; providing training and educational activities related to consumer abilities, respect, non discrimination, and advocacy group development/ improvement. Support advocacy groups and service providers in their efforts to insure quality services for chronically mentally ill consumers. Place an emphasis on developing consumers (other than OCA staff) who are capable as serving in an advisory role to the MHD and regional agencies in the formulation of policy. Do not become engaged in activities of individual helping and advocacy. Refer these to others such as ombuds persons or independent advocates at local levels.

It is feasible to have an OCA that focuses its energies on the promotion of consumer empowerment both outside and within the mental health system. It is *not* feasible for the OCA to be involved at the level of individualized helping or advocacy. This type of activity is not supported by key stakeholders both within the consumer and provider community. The OCA can be most effective operating on ground where there is wide spread stakeholder support. Helping and individual advocacy activities detract from the OCA mission in two ways. First, advocacy efforts lead providers to avoid OCA staff for fear of further confrontations and time consuming requirements. Because of this emotional unavailability, providers will not rely upon the OCA for educational and consultation purposes regarding consumer empowerment issues. Second, individual cases will consume OCA resources needed to develop consumer leadership and advocates

throughout the state - thereby reducing the demand for state level intervention.

- ▶ **Administrative support for mission/grant focused activities is critical. Clearly, to accomplish the dual empowerment mission of the OCA, while balancing the differing expectations of stakeholders there needs to be a unified consensus and policy on the part of the overall sponsoring agency (MHD) as to the most appropriate roles for the OCA as well as division of time. Limiting outside demands emanating from within the MHD as well as the OCA staff itself is needed to regain and maintain mission focus based on grant formulated guidelines. Additional administrative ground work is needed on the part of the MHD. This includes education of the broader MHD staff. To improve the OCA operating environment senior supervisory protocols and support are needed to insure maintainable boundaries and to handle internal personnel issues (such as non-performance of work and or conflictive patterns of relating that have impacted this OCA). Technical assistance is also needed to create adequate informational and record keeping systems. Assure management and supervisory oversight and accountability based on clear, time linked, measurable goals and objectives. Monitor outcomes, adjusting the provision of technical and supervisory assistance and support as needed. Conduct in-house and MHD ongoing education both formally and informally with a focus of improving communication, respect, and trust between the OCA staff and others.**

Interviews on the national level have stated that participation on the management team is and the hiring of one consumer only is necessary to insure success. While neither of these conditions were fulfilled by this OCA, this evaluator does not consider the position and number of staff to be the crucial factors. At the root of the suggestions are the need for an OCA to be insulated from outside demands, to maintain focus, and to have the ability to limit/control responses to internal and external conflict. Each of these abilities would have been invaluable in the light of the organizational turmoil that existed within the MHD, however these needs could have been met through clear ownership and attention on the part of the MHD director and the ability of the OCA director to appeal to directly to the OCA director from any organizational level when necessary to control outside interference.

Those directly above the OCA director must clearly understand and support the mission, the goals, the specific methodologies, and the tasks to be undertaken by the OCA. Clear lines of supervision are also necessary. Failure will occur under circumstances in which those with power over the OCA director are allowed to directly assign OCA line staff duties without the agreement of the OCA director, and who also negate the authority of the OCA director in issues of supervision of staff (both of which happened in this project). Similar circumstances in any organization will dramatically increase the probably of mission failure.

- ▶ Open the position of director of the OCA. In addition to the desired consumer status, stipulate that a masters degree or equivalent and mature successful experience in community organization, agency administration and program development be part of the selection criteria. It is critical that the consumer management and staff of the OCA have the technical skills and understanding to coordinate and implement a community organizational project such as this.

The lack of library resources, newsletters, training curriculum, announcements of the OCA and the role of individual helping and advocacy, reflect OCA individual staff agendas but also a lack of training in how to accomplish basic community organizational tasks. OCA time was consumed by individual demands from consumers and additional tasks/distractions, within the MHD that were only peripherally tied to the central grant mission. These are not personal issues but reflect a lack of appropriate theoretical understanding that allow for strategic planning and use of energy.

- ▶ Insure that the person hired understands the focus on capacity development and facilitation. Close familiarity with the consumer/family advocacy movement and values is needed as is an ability to interact with these and other stakeholder groups and individuals diplomatically.

The position of director requires a trained seasoned professional leader who is able

to objectively carry out policy and implement programmatic features while creating an environment of respect, trust and collegiality with persons both within the division and stakeholders without. The creation of such an environment requires basic dual values of respect for others and empowerment. These qualities are also needed to a lesser extent by all consumer staff involved with the OCA. There are consumers that can fulfill these criteria. Seeking a skilled educated consumer to fill this position should be a priority. Search efforts should take place at local, statewide and national levels.

In a related issue, McLean (1995) touches on the idea that those consumers who were most capable of promoting the inclusive egalitarian function of an organization remained in the background and did not vie for leadership. This implies that those most likely to seek such positions were inherently unable to promote organizational values needed to be successful. These observations were supported by both consumer, family member, and provider stakeholders during the course of interviews for this study. While all of the above need to be investigated further, these conditions, if true have direct impact on the nature of consumer employee recruitment and supervision.

Implications for recruitment are clear. Nominations need to be sought. Also the person hired needs to already achieved recognizable personal professional success following their consumer status. This will lesson the possibility of the consumer director or staff pursuing the immediate spotlight of being an active 'policy maker' rather than fulfilling the role of one who develops others through facilitation, training , education, and positioning others in key roles of policy input.

- ▶ Policy decisions consistent with MHD ethics, statutes, organizational vision and values are needed concerning what is appropriate information and traffic for the computer bulletin board system/world wide web site (BBS/WWW). The primary intent and direction of the BBS/WWW site as well as the OCA is to promote consumer voice, and meaningful participation in the decision making process regarding individual services as well as overall policy. Support this mechanism as a centralized focal point of communication and an informational tool for consumer and family advocates to increase networking, support, and education. Consistent with the MHD statewide coordination and facilitation role, the BBS/WWW goal should be to enhance consumer empowerment through involvement in policy change and advocacy development. Regardless of its impact to date, policy decisions are needed to insure clarity as to appropriate material to be shared, and to open the flow of material from the division and other sources that can be posted.
- ▶ To enhance stakeholder ownership, engage and assure OCA stakeholder involvement in partnership for selection of their representatives in OCA and AHCAC. Include individual consumers and organizational representatives from advocacy groups. Lift the decision making capacity onto an objective group of experts and stakeholders. Invite scheduled, ongoing input to MHD management and the OCA regarding OCA performance and accountability. Include consumers, (including the AHCAC) family members, and community service provider stakeholders in this feedback through the form of an oversight committee.
- ▶ Continue and expand support for the AHCAC under its new name. Maintain both training and policy feedback activities. In addition to engagement in meaningful activities the AHCAC can serve a role in the self perception of empowerment on the part of the broad range of consumers and family advocates in the state. There is a direct link between viewing a member of one's group as empowered and representing the larger group and feeling personally empowered.

In addition to ongoing training, an emphasis should be placed upon assisting members both individually, and as a group in operationalizing community and state level consumer empowerment activities. Provide direct technical support to members engaged in local advocacy development projects. Money for expenses is needed to enable AHCAC members to have broader consumer and community contact. Colorful pamphlets, readily available videos and training resources can be combined with the

regular presence of educated advocates within local agencies to increase the awareness of both consumers, providers, and family members as to the resources available to them through the OCA and other sources.

Local support for technical assistance and educational activities is needed.

Increased financial commitment is needed from local providers to enhance local development. Communities where this is happening are producing effective, respected consumer advocates. The OCA statewide role should link national, MHD, and local level efforts to identify and procure resources. Use these resources in the continuing development of consumer empowerment activities in local, regional, and state arenas that promote partnerships for systems change.

- ▶ Create AHCAC membership terms based on 1/3 rolling tenure. Institute a mentoring system for new members. Develop a coordinated training curriculum and identifiable tasks and roles for the AHCAC as a group. Facilitate constructive involvement of ex-members in the MH system at all levels to insure an expanding resource pool of informed educated consumers.

Conclusion

The Mental Health Division Office of Consumer Affairs is one of several relatively new state level mental health division offices that have been developing nationally. The primary purpose of the Washington OCA as described within the grant is to promote consumer empowerment through advocacy development at local levels. The goal is the education of consumers, family members, and providers in areas related to consumer empowerment and respect, and to achieve increased consumer representation at all levels

of the mental health system. The OCA which is the subject of this study is the first office of its type to be evaluated as to its impact. This dissertation study has reported the primary results of the stakeholder survey conducted as part of the overall evaluation and provided highlights to survey data from material gathered from the other streams of data included in the triangulation methods of the overall evaluation.

Accompanying wide support and a pronounced lack of stakeholder knowledge concerning the OCA, the findings of this study present a mixed picture of stakeholder opinion that predominantly views the overall efforts of the OCA as less than effective, and not focused on the original grant goals. The study also finds a distinct view of the Ad-Hoc Consumer Affairs Advisory Committee as being a helpful, successful addition to the mental health system and a boon for the consumer empowerment/advocacy movement within the state. The OCA has been responsible for the development and maintenance of this committee.

Issues observed in this study as impacting the OCA have also been touched upon in wider national research but not directly addressed in a comprehensive manner. These issues can potentially directly impact any consumer run program, particularly offices of consumer affairs. The few proposed solutions to problems experienced by the OCA that are found in the professional literature may be wide of the mark due to the noncomprehensive nature of the problem view. This study has made specific recommendations that will address the issues found within the OCA.

To best meet the intentions of the grant, the object of the OCA should be to develop a consumer and family voice within the mental health system to the point that there is no

need for individual advocacy on the part of the MHD at local levels and a pool of capable consumers and family members who actively participate in policy development and advocacy roles. Individual problems, whether of a personal or policy nature that do develop would ideally be met with aid from organized consumers and families in the community. Implementation of the recommendations outlined in this chapter will help insure that these goals can be met.

Interviews with all stakeholders envision the above circumstance as the ideal within the mental health system. These goals are where common ground can be found between all stakeholder groups. It is on this common ground that effective operation can take place. Such an environment will require an organization that functions in a facilitative, consensus building, developmental role. This coordinative role is appropriate for a state level agency.

There is overwhelming support for the concept of the OCA and support for its continuation. With adjustments, this consumer centered project can be much more effective in systems change than it has been to date. Some of the barriers to maximally effective service that have been confronted by the OCA have been encountered by other consumer run organizations and are occasionally briefly described in the limited professional literature. Many of the range of issues identified in this study have been to this point described only in fragments in the extant literature. This same literature has been even less forthcoming regarding solutions to observed problems. The author has proposed solutions based in the data that when implemented will increase focus and effectiveness of goal attainment. These recommendations are applicable across a wide

range of services - where ever similar issues may be encountered.

The identified issues, problems, successes, and recommended problem resolution strategies identified through this research are germane to other consumer run organizations and are not exclusive to offices of consumer affairs. Programs that can account for these eventualities in advance of project implementation and also make adjustments while in process will have higher probability of success, whatever their goals.

Ultimately, the goal of the OCA and other similar offices is empowerment of the mental health consumer. With adequate support, this type of service has potential to directly impact an entire state mental health system and thereby improve the lives of chronically mentally ill persons.

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Appendix A
Survey Instruments

**Day Treatment Client, Consumer Run Club House Member, &
1-800 & Computer BBS User**

(Day Tx. Client)(Cons. Run Club House Mem)(1-800 line)(Computer BBS User) (Circle One)

Code: ___ Number _____ Interviewer _____ Agency. _____ Date _____ Time Start
 ___ Phone _____ Face to Face

Read Consent

1. Female Male (circle one)
2. ___ yes ___ no: Have you heard of the Office of Consumer Affairs?
3. ___ yes ___ no: Have you heard of the Ad-hoc Consumer Affairs Advisory Committee?

4. If yes to 2 and 3 skip to # 6/7. If no to either 2 or 3 read the following:

The Office of Consumer Affairs was created in October 1992 in the mental health division and has been staffed by Marianne Neff-Daniels, Jon Ihler, Nancy Donigan, Chris Wilde, Yvonne Britt and supervised by David Hanig. Many of the staff are mental health consumers. Collectively the Office of Consumer Affairs was meant to provide information and referral services for consumers, provide a voice for consumers on the state level, promote consumer networking around the state and increase consumer employment and participation on mental health decision making bodies. The Office of Consumer Affairs also put together a group of consumers from around Washington that meet every other month and carry out projects in their home communities. This group is called the Ad-hoc Consumer Affairs Advisory Committee.

5. ___ yes ___ no (if no skip to question 35) Does this information bring anything to mind about what you might have heard about these people or the Office of Consumer Affairs or Ad-hoc Consumer Affairs Advisory Committee?

6. What do you know about the Office of Consumer affairs? (check for knowledge)

- | | | |
|--|---|---|
| <input type="checkbox"/> 1-800 information referral telephone line. | <input type="checkbox"/> Identify consumer as speakers to universities, schools and communities. | <input type="checkbox"/> Two major technical assistance activities events products per year. |
| <input type="checkbox"/> 1-800 complaint telephone line. | <input type="checkbox"/> Teleconferencing with national groups. | <input type="checkbox"/> Offer statewide training conference to promote consumer employment in the mental health system. |
| <input type="checkbox"/> Computer bulletin board. | <input type="checkbox"/> Coordinate presentations to MH conferences/meetings re consumer employment in the MH system. | <input type="checkbox"/> Evaluation activities by consumers/family members |
| <input type="checkbox"/> Create Consumer Advisory Sub-committee (AHCAC) | <input type="checkbox"/> Incorporate OCA into MH Div. | <input type="checkbox"/> Double the number of family and consumers represented on state and local advisory governing and management boards. |
| <input type="checkbox"/> Clearing house library function. | <input type="checkbox"/> Send one consumer and one family member to NIMH CSP learning conference. | <input type="checkbox"/> Demonstrate reasonable accommodation i.e., Americans With Disabilities Act. |
| <input type="checkbox"/> Produce informational materials. | <input type="checkbox"/> Provide 2 statewide trainings in grant writing and fund raising. | <input type="checkbox"/> Other. |
| <input type="checkbox"/> Technical assistance materials. | <input type="checkbox"/> Provide training in boardmanship to consumers and families. | |
| <input type="checkbox"/> Produce video newsletters. | | |
| <input type="checkbox"/> OCA to disseminate grant announcements and promote grant development. | | |
| <input type="checkbox"/> Make referrals to mental health boards. | | |

If Other. List:

7. A: What services of the OCA listed above have you used or tried to use? (U for used T for tried)
 B: For each service used which describes how satisfied you are. (ask for all U or T except 1-800 & Computer Bulletin Board System)

1	2	3	4	5
not at all	mostly	neutral	mostly	very
satisfied	not		satisfied	satisfied
	satisfied			

8. What do you know about the Ad-hoc Committee? (check for knowledge)

- Nothing
- Identify technical assistance needed to impact MH system change
- Build peer support and advocacy groups.
- AHCAC networking activities.
- Publish results/articles in NETWORK NEWS.
- Leadership seminars for AHCAC.
- AHCAC to report to State MH Advisory Committee.
- AHCAC to provide TA to peers, MH Centers, Advocacy Groups every month.
- Compile Speakers List of consumers and family advocates, make recommendations to conferences and seminars.
- AHCAC to establish learning goals.
- AHCAC to evaluate training experiences.
- AHCAC to monitor P.L. 99-660 Consumer/Family section implementation.
- AHCAC to recommend changes to P.L. 99-660 state implementation plan.
- Promote consumer involvement on biennial regional planning.
- AHCAC to serve as referral source for members of community MH boards.
- Others.

If Other, List:

(9) If knowledge and use of 1-800 is evident: (if not skip to #15)

9. How did you find out about the 1-800 phone line?

10. What are the kinds of reasons have you contacted the Office of Consumer Affairs by phone? (Read question, get answers, clarify categories and fill in subjects number for category)
- information
 - referral
 - complaint/need for advocate from the Office of Consumer Affairs
 - other

If Other, List:

11. Were you satisfied?

1	2	3	4	5
not at all satisfied	mostly not satisfied	neutral	mostly satisfied	very satisfied

12. Why?

13. What role has access to the 1-800 Office of Consumer Affairs phone line played in your life?

14. What changes would you make with the way the Office of Consumer Affairs handles the 1-800 calls to make the line more helpful?

(15) If knowledge and use of Computer Bulliten Board System is evident:(if tried skip to #21 if no skip to #27)

15. How did you find out about the Computer Bulletin Board System?

16. What features did you use the most?

Mail Room

Read Topic Areas

Document Downloading

Other *If other list:*

17. What features did you find easiest to use?

Mail Room

Read Topic Areas

Document Downloading

Other *If other list:*

Comments:

18. What role has the Computer Bulliten Board System played in your life?

19. What changes would you make with the Computer Bulliten Board System to make it more helpful?

20. Were you satisfied?

1
not at all
satisfied

2
mostly
not
satisfied

3
neutral

4
mostly
satisfied

5
very
satisfied

If tried:

21. What kept you from using the Computer Bulliten Board System successfully?

BBS was not operating

Lack of computer access

Information not useful

Lack of technical assistance to log on

Difficult format

Other *If other list:*

22. What are the 3 most important things the Office of Consumer Affairs Computer Bulliten Board System could do for you? (Rank 1,2,3 1 = most important: don't read to prompt but after answer make sure you clarify, then rank for importance ok for more if first 3 are ranked)
- Help me keep in touch with consumers, family members
 - Give me information about other Consumer activities
 - Give me information about State Mental health division
 - Don't know
 - Other
23. If the computer bulletin board system was contracted out to a consumer/group outside the mental health division rather than being run by consumers from within the division what impact do you believe this would have?
24. Why?
25. Yes No: Would you be in favor of contracting out the Computer Bulliten Board System?
26. Why?
27. _____ Year _____ Month: When did you first find out about Office of Consumer Affairs, Ad-hoc Committee?
29. How much has your life been impacted by the work of the Office of Consumer Affairs or Ad-hoc Committee?
- | | | | | |
|------------|---------------|--------------------|----------------|---------|
| 1 | 2 | 3 | 4 | 5 |
| nor at all | hardly
any | moderate
amount | a good
deal | greatly |
30. How? In what ways?
31. yes no: Has the life of any one individual you know been impacted? (if yes how many?)
32. How? In what ways?

33. yes no: Has any organization or group of people that you know of been impacted by the work of the Office of Consumer Affairs or Ad-hoc Committee? (if yes which ones?)

34. How? In what ways?

35. The Office of Consumer Affairs was created and placed in the state mental health division so that it could accomplish 3 things: 1) have a consumer ear and voice in the day to day workings of the mental health division; 2) promote consumer representation at the mental health division by communicating with other consumers, promoting placement of independent consumers and advocates on boards and policy making bodies at the state and local levels; and 3) help develop consumer communication, advocacy, and independence around Washington by serving as an information, referral, and training resource. These are the purposes of the 1-800 information and referral phone line, the resource library, the computer bulletin board system, and the Ad-hoc Committee.

36. How important do you believe this function is to mental health services in our state and particularly to consumers?

1	2	3	4	5
not at all important	mostly not important	somewhat important	mostly important	very important

37. Why?

38. yes no Is there a need for full time consumer representation at the Mental Health Division? Why? or Why not?

39. If yes to 38: What should this look like? (Staff structure, location?)

39b. (If yes to 38) What kind of role should consumers have in hiring their representatives at the state mental health division level?

- 39c. (If yes to 38) What kind of role should consumers have in supervising these representatives?
40. What other ways could Washington accomplish the goals of the Office of Consumer Affairs and Ad-hoc Committee?
41. What would you most like to see the Office of Consumer Affairs doing?
42. What would you most like to see the Ad-hoc Committee doing?
43. What would you like to see happen as a result of these efforts?
44. What is the most helpful thing the Office of Consumer Affairs could accomplish?
45. What is the most helpful thing the Ad-hoc Committee could accomplish?
46. Given what you know about the Office of Consumer Affairs and Ad-hoc Committee, consumers and State mental health services, what do you expect to see the Office of Consumer Affairs accomplish?

- 47. What do you expect of the Ad-hoc Committee?

- 48. Are there harmful things that could come from the Office of Consumer Affairs? (If yes then:) What are the most harmful things that could come from the Office of Consumer Affairs?

- 49. Are there harmful things that could come from the Ad-hoc Consumer Affairs Advisory Committee? (If yes then:) What are the most harmful things that could come from the Ad-hoc Committee?

50. How do you see the relationship of consumers with: (Read with each item followed by the scale starting with "mostly negative with conflict" then "somewhat negative" etc.)

- 1. their own families
- 2. family advocate groups
- 3. consumer advocacy groups
- 4. mental health service providers

Use with #50

1	2	3	4	5
mostly negative w/conflict	somewhat negative	neutral	somewhat positive	very positive, cooperative

51. What would you like to see the Office of Consumer Affairs and Ad-hoc Committee doing about these relationships?

52. Do you feel the Office of Consumer Affairs is successful? (skip if no knowledge of Office of Consumer Affairs go to #55)

1	2	3	4	5
not at all successful	mostly not successful	neutral	mostly successful	very successful

52b. What do you feel have been the greatest successes?

- 52c. Have there been failures? (If yes) What are they?
53. If yes: How? What makes it successful? 54. If no: What would it take to make it successful?
55. Are there any other ways the Office of Consumer Affairs can be improved? (If no knowledge of Office read: Based on our conversation so far and what you now know about the Office of Consumer affairs are there any other ways the Office can be improved?)
56. Do you feel the Ad-hoc Committee is successful? (skip if no knowledge of Ad-hoc Committee skip to #58)
- | | | | | |
|--------------------------|-----------------------------|---------|----------------------|--------------------|
| 1 | 2 | 3 | 4 | 5 |
| not at all
successful | mostly
not
successful | neutral | mostly
successful | very
successful |
57. How could the Ad-hoc Committee be improved?
58. The office of consumer affairs grant will run out during this coming year. Closing the office rather than continuing its funding is being considered. What impact do you believe that closure of the office would have?
59. yes no Do you feel it should be closed?

60. Why?
61. Do you know another consumer who would disagree with your overall views regarding the Office of Consumer Affairs and Ad-hoc Committee? This will help us get the widest range of views for further research about this. If these people are contacted we will not use your name. Names?
62. Do you know any other people/providers, family members or someone else who would disagree with you about this? This will help us get the widest range of views for further research about this. If these people are contacted we will not use your name. Names?

I have just a couple of very quick questions left. The answers will help us make sure we have the biggest number of different kinds of people represented in this study.

- 63a. ____ years ____ months How long have you been receiving mental health services no matter where you have lived?
- 63b. ____ years ____ months How long have you been receiving mental health services in Washington?
64. I'm going to read a list of services sometimes received by consumer of mental health services. Would you please tell me what services you are receiving as I read them?
- | | | |
|--|--|--|
| <input type="checkbox"/> Medication | <input type="checkbox"/> Paid part time employment | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Parenting Classes | <input type="checkbox"/> Food Stamps |
| <input type="checkbox"/> Day Treatment/Club-House | <input type="checkbox"/> Vocational Support | <input type="checkbox"/> AFDC |
| <input type="checkbox"/> Family Therapy | <input type="checkbox"/> Housing Individual/Group | <input type="checkbox"/> SSI |
| <input type="checkbox"/> Paid full time employment | <input type="checkbox"/> Medical Coupons | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> Supported Employment | | <input type="checkbox"/> Other |

If Other List:

65. _____ What is the highest level of education you have attained?
66. _____ Your date of birth (month/day/year)
67. _____ What is your ethnic group (race)?
68. Any questions?
69. (Time Finish: _____)

Advocacy Group Member

AMI, WAMI - Family Advocacy Group Member Interview (Circle one)

Code: ___ Number _____ Interviewer _____ Agency. _____ Date _____ Time Start
 ___ Phone _____ Face to Face

Read Consent

1. Female Male (circle one)
2. ___ yes ___ no: Have you heard of the Office of Consumer Affairs?
3. ___ yes ___ no: Have you heard of the Ad-hoc Consumer Affairs Advisory Committee?

4. If yes to 2 and 3 skip to # 6/7. If no to either 2 or 3 read the following:

The Office of Consumer Affairs was created in October 1992 in the mental health division and has been staffed by Marianne Neff-Daniels, Jon Ihler, Nancy Donigan, Chris Wilde, Yvonne Britt and supervised by David Hanig. Many of the staff are mental health consumers. Collectively the Office of Consumer Affairs was meant to provide information and referral services for consumers, provide a voice for consumers on the state level, promote consumer networking around the state and increase consumer employment and participation on mental health decision making bodies. The Office of Consumer Affairs has also put together a group of consumers from around Washington that meet every other month and carry out projects in their home communities. This group is called the Ad-hoc Consumer Affairs Advisory Committee.

5. ___ yes ___ no (if no skip to question 35) Does this information bring anything to mind about what you might have heard about these people or the Office of Consumer Affairs or Ad-hoc Consumer Affairs Advisory Committee?

6. What do you know about the Office of Consumer affairs? (check for knowledge)

- | | | |
|--|---|---|
| <input type="checkbox"/> 1-800 information referral telephone line. | <input type="checkbox"/> Identify consumer as speakers to universities, schools and communities. | <input type="checkbox"/> Offer statewide training conference to promote consumer employment in the mental health system. |
| <input type="checkbox"/> 1-800 complaint telephone line. | <input type="checkbox"/> Teleconferencing with national groups. | <input type="checkbox"/> Evaluation activities by consumers family members |
| <input type="checkbox"/> Computer bulletin board. | <input type="checkbox"/> Coordinate presentations to MH conferences/meetings re consumer employment in the MH system. | <input type="checkbox"/> Double the number of family and consumers represented on state and local advisory governing and management boards. |
| <input type="checkbox"/> Create Consumer Advisory Sub-committee (AHCAC) | <input type="checkbox"/> Incorporate OCA into MH Div. | <input type="checkbox"/> Demonstrate reasonable accommodation i.e., Americans With Disabilities Act. |
| <input type="checkbox"/> Cleaning house library function. | <input type="checkbox"/> Send one consumer and one family member to NIMH CSP learning conference. | <input type="checkbox"/> Other. |
| <input type="checkbox"/> Produce informational materials. | <input type="checkbox"/> Provide 2 statewide trainings in grant writing and fund raising. | |
| <input type="checkbox"/> Technical assistance materials. | <input type="checkbox"/> Provide training in boardmanship to consumers and families. | |
| <input type="checkbox"/> Produce video newsletters. | <input type="checkbox"/> Two major technical assistance activities events products per year. | |
| <input type="checkbox"/> OCA to disseminate grant announcements and promote grant development. | | |
| <input type="checkbox"/> Make referrals to mental health boards. | | |

If Other, List:

7. A: What services of the Office of Consumer Affairs listed above have you used or tried to use? (U for used T for tried)

B: For each service used which describes how satisfied you are. (ask for all U or T except 1-800 & Computer Bulletin Board System)

- | | | | | |
|----------------------|----------------------|---------|------------------|----------------|
| 1 | 2 | 3 | 4 | 5 |
| not at all satisfied | mostly not satisfied | neutral | mostly satisfied | very satisfied |

8. What do you know about the Ad-hoc Committee? (check for knowledge)

- Nothing
- Identify technical assistance needed to impact MH system change
- Build peer support and advocacy groups.
- AHCAC networking activities.
- Publish results/articles in NETWORK NEWS.
- Leadership seminars for AHCAC.
- AHCAC to report to State MH Advisory Committee.
- AHCAC to provide TA to peers, MH Centers, Advocacy Groups every month.
- Compile Speakers List of consumers and family advocates, make recommendations to conferences and seminars.
- AHCAC to establish learning goals.
- AHCAC to evaluate training experiences.
- AHCAC to monitor P.L. 99-660 Consumer/Family section implementation.
- AHCAC to recommend changes to P.L. 99-660 state implementation plan.
- Promote consumer involvement on biennial regional planning.
- AHCAC to serve as referral source for members of community MH boards.
- Others.

If Other, List:

(9) If knowledge and use of 1-800 is evident: (if not skip to #15)

9. How did you find out about the 1-800 phone line?
10. What are the kinds of reasons have you contacted the Office of Consumer Affairs by phone? (Read question, get answers, clarify categories and fill in subjects number for category)
- information
 - referral
 - complaint/need for advocate from the Office of Consumer Affairs
 - other

If Other, List:

11. Were you satisfied? 1 2 3 4 5
 not at all mostly neutral mostly very
 satisfied not satisfied satisfied satisfied
 satisfied satisfied
12. Why?
13. What role has access to the 1-800 Office of Consumer Affairs phone line played in your life?
14. What changes would you make with the way the Office of Consumer Affairs handles the 1-800 calls to make the line more helpful?

(15) If knowledge and use of Computer Bulliten Board System is evident:(if tried skip to #21 if no skip to #27)

15. How did you find out about the Computer Bulletin Board System?

16. What features did you use the most?

Mail Room

Document Downloading

Read Topic Areas

Other *If other list:*

17. What features did you find easiest to use?

Mail Room

Document Downloading

Read Topic Areas

Other *If other list:*

Comments:

18. What role has the Computer Bulliten Board System played in your life?

19. What changes would you make with the Computer Bulliten Board System to make it more helpful?

20. Were you satisfied?

1
not at all
satisfied

2
mostly
not
satisfied

3
neutral

4
mostly
satisfied

5
very
satisfied

If tried:

21. What kept you from using the Computer Bulliten Board System successfully?

BBS was not operating

Information not useful

Difficult format

Lack of computer access

Lack of technical assistance to log on

Other *If other list:*

22. What are the 3 most important things the Office of Consumer Affairs Computer Bulliten Board System could do for you? (Rank 1,2,3 1 = most important: don't read to prompt but after answer make sure you clarify, then rank for importance ok for more if first 3 are ranked)
- Help me keep in touch with consumers, family members
 - Give me information about other Consumer activities
 - Give me information about State mental health division
 - Don't know
 - Other
23. If the computer bulletin board system was contracted out to a consumer/group outside the mental health division rather than being run by consumers from within the division what impact do you believe this would have?
24. Why?
25. Yes No: Would you be in favor of contracting out the Computer Bulliten Board System?
26. Why?
27. _____ Year _____ Month: When did you first find out about Office of Consumer Affairs, Ad-hoc Committee?
28. How did you find out?
29. How much has your life been impacted by the work of the Office of Consumer Affairs or Ad-hoc Committee?
- | | | | | |
|------------|---------------|--------------------|----------------|---------|
| 1 | 2 | 3 | 4 | 5 |
| not at all | hardly
any | moderate
amount | a good
deal | greatly |
30. How? In what ways?
31. yes no: Has the life of any one individual you know been impacted? (if yes how many?)
32. How? In what ways?

33. yes no: Has any organization or group of people that you know of been impacted by the work of the Office of Consumer Affairs or Ad-hoc Committee? (if yes which ones?)

34. How? In what ways?

35. **The Office of Consumer Affairs was created and placed in the state mental health division so that it could accomplish 3 things: 1) have a consumer ear and voice in the day to day workings of the mental health division; 2) promote consumer representation at the mental health division by communicating with other consumers, promoting placement of independent consumers and advocates on boards and policy making bodies at the state and local levels; and 3) help develop consumer communication, advocacy, and independence around Washington by serving as an information, referral, and training resource. These are the purposes of the 1-800 information and referral phone line, the resource library, the computer bulletin board system, and the Ad-hoc Committee.**

36. How important do you believe this function is to mental health services in our state and particularly to consumers?

1	2	3	4	5
not at all	mostly not	somewhat important	mostly important	very important
important	important			

37. Why?

38. yes no Is there a need for full time consumer representation at the Mental Health Division? Why? or Why not?

39. If yes to 38: What should this look like? (Staff structure, location?)

39b. (If yes to 38) What kind of role should consumers have in hiring their representatives at the state mental health division level?

- 39c. (If yes to 38) What kind of role should consumers have in supervising these representatives?
40. What other ways could Washington accomplish the goals of the Office of Consumer Affairs and Ad-hoc Committee?
41. What would you most like to see the Office of Consumer Affairs doing?
42. What would you most like to see the Ad-hoc Committee doing?
43. What would you like to see happen as a result of these efforts?
44. What is the most helpful thing the Office of Consumer Affairs could accomplish?
45. What is the most helpful thing the Ad-hoc Committee could accomplish?
46. Given what you know about the Office of Consumer Affairs and Ad-hoc Committee, consumers and State mental health services, what do you expect to see the Office of Consumer Affairs accomplish?

- 47. What do you expect of the Ad-hoc Committee?

- 48. Are there harmful things that could come from the Office of Consumer Affairs? (If yes then:) What are the most harmful things that could come from the Office of Consumer Affairs?

- 49. Are there harmful things that could come from the Ad-hoc Consumer Affairs Advisory Committee? (If yes then:) What are the most harmful things that could come from the Ad-hoc Committee?

- 50. How do you see the relationship of consumers with: (Read with each item followed by the scale starting with "mostly negative with conflict" then "somewhat negative" etc.)

Use with #50

- 1. their own families
- 2. family advocate groups
- 3. consumer advocacy groups
- 4. mental health service providers

1	2	3	4	5
mostly negative, w/conflict	somewhat negative	neutral	somewhat positive	very positive, cooperative

- 51. What would you like to see the Office of Consumer Affairs and Ad-hoc Committee doing about these relationships?

- 52. Do you feel the Office of Consumer Affairs is successful? (skip if no knowledge of Office of Consumer Affairs go to #55)

1	2	3	4	5
not at all successful	mostly not successful	neutral	mostly successful	very successful

- 52b. What do you feel have been the greatest successes?

52c. Have there been failures? (If yes) What are they?

53. If yes: How? What makes it successful? 54. If no: What would it take to make it successful?

55. Are there any other ways the Office of Consumer Affairs can be improved? (If no knowledge of Office read: Based on our conversation so far and what you now know about the Office of Consumer affairs are there any other ways the Office can be improved?)

56. Do you feel the Ad-hoc Committee is successful? (skip if no knowledge of Ad-hoc Committee skip to #58)

1	2	3	4	5
nor at all	mostly	neutral	mostly	very
successful	not		successful	successful
	successful			

57. How could the Ad-hoc Committee be improved?

58. The office of consumer affairs grant will run out during this coming year. Closing the office rather than continuing its funding is being considered. What impact do you believe that closure of the office would have?

59. yes no Do you feel it should be closed?

60. Why?

61. Do you know another consumer who would disagree with your overall views regarding the Office of Consumer Affairs and Ad-hoc Committee? This will help us get the widest range of views for further research about this. If these people are contacted we will not use your name. Names?

62. Do you know any other people/providers, family members or someone else who would disagree with you about this? This will help us get the widest range of views for further research about this. If these people are contacted we will not use your name. Names?

I have just a couple of very quick questions left. The answers will help us make sure we have the biggest number of different kinds of people represented in this study.

63. years months How long have you been associated with a family advocacy group?

64. yes, no: Do you have a family member receiving mental health services? (Check all that apply) Spouse Child Parent Yourself Other

65a. years months How long has your family member been receiving mental health services no matter where they have lived?

65b. years months How long have you been receiving mental health services no matter where they have lived?

65c. years months How long has your family member been receiving mental health services in Washington?

65d. years months How long have you been receiving mental health services in Washington?

66a. (If subject is a consumer) I'm going to read a list of services sometimes received by consumers of mental health services. Would you please tell me what services you are receiving as I read them?

<input type="checkbox"/> Medication	<input type="checkbox"/> Paid part time employment	<input type="checkbox"/> Transportation
<input type="checkbox"/> Counseling	<input type="checkbox"/> Parenting Classes	<input type="checkbox"/> Food Stamps
<input type="checkbox"/> Day Treatment/Club-House	<input type="checkbox"/> Vocational Support	<input type="checkbox"/> AFDC
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Housing Individual/Group	<input type="checkbox"/> SSI
<input type="checkbox"/> Paid full time employment	<input type="checkbox"/> Medical Coupons	<input type="checkbox"/> Case Management
<input type="checkbox"/> Supported Employment		<input type="checkbox"/> Other

If Other List:

66b. (If subject has a family member who is a consumer) I'm going to read a list of services sometimes received by consumers of mental health services. Would you please tell me what services your family member is receiving as I read them?

- | | | |
|--|--|--|
| <input type="checkbox"/> Medication | <input type="checkbox"/> Paid part time employment | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Parenting Classes | <input type="checkbox"/> Food Stamps |
| <input type="checkbox"/> Day Treatment/Club-House | <input type="checkbox"/> Vocational Support | <input type="checkbox"/> AFDC |
| <input type="checkbox"/> Family Therapy | <input type="checkbox"/> Housing Individual Group | <input type="checkbox"/> SSI |
| <input type="checkbox"/> Paid full time employment | <input type="checkbox"/> Medical Coupons | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> Supported Employment | | <input type="checkbox"/> Other |

If Other List:

67a. _____ (If subject is a consumer) What Service Agency do you receive services from?

67b. _____ (If subject has a family member who is a consumer) What Service Agency does your family member receive services from?

68. _____ What is the highest level of education attained by your family member? (If subject has a family member who is a consumer)

68. _____ What is the highest level of education attained by you?

69. _____ What is your date of birth (month/day/year)?

69b. _____ What is the date of birth (month/day/year) of your family member?

70a. _____ What is the ethnic group (race) of your family member? (If family member is a consumer)

70b. _____ What is your ethnic group (race) of your family member?

71. Any questions?

72. (Time Finish: _____)

Ad-hoc Consumer Affairs Advisory Committee Member

.

Interview: Ad-hoc Consumer Affairs Advisory Committee Member

Code: ___ Number _____ Interviewer _____ Agency. _____ Date _____ Time Start
 ___ Phone _____ Face to Face

Read Consent

1. Female Male (circle one)
2. ___ Current ___ Former member of Ad-hoc Committee?
3. _____ How long have you been a member on the Ad-hoc Consumer Affairs Advisory Committee? or, From when to when?

4. What do you know about the Office of Consumer affairs? (check for knowledge)

- | | | |
|--|---|---|
| <input type="checkbox"/> 1-800 information referral telephone line. | <input type="checkbox"/> Identify consumer as speakers to universities, schools and communities. | <input type="checkbox"/> Two major technical assistance activities events products per year. |
| <input type="checkbox"/> 1-800 complaint telephone line. | <input type="checkbox"/> Teleconferencing with national groups. | <input type="checkbox"/> Offer statewide training conference to promote consumer employment in the mental health system. |
| <input type="checkbox"/> Computer bulletin board. | <input type="checkbox"/> Coordinate presentations to MH conferences/meetings re consumer employment in the MH system. | <input type="checkbox"/> Evaluation activities by consumers/family members |
| <input type="checkbox"/> Create Consumer Advisory Sub-committee (AHCAC) | <input type="checkbox"/> Incorporate OCA into MH Div. | <input type="checkbox"/> Double the number of family and consumers represented on state and local advisory governing and management boards. |
| <input type="checkbox"/> Clearing house library function. | <input type="checkbox"/> Send one consumer and one family member to NIMH CSP learning conference. | <input type="checkbox"/> Demonstrate reasonable accommodation i.e., Americans With Disabilities Act. |
| <input type="checkbox"/> Produce informational materials. | <input type="checkbox"/> Provide 2 statewide trainings in grant writing and fund raising. | <input type="checkbox"/> Other. |
| <input type="checkbox"/> Technical assistance materials. | <input type="checkbox"/> Provide training in boardmanship to consumers and families. | |
| <input type="checkbox"/> Produce video newsletters. | | |
| <input type="checkbox"/> OCA to disseminate grant announcements and promote grant development. | | |
| <input type="checkbox"/> Make referrals to mental health boards. | | |

If Other, List:

5. A: What services of the Office of Consumer Affairs listed above have you used or tried to use? (U for used T for tried)
 B: For each service used which describes how satisfied you are. (ask for all U or T except 1-800 & Computer Bulletin Board System)

1	2	3	4	5
not at all satisfied	mostly not satisfied	neutral	mostly satisfied	very satisfied

6. What do you know about the Ad-hoc Committee? (check for knowledge)

- Nothing
- Identify technical assistance needed to impact MH system change
- Build peer support and advocacy groups.
- AHCAC networking activities.
- Publish results/articles in NETWORK NEWS.
- Leadership seminars for AHCAC.
- AHCAC to report to State MH Advisory Committee.
- AHCAC to provide TA to peers, MH Centers, Advocacy Groups every month.
- Compile Speakers List of consumers and family advocates, make recommendations to conferences and seminars.
- AHCAC to establish learning goals.
- AHCAC to evaluate training experiences.
- AHCAC to monitor P.L. 99-660 Consumer/Family section implementation.
- AHCAC to recommend changes to P.L. 99-660 state implementation plan.
- Promote consumer involvement on biennial regional planning.
- AHCAC to serve as referral source for members of community MH boards.
- Others.

If Other, List:

(7) If knowledge and use of 1-800 is evident: (if not skip to #13)

7. How did you find out about the 1-800 phone line?

8. What are the kinds of reasons have you contacted the Office of Consumer Affairs by phone?
(Read question, get answers, clarify categories and fill in subjects number for category)

- information
- referral
- complaint/need for advocate from the Office of Consumer Affairs
- other

If Other, List:

9. Were you satisfied?

1	2	3	4	5
not at all satisfied	mostly not satisfied	neutral	mostly satisfied	very satisfied

10. Why?

11. What role has access to the 1-800 Office of Consumer Affairs phone line played in your life?

12. What changes would you make with the way the Office of Consumer Affairs handles the 1-800 calls to make the line more helpful?

(13) If knowledge and use of Computer Bulliten Board System is evident:(if tried skip to #19 if no skip to #25)

13. How did you find out about the Computer Bulletin Board System?

14. What features did you use the most?

Mail Room

Document Downloading

Read Topic Areas

Other *If other list:*

15. What features did you find easiest to use?

Mail Room

Document Downloading

Read Topic Areas

Other *If other list:*

Comments:

16. What role has the Computer Bulliten Board System played in your life?

17. What changes would you make with the Computer Bulliten Board System to make it more helpful?

18. Were you satisfied?

1
not at all
satisfied

2
mostly
not
satisfied

3
neutral

4
mostly
satisfied

5
very
satisfied

If tried:

19. What kept you from using the Computer Bulliten Board System successfully?

BBS was not operating

Information not useful

Difficult format

Lack of computer access

Lack of technical assistance to log on

Other *If other list:*

20. What are the 3 most important things the Office of Consumer Affairs Computer Bulliten Board System could do for you? (Rank 1,2,3 1 = most important; don't read to prompt but after answer make sure you clarify, then rank for importance ok for more if first 3 are ranked)
- Help me keep in touch with consumers, family members
 - Give me information about other Consumer activities
 - Give me information about State mental health division
 - Don't know
 - Other
21. If the computer bulletin board system was contracted out to a consumer/group outside the mental health division rather than being run by consumers from within the division what impact do you believe this would have?
22. Why?
23. Yes No: Would you be in favor of contracting out the Computer Bulliten Board System?
24. Why?
25. _____ Year _____ Month: When did you first find out about Office of Consumer Affairs,
_____ Year _____ Month Ad-hoc Committee?
26. How did you find out?
27. How much has your life been impacted by the work of the Office of Consumer Affairs or Ad-hoc Committee?
- | | | | | |
|------------|---------------|--------------------|----------------|---------|
| 1 | 2 | 3 | 4 | 5 |
| not at all | hardly
any | moderate
amount | a good
deal | greatly |
28. How? In what ways?
29. yes no: Has the life of any one individual you know been impacted? (if yes how many?)
30. How? In what ways?

31. yes no: Has any organization or group of people that you know of been impacted by the work of the Office of Consumer Affairs or Ad-hoc Committee? (if yes which ones?)
32. How? In what ways?
33. What have you been able to accomplish in your community or for consumers as a result of your membership on the Ad-hoc Committee?
34. What is your evaluation of the training experiences that you have received through Ad-hoc Committee?
35. Were you satisfied?
- | | | | | |
|-------------------------|----------------------------|---------|---------------------|-------------------|
| 1 | 2 | 3 | 4 | 5 |
| not at all
satisfied | mostly
not
satisfied | neutral | mostly
satisfied | very
satisfied |
36. Of the training that has been provided for you through Ad-hoc Committee what has been most valuable?
37. How could training be improved?
38. What have you observed the Ad-hoc Committee do during the time you have been on the Ad-hoc Committee?

39. The Office of Consumer Affairs was created and placed in the state mental health division so that it could accomplish 3 things: 1) have a consumer ear and voice in the day to day workings of the mental health division; 2) promote consumer representation at the mental health division by communicating with other consumers, promoting placement of independent consumers and advocates on boards and policy making bodies at the state and local levels; and 3) help develop consumer communication, advocacy, and independence around Washington by serving as an information, referral, and training resource. These are the purposes of the 1-800 information and referral phone line, the resource library, the computer bulletin board system, and the Ad-hoc Committee.

40. How important do you believe this function is to mental health services in our state and particularly to consumers?

1	2	3	4	5
not at all important	mostly not important	somewhat important	mostly important	very important

41. Why?

42. yes no Is there a need for full time consumer representation at the Mental Health Division? Why? or Why not?

43a. If yes: What should this look like? (Staff structure, location?)

43b. (If yes to 42) What kind of role should consumers have in hiring their representatives at the state mental health division level?

43c. (If yes to 42) What kind of role should consumers have in supervising these representatives?

44. What other ways could Washington accomplish the goals of the Office of Consumer Affairs and Ad-hoc Committee?

45. What would you most like to see the Office of Consumer Affairs doing?
46. What would you most like to see the Ad-hoc Committee doing?
47. What would you like to see happen as a result of these efforts?
48. What is the most helpful thing the Office of Consumer Affairs could accomplish?
49. What is the most helpful thing the Ad-hoc Committee could accomplish?
50. Given what you know about the Office of Consumer Affairs and Ad-hoc Committee, consumers and State mental health services, what do you expect to see the Office of Consumer Affairs accomplish?
51. What do you expect of the Ad-hoc Committee?
52. Are there harmful things that could come from the Office of Consumer Affairs? (If yes then:)
What are the most harmful things that could come from the Office of Consumer Affairs?

53. Are there harmful things that could come from the Ad-hoc Consumer Affairs Advisory Committee? (If yes then:) What are the most harmful things that could come from the Ad-hoc Committee?

54. How do you see the relationship of consumers with: (Read with each item followed by the scale starting with "mostly negative with conflict" then "somewhat negative" etc.)

- 1. their own families
- 2. family advocate groups
- 3. consumer advocacy groups
- 4. mental health service providers

Use with #54

1	2	3	4	5
mostly negative, w/conflict	somewhat negative	neutral	somewhat positive	very positive, cooperative

55. What would you like to see the Office of Consumer Affairs and Ad-hoc Committee doing about these relationships?

56. What role has interpersonal conflict played in the development and course of the Office of Consumer Affairs and the Ad-hoc Committee?

57. Do you feel the Office of Consumer Affairs is successful?

1	2	3	4	5
nor at all successful	mostly not successful	neutral	mostly successful	very successful

58. What do you feel have been the greatest successes?

58b. Have there been failures? (If yes) What are they?

59. If yes: How? What makes it successful? 60. If no: What would it take to make it successful?
61. Are there any other ways the Office of Consumer Affairs can be improved?
62. Do you feel the Ad-hoc Committee is successful?
- | | | | | |
|--------------------------|-----------------------------|---------|----------------------|--------------------|
| 1 | 2 | 3 | 4 | 5 |
| not at all
successful | mostly
not
successful | neutral | mostly
successful | very
successful |
63. How could the Ad-hoc Committee be improved?
64. The office of consumer affairs grant will run out during this coming year. Closing the office rather than continuing its funding is being considered. What impact do you believe that closure of the office would have?
65. yes no Do you feel it should be closed?
66. Why?
67. Do you know another consumer who would disagree with your overall views regarding the Office of Consumer Affairs and Ad-hoc Committee? This will help us get the widest range of views for further research about this. If these people are contacted we will not use your name. Names?

68. Do you know any other people/providers, family members or someone else who would disagree with you about this? This will help us get the widest range of views for further research about this. If these people are contacted we will not use your name. Names?

I have just a couple of very quick questions left. The answers will help us make sure we have the biggest number of different kinds of people represented in this study.

- 69a. ____ years ____ months How long have you been receiving mental health services no matter where you have lived?

- 69b. ____ years ____ months How long have you been receiving mental health services in Washington?

70. I'm going to read a list of services sometimes received by consumer of mental health services. Would you please tell me what services you are receiving as I read them?

- | | | |
|--|--|--|
| <input type="checkbox"/> Medication | <input type="checkbox"/> Paid part time employment | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Parenting Classes | <input type="checkbox"/> Food Stamps |
| <input type="checkbox"/> Day Treatment/Club-House | <input type="checkbox"/> Vocational Support | <input type="checkbox"/> AFDC |
| <input type="checkbox"/> Family Therapy | <input type="checkbox"/> Housing Individual/Group | <input type="checkbox"/> SSI |
| <input type="checkbox"/> Paid full time employment | <input type="checkbox"/> Medical Coupons | <input type="checkbox"/> Case Management |
| <input type="checkbox"/> Supported Employment | | <input type="checkbox"/> Other |

If Other List:

71. _____ What is the highest level of education you have attained.
72. _____ What is your date of birth? (month/day/year)
73. Any questions?
74. (Time Finish: _____)

Mental Health Division Staff

Interview: (Mental Health Division Staff)

Code: ___ Number _____ Interviewer _____ Agency: _____ Date _____ Time Start
 ___ Phone _____ Face to Face

Read Consent

1. Female Male (circle one)
2. ___ When did you first hear of the Office of Consumer Affairs that has been staffed by Jon Ihler, Nancy Donigan, Yvonne Britt, Chris Wilde, Marianne Neff-Daniels, and supervised by David Hanig?
3. ___ yes ___ no: Have you heard of the Ad-hoc Consumer Affairs Advisory Committee?

4. What do you know about the Office of Consumer affairs? (check for knowledge)

- | | | |
|--|---|---|
| <input type="checkbox"/> 1-800 information referral telephone line. | <input type="checkbox"/> Identify consumer as speakers to universities, schools and communities. | <input type="checkbox"/> Two major technical assistance activities events products per year. |
| <input type="checkbox"/> 1-800 complaint telephone line. | <input type="checkbox"/> Teleconferencing with national groups. | <input type="checkbox"/> Offer statewide training conference to promote consumer employment in the mental health system. |
| <input type="checkbox"/> Computer bulletin board. | <input type="checkbox"/> Coordinate presentations to MH conferences/meetings re consumer employment in the MH system. | <input type="checkbox"/> Evaluation activities by consumers/family members |
| <input type="checkbox"/> Create Consumer Advisory Sub-committee (AHCAC) | <input type="checkbox"/> Incorporate OCA into MH Div. | <input type="checkbox"/> Double the number of family and consumers represented on state and local advisory governing and management boards. |
| <input type="checkbox"/> Clearing house library function. | <input type="checkbox"/> Send one consumer and one family member to NIMH CSP learning conference. | <input type="checkbox"/> Demonstrate reasonable accommodation i.e., Americans With Disabilities Act. |
| <input type="checkbox"/> Produce informational materials. | <input type="checkbox"/> Provide 2 statewide trainings in grant writing and fund raising. | <input type="checkbox"/> Other. |
| <input type="checkbox"/> Produce technical assistance materials. | <input type="checkbox"/> Provide training in boardmanship to consumers and families. | |
| <input type="checkbox"/> Produce video newsletters. | | |
| <input type="checkbox"/> OCA to disseminate grant announcements and promote grant development. | | |
| <input type="checkbox"/> Make referrals to mental health boards. | | |

If Other, List:

5. A: What services of the Office of Consumer Affairs listed above have you used or tried to use? (U for used T for tried)

B: For each service used which describes how satisfied you are. (ask for all U or T except 1-800 & Computer Bulletin Board System)

- | | | | | |
|----------------------|----------------------|---------|------------------|----------------|
| 1 | 2 | 3 | 4 | 5 |
| not at all satisfied | mostly not satisfied | neutral | mostly satisfied | very satisfied |

6. What do you know about the Ad-hoc Committee? (check for knowledge)

- Nothing
- Identify technical assistance needed to impact MH system change
- Build peer support and advocacy groups.
- AHCAC networking activities.
- Publish results/articles in NETWORK NEWS.
- Leadership seminars for AHCAC.
- AHCAC to report to State MH Advisory Committee.
- AHCAC to provide TA to peers. MH Centers, Advocacy Groups every month.
- Compile Speakers List of consumers and family advocates. make recommendations to conferences and seminars.
- AHCAC to establish learning goals.
- AHCAC to evaluate training experiences.
- AHCAC to monitor P.L. 99-660 Consumer/Family section implementation.
- AHCAC to recommend changes to P.L. 99-660 state implementation plan.
- Promote consumer involvement on biennial regional planning.
- AHCAC to serve as referral source for members of community MH boards.
- Others.

If Other, List:

(7) If knowledge and use of 1-800 is evident: (if not skip to #12)

7. How did you find out about the 1-800 phone line?
8. What role has the 1-800 information and referral phone line at the Office of Consumer Affairs played in how you conduct your job?
9. Are you satisfied with its performance?
10. Why?
- | | | | | |
|-------------------------|----------------------------|---------|---------------------|-------------------|
| 1 | 2 | 3 | 4 | 5 |
| not at all
satisfied | mostly
not
satisfied | neutral | mostly
satisfied | very
satisfied |
11. What changes would you make with the way the Office of Consumer Affairs handles the 1-800 calls to make the line more helpful?

(12) If knowledge and use of Computer Bulliten Board System is evident:(if try, skip to #18 if no, skip to #19)

12. How did you find out about the Computer Bulletin Board System?

13. What features did you use the most?
- Mail Room Read Topic Areas
 Document Downloading Other *If other list:*

14. What features did you find easiest to use?
- Mail Room Read Topic Areas
 Document Downloading Other *If other list:*

Comments:

15. What role has the Computer Bulliten Board System played in your carrying out your job?
16. What changes would you make with the Computer Bulliten Board System to make it more helpful?

17. Are you satisfied?
- | | | | | |
|-------------------------|----------------------------|---------|---------------------|-------------------|
| 1 | 2 | 3 | 4 | 5 |
| not at all
satisfied | mostly
not
satisfied | neutral | mostly
satisfied | very
satisfied |

If tried:

18. What kept you from using the Computer Bulliten Board System successfully?
- Computer Bulliten Board System was not operating Lack of computer access
 Information not useful Lack of technical assistance to log on
 Difficult format Other *If other list:*
19. What are the 3 most important things the Office of Consumer Affairs Computer Bulliten Board System could do for you? (Rank 1,2,3 1 = most important: don't read to prompt but after answer make sure you clarify, then rank for importance ok for more if first 3 are ranked)
- Help me keep in touch with consumers, family members
 Give me information about other Consumer activities
 Give me information about State mental health division
 Don't know
 Other *If other list:*
20. If the computer bulletin board system was contracted out to a consumer/group outside the mental health division rather than being run by consumers from within the division what impact do you believe this would have?
21. Why?

22. Yes No: Would you be in favor of contracting out the Computer Bulliten Board System?
23. Why?
24. How much has your job been impacted by the work of the Office of Consumer Affairs or Ad-hoc Committee?
25. How? In what ways? 1 2 3 4 5
 not at all hardly moderate a good greatly
 any amount deal
26. yes no: Has the life of any one individual you know been impacted? (if yes how many?)
27. How? In what ways?
28. yes no: Has any organization or group of people that you know of been impacted by the work of the Office of Consumer Affairs or Ad-hoc Committee? (if yes which ones?)
29. How? In what ways?
30. One issue that was of concern in the starting of the Office of Consumer Affairs was how well staff members would be received into and function in the mental health division. How have the Office of Consumer Affairs staff fit in? How well have they been received? What are your reflections on this issue?

31. How much direct contact with Office of Consumer Affairs persons have you experienced?

1	2	3	4	5
not at all	hardly	moderate	a good	a lot
	any	amount	deal	

32. The Office of Consumer Affairs was created and placed in the state mental health division so that it could accomplish 3 things: 1) have a consumer ear and voice in the day to day workings of the mental health division; 2) promote consumer representation at the mental health division by communicating with other consumers, promoting placement of independent consumers and advocates on boards and policy making bodies at the state and local levels; and 3) help develop consumer communication, advocacy, and independence around Washington by serving as an information, referral, and training resource. These are the purposes of the 1-800 information and referral phone line, the resource library, the computer bulletin board system, and the Ad-hoc Committee.

33. How important do you believe this function is to mental health services in our state and particularly to consumers?

1	2	3	4	5
not at	mostly	somewhat	mostly	very
all	not	important	important	important
important	important			

34. Why?

35. yes no Is there a need for full time consumer representation at the Mental Health Division? Why? or Why not?

36a. If yes: what should this look like? (staff, structure, location?)

36b. (If yes to 35) What kind of role should consumers have in hiring their representatives at the state mental health division level?

36c. (If yes to 35) What kind of role should consumers have in supervising these representatives?

37. What other ways could Washington accomplish the goals of the Office of Consumer Affairs and Ad-hoc Committee?

38. What would you most like to see the Office of Consumer Affairs doing?
39. What would you most like to see the Ad-hoc Committee doing?
40. What would you like to see happen as a result of these efforts?
41. What is the most helpful thing the Office of Consumer Affairs could accomplish?
42. What is the most helpful thing the Ad-hoc Committee could accomplish?
43. Given what you know about the Office of Consumer Affairs and Ad-hoc Committee, consumers and State mental health services, what do you expect to see the Office of Consumer Affairs accomplish?
44. What do you expect of the Ad-hoc Committee?
45. Are there harmful things that could come from the Office of Consumer Affairs? (If yes then:) What are the most harmful things that could come from the Office of Consumer Affairs?
46. Are there harmful things that could come from the Ad-hoc Consumer Affairs Advisory Committee? (If yes then:) What are the most harmful things that could come from the Ad-hoc Committee?

47. How do you see the relationship of consumers with: (Read with each item followed by the scale starting with "mostly negative with conflict" then "somewhat negative" etc.)

1. their own families
 2. family advocate groups
 3. consumer advocacy groups
 4. mental health service providers

Use with #47

1	2	3	4	5
mostly negative, w/conflict	somewhat negative	neutral	somewhat positive	very positive, cooperative

48. What would you like to see the Office of Consumer Affairs and Ad-hoc Committee doing about these relationships?
49. Do you feel the Office of Consumer Affairs is successful?
- | | | | | |
|--------------------------|-----------------------------|---------|----------------------|--------------------|
| 1 | 2 | 3 | 4 | 5 |
| not at all
successful | mostly
not
successful | neutral | mostly
successful | very
successful |
50. What do you feel have been the greatest successes?
- 50b. Have there been failures? (If yes) What are they?
51. If yes: How? What makes it successful? 52. If no: What would it take to make it successful?
53. Are there any other ways the Office of Consumer Affairs can be improved?
54. What role has interpersonal conflict had in the development and course of the Office of Consumer Affairs. Ad-hoc Committee?

55. Do you feel the Ad-hoc Committee is successful? (skip if no knowledge of Ad-hoc Committee)

1	2	3	4	5
not at all	mostly	neutral	mostly	very
successful	not successful		successful	successful

56. How could the Ad-hoc Committee be improved?

57. The office of consumer affairs grant will run out during this coming year. Closing the office rather than continuing its funding is being considered. What impact do you believe that closure of the office would have?

58. yes no Do you feel it should be closed?

59. Why?

60. Do you know another consumer who would disagree with your overall views regarding the Office of Consumer Affairs and Ad-hoc Committee? This will help us get the widest range of views for further research about this. If these people are contacted we will not use your name. Names?

61. Do you know any other people: providers, family members or someone else who would disagree with you about this? This will help us get the widest range of views for further research about this. If these people are contacted we will not use your name. Names?

I have just a couple of very quick questions left. The answers will help us make sure we have the biggest number of different kinds of people represented in this study.

62. _____ What is the highest level of education you have attained?

63a. yes no: Are you a consumer of mental health services?

63b. If yes: _____ years _____ months How long have you been receiving mental health services no matter what area or state you have lived?

- 63c. If yes to 63a: ___ years ___ months How long have you been receiving mental health services in Washington State?
64. _ yes _ no: Are you a family member of a mental health consumer?
- 65a. _ years _ months How long have you been providing mental health services?
- 65b. _ years _ months How long have you been providing mental health services in Washington?
66. _ years _ months How long have you been with the Mental Health Division?
67. _____ What is your date of birth? (month/day/year)
68. _____ What is your ethnic background?
68. Any questions?
69. (Time Finish: _____)

Provider: Line Staff, Administrator, Board Member, RSN Personnel

Interview: (Line Staff) (Administrator) (Board Member) (RSN Personnel) (Circle One)

Code: ___ Number _____ Interviewer _____ Agency: _____ Date _____ Time Start
 ___ Phone _____ Face to Face

Read Consent

1. Female Male (circle one)
2. ___ yes ___ no: Have you heard of the Office of Consumer Affairs?
3. ___ yes ___ no: Have you heard of the Ad-hoc Consumer Affairs Advisory Committee?

4. If yes to 2 and 3 skip to # 6/7, If no to either 2 or 3 read the following:
 The Office of Consumer Affairs was created in October 1992 in the mental health division and has been staffed by Marianne Neff-Daniels, Jon Ihler, Nancy Donigan, Chris Wilde, Yvonne Britt and supervised by David Hanig. Many of the staff are mental health consumers. Collectively the Office of Consumer Affairs was meant to provide information and referral services for consumers, provide a voice for consumers on the state level, promote consumer networking around the state and increase consumer employment and participation on mental health decision making bodies. The Office of Consumer Affairs has also put together a group of consumers from around Washington that meet every other month and carry out projects in their home communities. This group is called the Ad-hoc Consumer Affairs Advisory Committee.

5. ___ yes ___ no (if no skip to question 35) Does this information bring anything to mind about what you might have heard about these people or the Office of Consumer Affairs or Ad-hoc Consumer Affairs Advisory Committee?

6. What do you know about the Office of Consumer affairs? (check for knowledge)
- | | | |
|--|---|---|
| <input type="checkbox"/> 1-800 information referral telephone line. | <input type="checkbox"/> Identify consumer as speakers to universities, schools and communities. | <input type="checkbox"/> Offer statewide training conference to promote consumer employment in the mental health system. |
| <input type="checkbox"/> 1-800 complaint telephone line. | <input type="checkbox"/> Teleconferencing with national groups. | <input type="checkbox"/> Evaluation activities by consumers/family members |
| <input type="checkbox"/> Computer bulletin board. | <input type="checkbox"/> Coordinate presentations to MH conferences/meetings re consumer employment in the MH system. | <input type="checkbox"/> Double the number of family and consumers represented on state and local advisory governing and management boards. |
| <input type="checkbox"/> Create Consumer Advisory Sub-committee (AHCAC) | <input type="checkbox"/> Incorporate OCA into MH Div. | <input type="checkbox"/> Demonstrate reasonable accommodation i.e., Americans With Disabilities Act. |
| <input type="checkbox"/> Clearing house library function. | <input type="checkbox"/> Send one consumer and one family member to NIMH CSP learning conference. | <input type="checkbox"/> Other. |
| <input type="checkbox"/> Produce informational materials. | <input type="checkbox"/> Provide 2 statewide trainings in grant writing and fund raising. | |
| <input type="checkbox"/> Technical assistance materials. | <input type="checkbox"/> Provide training in boardmanship to consumers and families. | |
| <input type="checkbox"/> Produce video newsletters. | <input type="checkbox"/> Two major technical assistance activities events products per year. | |
| <input type="checkbox"/> OCA to disseminate grant announcements and promote grant development. | | |
| <input type="checkbox"/> Make referrals to mental health boards. | | |

If Other, List:

7. A: What services of the Office of Consumer Affairs listed above have you used or tried to use? (U for used T for tried)
 B: For each service used which describes how satisfied you are. (ask for all U or T except 1-800 & Computer Bulletin Board System)

1	2	3	4	5
not at all satisfied	mostly not satisfied	neutral	mostly satisfied	very satisfied

8. What do you know about the Ad-hoc Committee? (check for knowledge)

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Nothing <input type="checkbox"/> Identify technical assistance needed to impact MH system change <input type="checkbox"/> Build peer support and advocacy groups. <input type="checkbox"/> AHCAC networking activities. <input type="checkbox"/> Publish results/articles in <u>NETWORK NEWS</u>. <input type="checkbox"/> Leadership seminars for AHCAC. | <ul style="list-style-type: none"> <input type="checkbox"/> AHCAC to report to State MH Advisory Committee. <input type="checkbox"/> AHCAC to provide TA to peers, MH Centers, Advocacy Groups every month. <input type="checkbox"/> Compile Speakers List of consumers and family advocates, make recommendations to conferences and seminars. <input type="checkbox"/> AHCAC to establish learning goals. <input type="checkbox"/> AHCAC to evaluate training experiences. | <ul style="list-style-type: none"> <input type="checkbox"/> AHCAC to monitor P.L. 99-660 Consumer/Family section implementation. <input type="checkbox"/> AHCAC to recommend changes to P.L. 99-660 state implementation plan. <input type="checkbox"/> Promote consumer involvement on biennial regional planning. <input type="checkbox"/> AHCAC to serve as referral source for members of community MH boards. <input type="checkbox"/> Others. |
|---|---|--|

If Other, List:

(9) If knowledge and use of 1-800 is evident: (if not skip to #15)

9. How did you find out about the 1-800 phone line?

10. What are the kinds of reasons have you contacted the Office of Consumer Affairs by phone? (Read question, get answers, clarify categories and fill in subjects number for category)
- information
 - referral
 - complaint/need for advocate from the Office of Consumer Affairs
 - other

If Other, List:

11. Were you satisfied?

1	2	3	4	5
not at all	mostly	neutral	mostly	very
satisfied	not		satisfied	satisfied
	satisfied			

12. Why?

13. What role has access to the 1-800 Office of Consumer Affairs phone line played in your life?

14. What changes would you make with the way the Office of Consumer Affairs handles the 1-800 calls to make the line more helpful?

(15) If knowledge and use of Computer Bulliten Board System is evident:(if tried skip to #21 if no skip to #27)

15. How did you find out about the Computer Bulletin Board System?

16. What features did you use the most?

Mail Room

Document Downloading

Read Topic Areas

Other *If other list:*

17. What features did you find easiest to use?

Mail Room

Document Downloading

Read Topic Areas

Other *If other list:*

Comments:

18. What role has the Computer Bulletin Board System played in your life?

19. What changes would you make with the Computer Bulletin Board System to make it more helpful?

20. Were you satisfied?

1
not at all
satisfied

2
mostly
not
satisfied

3
neutral

4
mostly
satisfied

5
very
satisfied

If tried:

21. What kept you from using the Computer Bulletin Board System successfully?

BBS was not operating

Information not useful

Difficult format

Lack of computer access

Lack of technical assistance to log on

Other *If other list:*

22. What are the 3 most important things the Office of Consumer Affairs Computer Bulliten Board System could do for you? (Rank 1,2,3 1 = most important: don't read to prompt but after answer make sure you clarify, then rank for importance ok for more if first 3 are ranked)
- Help me keep in touch with consumers, family members
 - Give me information about other Consumer activities
 - Give me information about State mental health division
 - Don't know
 - Other
23. If the computer bulletin board system was contracted out to a consumer group outside the mental health division rather than being run by consumers from within the division what impact do you believe this would have?
24. Why?
25. Yes No: Would you be in favor of contracting out the Computer Bulliten Board System?
26. Why?
27. _____ Year _____ Month: When did you first find out about Office of Consumer Affairs,
_____ Year _____ Month Ad-hoc Committee?
28. How did you find out?
29. How much has your agency been impacted by the work of the Office of Consumer Affairs or Ad-hoc Committees?
- | | | | | |
|------------|---------------|--------------------|----------------|---------|
| 1 | 2 | 3 | 4 | 5 |
| not at all | hardly
any | moderate
amount | a good
deal | greatly |
30. How? In what ways?
31. yes no: Has the life of any one individual you know been impacted? (if yes how many?)
32. How? In what ways?

33. yes no: Has any organization or group of people that you know of been impacted by the work of the Office of Consumer Affairs or Ad-hoc Committee? (if yes which ones?)

34. How? In what ways?

29. How much have the lives of consumers been impacted by the work of the Office of Consumer Affairs or Ad-hoc Committee?

1	2	3	4	5
not at all	hardly any	moderate amount	a good deal	greatly

35. The Office of Consumer Affairs was created and placed in the state mental health division so that it could accomplish 3 things: 1) have a consumer ear and voice in the day to day workings of the mental health division; 2) promote consumer representation at the mental health division by communicating with other consumers, promoting placement of independent consumers and advocates on boards and policy making bodies at the state and local levels; and 3) help develop consumer communication, advocacy, and independence around Washington by serving as an information, referral, and training resource. These are the purposes of the 1-800 information and referral phone line, the resource library, the computer bulletin board system, and the Ad-hoc Committee.

36. How important do you believe this function is to mental health services in our state and particularly to consumers?

1	2	3	4	5
not at all important	mostly not important	somewhat important	mostly important	very important

37. Why?

38. yes no Is there a need for full time consumer representation at the Mental Health Division? Why? or Why not?

39. If yes: what should this look like? (Staff structure, location?)

39b. (If yes to 38) What kind of role should consumers have in hiring their representatives at the state mental health division level?

- 39c. (If yes to 38) What kind of role should consumers have in supervising these representatives?
40. What other ways could Washington accomplish the goals of the Office of Consumer Affairs and Ad-hoc Committee?
41. What would you most like to see the Office of Consumer Affairs doing?
42. What would you most like to see the Ad-hoc Committee doing?
43. What would you like to see happen as a result of these efforts?
44. What is the most helpful thing the Office of Consumer Affairs could accomplish?
45. What is the most helpful thing the Ad-hoc Committee could accomplish?
46. Given what you know about the Office of Consumer Affairs and Ad-hoc Committee, consumers and State mental health services, what do you expect to see the Office of Consumer Affairs accomplish?

47. What do you expect of the Ad-hoc Committee?
48. Are there harmful things that could come from the Office of Consumer Affairs? (If yes then:) What are the most harmful things that could come from the Office of Consumer Affairs?
49. Are there harmful things that could come from the Ad-hoc Consumer Affairs Advisory Committee? (If yes then:) What are the most harmful things that could come from the Ad-hoc Committee?

50. How do you see the relationship of consumers with: (Read with each item followed by the scale starting with "mostly negative with conflict" then "somewhat negative" etc.)

- 1. their own families
- 2. family advocate groups
- 3. consumer advocacy groups
- 4. mental health service providers

Use with #50

1	2	3	4	5
mostly negative, w:conflict	somewhat negative	neutral	somewhat positive	very positive, cooperative

51. What would you like to see the Office of Consumer Affairs and Ad-hoc Committee doing about these relationships?
52. Do you feel the Office of Consumer Affairs is successful? (skip if no knowledge of Office of Consumer Affairs go to #55)
- | | | | | |
|--------------------------|-----------------------------|---------|----------------------|--------------------|
| 1 | 2 | 3 | 4 | 5 |
| not at all
successful | mostly
not
successful | neutral | mostly
successful | very
successful |
- 52b. What do you feel have been the greatest successes?
- 52c. Have there been failures? (If yes) What are they?

53. If yes: How? What makes it successful? 54. If no: What would it take to make it successful?
55. Are there any other ways the Office of Consumer Affairs can be improved? (If no knowledge of Office read: Based on our conversation so far and what you now know about the Office of Consumer affairs are there any other ways the Office can be improved?)
56. Do you feel the Ad-hoc Committee is successful? (skip if no knowledge of Ad-hoc Committee skip to #58)
- | | | | | |
|--------------------------|-----------------------------|---------|----------------------|--------------------|
| 1 | 2 | 3 | 4 | 5 |
| not at all
successful | mostly
not
successful | neutral | mostly
successful | very
successful |
57. How could the Ad-hoc Committee be improved?
58. The office of consumer affairs grant will run out during this coming year. Closing the office rather than continuing its funding is being considered. What impact do you believe that closure of the office would have?
59. __ yes __ no Do you feel it should be closed?
60. Why?

61. Do you know another consumer who would disagree with your overall views regarding the Office of Consumer Affairs and Ad-hoc Committee? This will help us get the widest range of views for further research about this. If these people are contacted we will not use your name. Names?
62. Do you know any other people/providers, family members or someone else who would disagree with you about this? This will help us get the widest range of views for further research about this. If these people are contacted we will not use your name. Names?

I have just a couple of very quick questions left. The answers will help us make sure we have the biggest number of different kinds of people represented in this study.

63. ___ years ___ months . How long have you been providing mental health services?
64. ___ years ___ months How long have you been with this agency/RSN?
65. ___ years ___ months How long have you been in your present position?
66. ___ yes ___ no: Are you a consumer of mental health services?
67. ___ yes ___ no: Are you a family member of a mental health consumer?
- 68a. ___ years ___ months (If a consumer) How long have you been receiving mental health services no matter where you have lived?
- 68b. ___ years ___ months (If a consumer) How long have you been receiving mental health services in Washington?
- 68c. ___ years ___ months (If family member) How long has your family member been receiving mental health services no matter where they have lived?
- 68d. ___ years ___ months (If family member) How long has your family member been receiving mental health services in Washington?
69. _____ What is the highest level of education you have attained?
70. _____ What is your date of birth (month/day/year)
71. _____ What is your ethnic background?
72. Any questions?
73. (Time Finish: _____)

Appendix B

Letter Samples From Mental Health Division to Organizations



STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Mental Health Division • PO Box 45320 • Olympia WA 98504-5320 • FAX (360) 753-2746

July 27, 1995


Joanne Asaba, Acting RSN Manager
Mental Health Division
506 2nd Avenue
Smith Tower, Room 512
Seattle, Washington 98104

Dear Ms. Asaba:

During the next few weeks, Mr. David Schantz, ACSW, Ph.C., will be contacting you for an interview and your assistance in facilitating interviews of your staff and board members regarding the evaluation of the Office of Consumer Affairs in the Mental Health Division. Mr. Schantz is a Ph.D. candidate at the University of Washington School of Social Welfare and is an independent evaluator of the Office of Consumer Affairs. All interviews will be confidential, voluntary and will take from 20 minutes to 1 hour. Information will only be available to the division in group form.

What will be needed from your agency is private space for interviews to be held and the availability of your staff and board members for interviews. Your assistance in facilitating this process will be appreciated.

Sincerely,


Carroi A. Hernandez, Ph.D.
Director
Mental Health Division

cc: Contract Liaison



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington 98504-0095

December 14, 1995

Dear Mental Health Division Advisory Board Member,

During the next few weeks Mr. David Schantz ACSW, Ph.C. or a research assistant will be contacting you for an interview regarding the evaluation of the Office of Consumer Affairs in the Mental Health Division. Mr. Schantz is a Ph.D. Candidate at the University of Washington and is also independent evaluator of the Office of Consumer Affairs. If you are called, it will be because of your membership on the Advisory Board. We at the Mental Health Division wish to make the services provided through the Office of Consumer Affairs as effective as possible. To help us do so, Mr. Schantz has been asked to provide an independent evaluation of the Office of Consumer Affairs.

Participation is entirely voluntary and refusal or stopping an interview will not affect any benefit or service that you may be receiving, or your membership. Your help in this matter will be appreciated. Your answers and the answers of everyone else who is interviewed will be confidential. Mental Health Division Headquarters, and Office of Consumer Affairs, including myself, will not have any information as to those who were or were not interviewed. Your feedback will only be available to the Mental Health Division in group form. The interviews will take from 20 minutes to 1 hour.

Your assistance in facilitating this evaluation and anything you have to share will be appreciated. By sharing you will have an opportunity to provide anonymous feedback to the Mental Health Division that will help us to be more responsive to the needs of the community and do a better job.

Sincerely,

A handwritten signature in black ink that reads "Carol Hernandez".

Carol Hernandez, Ph.D.
Director, Washington State Mental Health Division



STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Mental Health Division • PO Box 45320 • Olympia WA 98504-5320 • FAX (360) 733-2746

July 27, 1995

Eleanor Owen, Executive Director
 Washington Advocates for the Mentally Ill
 802 N.W. 70th
 Seattle, Washington 98117

Dear Ms. Owen: *Eleanor*

During the next few weeks, Mr. David Schantz, ACSW, Ph.C., will be contacting you for an interview and your assistance in facilitating interviews of yourself, staff, board members, and 15 members regarding the evaluation of the Office of Consumer Affairs in the Mental Health Division. Mr. Schantz is a Ph.D. candidate at the University of Washington School of Social Welfare and is an independent evaluator of the Office of Consumer Affairs. All interviews will be confidential, voluntary and will take from 20 minutes to 1 hour. Information will only be available to the division in group form.

What will be needed from your agency is private space for interviews to be held, help with randomly selecting the members for interview and the availability of your staff and board members for interviews. Members and board can be interviewed by phone if they are not readily available. Mr Schantz will be able to answer your questions concerning the process when he calls. Your assistance in facilitating this process will be appreciated.

Sincerely,

Carrol A. Hernandez, Ph.D.
 Director
 Mental Health Division

cc: Contract Liaison



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Mental Health Division • PO Box 45320 • Olympia WA 98504-5320 • FAX (360) 753-2746

July 27, 1995

Bob LeBeau, Executive Director
North Sound RSN
419 S. First Street, Suite 200
Mount Vernon, Washington 98273-3806

Dear Mr. LeBeau: *Bob*

During the next few weeks, Mr. David Schantz, ACSW, Ph.C., will be contacting you for an interview and your assistance in facilitating interviews of your staff and board members regarding the evaluation of the Office of Consumer Affairs in the Mental Health Division. Mr. Schantz is a Ph.D. candidate at the University of Washington School of Social Welfare and is an independent evaluator of the Office of Consumer Affairs. All interviews will be confidential and voluntary and will take from 20 minutes to 1 hour. Information will only be available to the division in group form.

What will be needed from your agency is private space for interviews to be held and the availability of your staff and board members for interviews. Your assistance in facilitating this process will be appreciated.

Sincerely,

A handwritten signature in black ink, appearing to read "Carol A. Hernandez".

Carol A. Hernandez, Ph.D.
Director
Mental Health Division

cc: Contract Liaison



STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Mental Health Division • PO Box 45320 • Olympia WA 98504-5320 • FAX (360) 753-2746

July 27, 1995

Scott Bond, Administrator
Greater Columbia RSN/PHP
3311 Clearwater Avenue, Suite 1000
Kennewick, Washington 99336

Dear Mr. Bond:

Scott

During the next few weeks, Mr. David Schantz, ACSW, Ph.C., will be contacting you for an interview and your assistance in facilitating interviews of your staff and board members regarding the evaluation of the Office of Consumer Affairs in the Mental Health Division. Mr. Schantz is a Ph.D. candidate at the University of Washington School of Social Welfare and is an independent evaluator of the Office of Consumer Affairs. All interviews will be confidential and voluntary and will take from 20 minutes to 1 hour. Information will only be available to the division in group form.

What will be needed from your agency is private space for interviews to be held and the availability of your staff and board members for interviews. Your assistance in facilitating this process will be appreciated.

Sincerely,

Handwritten signature of Caroi A. Hernandez.

Caroi A. Hernandez, Ph.D.
Director
Mental Health Division

cc: Contract Liaison



STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Mental Health Division • PO Box 45320 • Olympia WA 98504-5320 • FAX (360) 753-2746

July 27, 1995

Kasey Kramer, RSN Program Manager
Community Services Department
North 721 Jefferson, Suite 403
Spokane, Washington 99260

Dear Mr. Kramer:

During the next few weeks, Mr. David Schantz, ACSW, Ph.C., will be contacting you for an interview and your assistance in facilitating interviews of your staff and board members regarding the evaluation of the Office of Consumer Affairs in the Mental Health Division. Mr. Schantz is a Ph.D. candidate at the University of Washington School of Social Welfare and is an independent evaluator of the Office of Consumer Affairs. All interviews will be confidential, voluntary and will take from 20 minutes to 1 hour. Information will only be available to the division in group form.

What will be needed from your agency is private space for interviews to be held and the availability of your staff and board members for interviews. Your assistance in facilitating this process will be appreciated.

Sincerely,

Handwritten signature of Carol A. Hernandez.

Carol A. Hernandez, Ph.D.
Director
Mental Health Division

cc: Contract Liaison



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Mental Health Division • PO Box 45320 • Olympia WA 98504-5320 • FAX (360) 753-2746

July 27, 1995

David H. Panken, Chief Executive Officer
Spokane Community Mental Health Center
S. 107 Division St.
Spokane, Washington 99202-1586

Dear Mr. Panken:

During the next few weeks, Mr. David Schantz, ACSW, Ph.C., will be contacting you for an interview and your assistance in facilitating interviews of 18-day treatment clients and 4-5 staff and your board regarding the evaluation of the Office of Consumer Affairs in the Mental Health Division. Mr. Schantz is a Ph.D. candidate at the University of Washington School of Social Welfare and is an independent evaluator of the Office of Consumer Affairs. All interviews will be voluntary and confidential and will take from 20 minutes to 1 hour. Information will only be available to the division in group form.

What will be needed from your agency is access to your day treatment clients, private space for interviews to be held, assistance in making random selection of clients present during the program day and the availability of a few of your staff and your board for interviews. Board members can be contacted by phone for interviews. Your assistance in facilitating this process will be appreciated.

Sincerely,

A handwritten signature in black ink, appearing to read "Carol A. Hernandez".

Carol A. Hernandez, Ph.D.
Director
Mental Health Division

cc: Contract Liaison



STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Mental Health Division • PO Box 45320 • Olympia WA 98504-5320 • FAX (360) 733-2746

July 27, 1995

Leslie Mariner, Executive Director
 Central Washington Comprehensive Mental Health
 P.O. Box 959
 Yakima, Washington 98907

Dear Ms. Mariner: *Leslie*

During the next few weeks, Mr. David Schantz, ACSW, Ph.C., will be contacting you for an interview and your assistance in facilitating interviews of 18-day treatment clients and 4-5 staff and your board regarding the evaluation of the Office of Consumer Affairs in the Mental Health Division. Mr. Schantz is a Ph.D. candidate at the University of Washington School of Social Welfare and is an independent evaluator of the Office of Consumer Affairs. All interviews will be voluntary and confidential and will take from 20 minutes to 1 hour. Information will only be available to the division in group form.

What will be needed from your agency is access to your day treatment clients, private space for interviews to be held, assistance in making random selection of clients present during the program day and the availability of a few of your staff and your board for interviews. Board members can be contacted by phone for interviews. Your assistance in facilitating this process will be appreciated.

Sincerely,

Carol A. Hernandez, Ph.D.
 Director
 Mental Health Division

cc: Contract Liaison



STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Mental Health Division • PO Box 45320 • Olympia WA 98504-5320 • FAX (360) 753-2746

July 27, 1995


Christopher Szala, Executive Director
Community House Mental Health Center
431 Boylston Avenue East
Seattle, Washington 98102

Dear Mr. Szala:

During the next few weeks, Mr. David Schantz, ACSW, Ph.C., will be contacting you for an interview and your assistance in facilitating interviews of 13-day treatment clients and 4-5 staff and your board regarding the evaluation of the Office of Consumer Affairs in the Mental Health Division. Mr. Schantz is a Ph.D. candidate at the University of Washington School of Social Welfare and is an independent evaluator of the Office of Consumer Affairs. All interviews will be voluntary and confidential and will take from 20 minutes to 1 hour. Information will only be available to the division in group form.

What will be needed from your agency is access to your day treatment clients, private space for interviews to be held, assistance in making random selection of clients present during the program day and the availability of a few of your staff and your board for interviews. Board members can be contacted by phone for interviews. Your assistance in facilitating this process will be appreciated.

Sincerely,


Carol A. Hernandez, Ph.D.
Director
Mental Health Division

cc: Contract Liaison



STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Mental Health Division • PO Box 45320 • Olympia WA 98504-5320 • FAX (360) 753-2746

July 27, 1995

Jere LaFollette, Director
 Skagit Community Mental Health Center
 208 Kincaid Street
 Mount Vernon, Washington 98273

Dear Mr. LaFollette: 

During the next few weeks, Mr. David Schantz, ACSW, Ph.C., will be contacting you for an interview and your assistance in facilitating interviews of 18-day treatment clients and 4-5 staff and your board regarding the evaluation of the Office of Consumer Affairs in the Mental Health Division. Mr. Schantz is a Ph.D. candidate at the University of Washington School of Social Welfare and is an independent evaluator of the Office of Consumer Affairs. All interviews will be voluntary and confidential and will take from 20 minutes to 1 hour. Information will only be available to the division in group form.

What will be needed from your agency is access to your day treatment clients, private space for interviews to be held, assistance in making random selection of clients present during the program day, and the availability of a few of your staff and your board for interviews. Board members can be contacted by phone for interviews. Your assistance in facilitating this process will be appreciated.

Sincerely,



Carrol A. Hernandez, Ph.D.
 Director
 Mental Health Division

cc: Contract Liaison



STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Mental Health Division • PO Box 45320 • Olympia WA 98504-5320 • FAX (360) 753-2746

July 27, 1995

Brad Bell, Executive Director
 Chehalis Avenue Club
 Cascade Mental Health Care
 P.O. Box 1445
 Chehalis, Washington 98532

Dear Mr. Bell:

During the next few weeks, Mr. David Schantz, ACSW, Ph.C., will be contacting you for an interview and your assistance in facilitating interviews of 18 club members, 4-5 staff and your board regarding the evaluation of the Office of Consumer Affairs in the Mental Health Division. Mr. Schantz is a Ph.D. candidate at the University of Washington School of Social Welfare and is an independent evaluator of the Office of Consumer Affairs. All interviews will be voluntary and confidential and will take from 20 minutes to 1 hour. Information will only be available to the division in group form.

What will be needed from your agency is access to your day treatment clients, private space for interviews to be held, assistance in making random selection of clients present during the program day and the availability of a few of your staff and your board for interviews. Board members can be contacted by phone for interviews. Your assistance in facilitating this process will be appreciated.

Sincerely,

A handwritten signature in black ink, appearing to read "Carol A. Hernandez".

Carol A. Hernandez, Ph.D.
 Director
 Mental Health Division

cc: Contract Liaison



STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Mental Health Division • PO Box 45320 • Olympia WA 98504-5320 • FAX (360) 753-2746

July 27, 1995

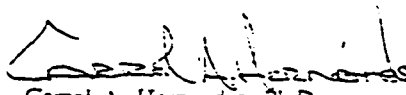
Al Ericksen, Manager
Capital Clubhouse
1217 Cooper Point Road S.W., Suite 7
Olympia, Washington 98502

Dear Mr. Ericksen:

During the next few weeks, Mr. David Schantz, ACSW, Ph.C., will be contacting you for an interview and your assistance in facilitating interviews of 18 club members, 4-5 staff and your board regarding the evaluation of the Office of Consumer Affairs in the Mental Health Division. Mr. Schantz is a Ph.D. candidate at the University of Washington School of Social Welfare and is an independent evaluator of the Office of Consumer Affairs. All interviews will be voluntary and confidential and will take from 20 minutes to 1 hour. Information will only be available to the division in group form.

What will be needed from your agency is access to your day treatment clients, private space for interviews to be held, assistance in making random selection of clients present during the program day and the availability of a few of your staff and your board for interviews. Board members can be contacted by phone for interviews. Your assistance in facilitating this process will be appreciated.

Sincerely,



Carol A. Hernandez, Ph.D.
Director
Mental Health Division

cc: Contract Liaison



STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Mental Health Division • PO Box 45320 • Olympia WA 98504-5320 • FAX (360) 753-2746

July 27, 1995


Sherry Howard, Executive Director
 Coastal Clubhouse
 2720 Sumner Avenue
 Hoquiam, Washington 98550

Dear Ms. Howard:

During the next few weeks, Mr. David Schantz, ACSW, Ph.C., will be contacting you for an interview and your assistance in facilitating interviews of 18 club members, 4-5 staff and your board regarding the evaluation of the Office of Consumer Affairs in the Mental Health Division. Mr. Schantz is a Ph.D. candidate at the University of Washington School of Social Welfare and is an independent evaluator of the Office of Consumer Affairs. All interviews will be voluntary and confidential and will take from 20 minutes to 1 hour. Information will only be available to the division in group form.

What will be needed from your agency is access to your day treatment clients, private space for interviews to be held, assistance in making random selection of clients present during the program day and the availability of a few of your staff and your board for interviews. Board members can be contacted by phone for interviews. Your assistance in facilitating this process will be appreciated.

Sincerely,



Carol A. Hernandez, Ph.D.
 Director
 Mental Health Division

cc: Contract Liaison




STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Mental Health Division • PO Box 45320 • Olympia WA 98504-5320 • FAX (360) 753-2746

July 27, 1995

Tom Martin, President
Alliance for the Mentally Ill/Washington State
4305 Lacey Boulevard, Suite 11
Lacey, Washington 98503

Dear Mr. Martin: 

During the next few weeks, Mr. David Schantz, ACSW, Ph.C., will be contacting you for an interview and your assistance in facilitating interviews of yourself, staff, board members, and 15 members regarding the evaluation of the Office of Consumer Affairs in the Mental Health Division. Mr. Schantz is a Ph.D. candidate at the University of Washington School of Social Welfare and is an independent evaluator of the Office of Consumer Affairs. All interviews will be confidential, voluntary and will take from 20 minutes to 1 hour. Information will only be available to the division in group form.

What will be needed from your agency is private space for interviews to be held, help with randomly selecting the members for interview and the availability of your staff and board members for interviews. Members and board can be interviewed by phone if they are not readily available. Mr Schantz will be able to answer your questions concerning the process when he calls. Your assistance in facilitating this process will be appreciated.

Sincerely,



Carol A. Hernandez, Ph.D.
Director
Mental Health Division

cc: Contract Liaison



STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Mental Health Division • PO Box 43320 • Olympia WA 98504-3320 • FAX (360) 733-2746

July 27, 1995

Barbara Bieren, Acting Facilitator
Washington Education Consumer Action Network
P.O. Box 910
Yakima, Washington 98907

Dear Ms. Bieren: 

During the next few weeks, Mr. David Schantz, ACSW, Ph.C., will be contacting you for an interview and your assistance in facilitating interviews of yourself, staff, board members, and 15 members regarding the evaluation of the Office of Consumer Affairs in the Mental Health Division. Mr. Schantz is a Ph.D. candidate at the University of Washington School of Social Welfare and is an independent evaluator of the Office of Consumer Affairs. All interviews will be confidential, voluntary and will take from 20 minutes to 1 hour. Information will only be available to the division in group form.

What will be needed from your agency is private space for interviews to be held, help with randomly selecting the members for interview and the availability of your staff and board members for interviews. Members and board can be interviewed by phone if they are not readily available. Mr Schantz will be able to answer your questions concerning the process when he calls. Your assistance in facilitating this process will be appreciated.

Sincerely,



Carol A. Hernandez, Ph.D.
Director
Mental Health Division

cc: Contract Liaison

Appendix C


Sample Letters from Agencies and Organizations to their Boards or Membership



Central Washington Comprehensive
mental health

MEMORANDUM

TO: Board Members

FROM: Leslie Mariner, CEO 
Central Washington Comprehensive Mental Health

DATE: August 15, 1995

RE: Department of Social and Health Services
Evaluation of State Office of Consumer Affairs

We have been notified by DSHS that they are conducting an evaluation of their Office of Consumer Affairs within the next few weeks. They have determined they want to interview 18 clients, 4-5 staff in a select program area and governing board members. We have been instructed to let you know and coordinate the activity.

The interviews will take 20 minutes to an hour. They can be held over the phone or face to face at a convenient time for you. David Schantz will be coordinating the interview team. Please be aware, you can decline the interview if you desire and it is not important that you know anything about the Office of Consumer Affairs. Part of the evaluation is to determine how well information has been disseminated and how informed people are. Please notify us at the Board meeting or call Nancy if you do not want your name given to the evaluator.

All responses will be confidential and all information will be summarized prior to presentation to DSHS. Only the final report will be made public.

Please call me if you have questions or we can discuss this at the Board meeting.

Yakima
321 East Yakima Avenue
P O Box 959
Yakima, WA 98901
(509) 575-4034

Ellensburg
220 West 4th Avenue
Ellensburg, WA 99026
(509) 925-9226


Sunnyside
1319 34th Road South
Sunnyside, WA 99088
(509) 337-2037



SOUTH 107 DIVISION ■ SPOKANE, WASHINGTON 99202 ■ PHONE (509) 338-4651 ■ FAX (509) 458-7449 ■ TTY (509) 624-C004

MEMORANDUM

TO: CMHC Board of Directors

FROM: David H. Panken, CEO 

DATE: October 19, 1995

RE: Office of Consumer Affairs Evaluation

We have been contacted by Carroll Hernandez, PhD, Director, State Mental Health Division, requesting that we assist Mr. David Schantz with an independent evaluation of the Office of Consumer Affairs located in the Mental Health Division. Mr. Schantz is a PhD candidate at the University of Washington School of Social Welfare. He has been requested by the Mental Health Division to perform this evaluation. Mr. Schantz seeks permission to contact each member of the Board. He plans to do this via a telephone interview with either himself or a research assistant. The purpose of the interviews will be to help evaluate how much people know about the Office of Consumer Affairs and what they envision as essential functions of this office. It is not necessary to know anything at all concerning the Office of Consumer Affairs in order to be helpful. All interviews will be voluntary and confidential. Consumers, mental health staff and members of governing boards are being interviewed throughout the state. Mr. Schantz has already interviewed some of our staff and consumers. Information will be made available to the Mental Health Division in summary form.

If you have any objections to being contacted for an interview please let my secretary, Vera Crawford, know by phone (458-7453). Otherwise, if we have not heard from you by October 30, 1995, we will forward the names and appropriate telephone numbers to Mr. Schantz and he will begin to reach Board members by phone in order to schedule a time to speak with you. Interviews will take from 20 minutes to an hour.

Thank you for your willingness to assist both Mr. Schantz and the Mental Health Division by providing important information that will facilitate an evaluation of the Office of Consumer Affairs.

bcc: David Schantz

BOARD OF DIRECTORS

Rick Scamwell
President

John T. Krae
First Vice President

Karen Bishop
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Ned M. Barnes
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Michael B. Herzog, PhD
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John V. Geraghty, Jr.

Phyllis Nelson

Mark Mays, PhD, JD

Chris D. Mikkelsen, CPA

Michael A. Perrot, MD

Maria Hernandez-Peck, PhD

Col. Clifford V. Wagon

CHIEF EXECUTIVE OFFICER
David H. Panken, Esq.



A United Way Agency



Alliance for the Mentally Ill of Washington State

4305 Lacey Blvd, Suite 11, Lacey, Washington 98503
(206) 438-0211 - FAX (206) 493-0431

Dear Members,

During the next few weeks you may be contacted by a member of an independent evaluation team that is evaluating the Mental Health Division Office of Consumer Affairs. Members will be randomly selected for interview from our membership. The evaluation is being done for the Office of Consumer Affairs by an independent evaluator, Mr. David Schantz who is a Ph.D. Candidate at the University of Washington. This group is gathering information from different groups about the office with the intention of helping the Mental Health Division to be more responsive to the needs of mental health consumers and their families. Interviews are entirely voluntary and refusal or stopping an interview will not effect in any way any benefits or services you receive. All the answers will be confidential and information will only be shared on a group basis. Your help in this matter is needed and will be appreciated. Thank you.

Sincerely,

Arlene Engel vmp

*P.S. We need your phone number
for our records please call
1-800-877-2649.*

Appendix D

Client, Staff Meeting Announcement Protocol

Revised Contact Protocols:

After initial consent is obtained, the verbal consent (long version) for interview will be read and a formal one left with subject.

Protocol for agency day tx & club house announcement for client recruitment:

By Agency Staff Member to Day Treatment or Consumer Run Club House Community Meeting:

Some time in the next couple of days some folks that are evaluating the Office of Consumer Affairs at the Mental Health Division in Olympia will be by. The evaluation is being done for the Office of Consumer Affairs by an independent evaluator, Mr. David Schantz who is a Ph.D. candidate at the University of Washington. Our visitors want to ask some of you questions regarding the office and its activities. They will be doing one to one interviews and would greatly appreciate your assistance. When they come, they will be selecting people for interview by random chance from the people who are here. Even if you have never heard of the Office of Consumer affairs, they still need to interview people who don't know about it in order to get some ideas about what you think too. The interviews will be confidential. Nothing you say will ever be reported in such a way as someone will know that you as an individual shared what you did. This is your chance to have confidential input about some of the ways the state does things in the mental health system. If you don't want to be interviewed that's OK. Your participation is voluntary and nothing will happen to any of your services or benefits if you don't want to be interviewed or if you stop an interview before it is finished. If you are not sure, the interviewer will be able to fill you in on more details. Then you can decide. The interviewers will also be able to answer other questions you might have.

Any Questions?

Protocol for individual client contact by agency person on day of interview:

[On the day the interviewers are present an announcement will be made to the community meeting.]

"The other day I announced that some folks who are evaluating the Office of Consumer Affairs in Olympia would be coming. Well today they (are, will be) here. They will be asking some of you for interviews and you will be contacted throughout the day to find out if you will be willing. They will be asking people for interview by random selection. Remember your participation is entirely voluntary. If you don't want to be interviewed it won't effect any of your services or benefits. If you do an interview this is a chance to give some input into what the State Office of Consumer Affairs does to represent your interests."

[Following announcement throughout the day individual contacts will be made by agency person.]

"Hi Joe, you were randomly selected for an interview. Would you be interested in sharing what you think and how you think the State should run the Office of Consumer Affairs? Your participation is voluntary and if you refuse or stop the interview, there won't be any effect on your services or benefits but your input is needed. Would you be willing to be interviewed?" [if yes, the interview arrangements will be set up]

Protocol for phone contact by researcher or assistant with AHCAC member:

Hi. My name is _____. I am working with Mr. David Schantz who is the evaluator of the Office of Consumer Affairs and is a Ph.D. candidate at the School of Social Work at the University of Washington. I'm calling to set up an interview with you for the Office of Consumer Affairs evaluation. You were selected because you are (or have been) a member of the Ad-hoc committee. Your opinions are very important to what will be happening to the office and what it does later. The interview is voluntary and not interviewing or stopping it will not effect any benefits or services that you receive. Would you like to go ahead now, schedule an interview over the phone [or in person] for later, or would you rather not do the interview? It will take about one hour and nothing that you share will be tied to you individually in any reporting. We are trying to find out what AHCAC members think as a whole group and so will share your thoughts that way, unless you specifically say otherwise. Do you want to do the interview now or later, or not at all? (Wait for response) Thanks.

Protocol for contact by research team member of 1-800 line or computer BBS user:

Hi, My name is _____. I work for an independent group that is in charge of evaluating the Office of Consumer Affairs in the Mental Health Division. The evaluation is being headed by Mr. David Schantz who is a Ph.D. Candidate at the University of Washington School of Social Work. I am calling you because you have used the (1-800 phone line or BBS) and were randomly selected from those that have used this service. The mental health division wants to do a better job with this service and with the Office of Consumer Affairs. One good way to do this is to ask people who have been served what they think. Everything you will say is confidential and will only be shared with the MHD with a group of answers from others who have an interest in the service and office. The interview is entirely voluntary and not interviewing or stopping it will not effect any benefits or services that you receive. This will be your chance to give the Office of Consumer Affairs your thoughts about the office and its services. What you think is very important. The interview will take anywhere from 15 minutes to an hour. May I interview you? Thank you.

Appendix E

Protocol for Contact of 1-800 User by OCA Staff Member

Protocol for contact by OCA staff member of 1-800 line caller:

1. "Hello is _____ there? Hi, this is _____ from the Office of Consumer Affairs at the Mental Health Division in Olympia. I am calling because we need to ask you for some help."
2. (If subject responds: "how is that?" or something to the same effect the caller responds...)
3. "Let me tell you about what we've been up to." (Caller then skips to par. 10).
4. (If subject asks some question about the office that the caller can respond to very briefly caller should briefly respond and then say...)
5. "Now I'd like to tell you about why I called today." (If subject says OK or nothing, caller skips to par. 10).
6. (If subject asks another question or leads on with other comments the caller is to respond...)
7. "I'm not the right person to respond to this and I want to make sure the right person talks to you so what I will do is take a message and make sure someone from our office calls you back about this. Today I called about a different matter. The reason I called is to tell you about a research project that we are doing and ask for your help." (If subject responds: "how is that?" or something to the same effect the caller skips to par. 10).
8. (If subject continues by asking another question or leads on with other comments the caller is to respond...)
9. "I'll make sure some one from the office who is in a position to help you calls you back, but today I'm calling several people who have called the Office of Consumer Affairs. All the calls are supposed to be the same so what I am supposed to do if questions come up that are not related to the call is take a message and make sure someone calls you back as soon as they can with some help. What I am supposed to do after writing down your message or question is tell you what I am calling for and then find out from you if you would be willing to help us." (Then caller is to skip directly to next par..)
10. "We've been working with a program evaluator who is a Ph.D. candidate at the University of Washington. His name is David Schantz. He is helping us evaluate our services so we can do a better job. As part of his work David and some assistants are conducting confidential voluntary interviews with many people around the State about this Office. David especially needs to talk directly with people who have had contact with the Office of Consumer Affairs and he would like permission to talk with you. Your name was selected randomly from people who have called us on the 1-800 line and left their phone number so we can call them back." *
11. "What the interview will be about is what you think about your experience with the Office of Consumer Affairs and also to get ideas from you about how the Office could be improved. This is a chance for you to give some important confidential feedback to us about how we are doing. David is an independent researcher so your confidentiality will be protected. You can say anything you like about the Office of Consumer Affairs or any thing else and we won't know what different individuals said. To protect individual confidentiality David will pool everyone's answers and report them in group form. To protect your privacy David has made sure that we know that he doesn't want us to share with him why you have called the Office of Consumer Affairs in the first place. I also want to make sure that you know this is entirely voluntary and you can refuse or stop an interview and it will not effect any benefit or service that you receive in any way. They take about 20 minutes to an hour depending on how many ideas you may have." *

12. "Mr Schantz has been working with us for about 3 years and has been able to provide us with helpful feedback already. He needs to talk with people who have called us and used the 1-800 phone line. You were selected but before we give him your name we need your permission. This is a chance for people that we have contact with to help us do a better job, to tell us what we are doing well and what we could do better. It's your chance to give us and the State some feedback about how we are doing our jobs. It would be helpful and we would appreciate it if you said yes to being interviewed." *
13. "Would it be OK for Mr. Schantz or one of his assistants to contact you for an interview?" **

14. (If subject says yes:
"Thank you." (Caller then gets best times to call and any alternative numbers.) "I will give your phone number to Mr Schantz and he will contact you sometime in the next few days for an interview..If there is any thing further that we at the Office of Consumer Affairs can do for you?" (If yes, then take a message) "Thank you for your help. Good by."
15. (If subject says no:
16. "Thank you for listening and for your help. If there is any thing further that we at the Office of Consumer Affairs can do for you please let us know." (If yes then take a message) "Thank you. Good by."
17. **At this point there may be more questions for the caller about the proposed interview
Caller is to respond:
18. "You know, I don't know enough about this to be able to give you an accurate answer. What we can do is have Mr Schantz call and talk with you. Why don't you let me have Mr. Schantz call you and talk about the interview with you. He should be able to answer any questions you have and then you can decide if you want to do an interview. Would it'll be alright if David called you?" (if yes: caller record name and any questions and best times to call) (if no: caller responds) "Well, without your permission to have Mr. Schantz call you I don't know is there is any other way to get your question(s) answered. Maybe it would be best just to not participate in this survey, so unless you say otherwise we wont give your name to Mr Schantz. If there is any thing further that we at the Office of Consumer Affairs can do for you please let us know. OK? Thank you. Good by."
19. *** At this point there may be more questions for the caller about other matters other than the proposed interview the caller is to respond.
20. "I want to make sure you get a response to this so what I will do is take a message and make sure the right person from the Office calls you back about this." (Caller then takes message and then asks:) "Would it be OK for Mr. Schantz or one of his assistants to contact you for an interview?" **
21. *At any point in the interview if the caller digresses with questions about the survey the caller is to respond:
22. "You know, I don't know enough about this to be able to give you an accurate answer. I've got some more information here that may help with your questions. Why don't you let me finish and then we'll see if that answers your questions. If it doesn't then we'll talk. (Caller then resumes reading the script. If the subject resumes interrupting the caller repeats par. 22 then refers to place where they were interrupted.)

Protocol for contact by OCA staff member of computer BBS user:

1. "Hello is _____ there? Hi, this is _____ from the Office of Consumer Affairs at the Mental Health Division in Olympia. I am calling because we need to ask you for some help."
2. (If subject responds: "how is that?" or something to the same effect the caller responds....)
3. "Let me tell you about what we've been up to." (Caller then skips to par. 10).
4. (If subject asks some question about the office that the caller can respond to very briefly caller should briefly respond and then say...)
5. "Now I'd like to tell you about why I called today." (If subject says OK or nothing, caller skips to par.. 10).
6. (If subject asks another question or leads on with other comments the caller is to respond...)
7. "I'm not the right person to respond to this and I want to make sure the right person talks to you so what I will do is take a message and make sure someone from our office calls you back about this. Today I called about a different matter. The reason I called is to tell you about a research project that we are doing and ask for your help." (If subject responds: "how is that?" or something to the same effect the caller skips to par.. 10).
8. (If subject continues by asking another question or leads on with other comments the caller is to respond...)
9. "I'll make sure some one from the office who is in a position to help you calls you back, but today I'm calling several people who have used the Office of Consumer Affairs computer bulletin board service. All the calls are supposed to be the same so what I am supposed to do if questions come up that are not related to the call is take a message and make sure someone calls you back as soon as they can with some help. What I am supposed to do after writing down your message or question is tell you what I am calling for and then find out from you if you would be willing to help us." (Then caller is to skip directly to next par..)
10. "We've been working with a program evaluator who is a Ph.D. candidate at the University of Washington. His name is David Schantz. He is helping us evaluate our services so we can do a better job. As part of his work David and some assistants are conducting confidential voluntary interviews with many people around the State about this Office. David especially needs to talk directly with people who have had contact with the Office of Consumer Affairs and he would like permission to talk with you. Your name was selected randomly from people who have called us on the 1-800 line and left their phone number so we can call them back." *
11. "What the interview will be about is what you think about your experience with the Office of Consumer Affairs and the computer bulletin board, and also to get ideas from you about how the Office could be improved. This is a chance for you to give some important confidential feedback to us about how we are doing. David is an independent researcher so your confidentiality will be protected. You can say anything you like about the Office of Consumer Affairs or any thing else and we won't know what different individuals said. To protect individual confidentiality David will pool everyone's answers and report them in group form. To protect your privacy David has made sure that we know that he doesn't want us to share with him why you have called the Office of Consumer Affairs in the first place. I also want to make sure that you know this is entirely voluntary and you can refuse or stop an interview and it will not effect any benefit or service that you receive in any way. They take about 20 minutes to an hour depending on how many ideas you may have." *

12. "Mr Schantz has been working with us for about 3 years and has been able to provide us with helpful feedback already. He needs to talk with people who have used the compute BBS. You were selected but before we give him your name we need your permission. This is a chance for people that we have contact with to help us do a better job. to tell us what we are doing well and what we could do better. It's your chance to give us and the State some feedback about how we are doing our jobs. It would be helpful and we would appreciate it if you said yes to being interviewed."*
13. "Would it be OK for Mr. Schantz or one of his assistants to contact you for an interview?" **

14. (If subject says yes:)
"Thank you." (Caller then gets best times to call and any alternative numbers.) "I will give your phone number to Mr Schantz and he will contact you sometime in the next few days for an interview. If there is any thing further that we at the Office of Consumer Affairs can do for you?" (If yes, then take a message) "Thank you for your help. Good by."
15. (If subject says no:)
16. "Thank you for listening and for your help. If there is any thing further that we at the Office of Consumer Affairs can do for you please let us know." (If yes then take a message) "Thank you. Good by."
17. **At this point there may be more questions for the caller about the proposed interview
Caller is to respond:
18. "You know, I don't know enough about this to be able to give you an accurate answer. What we can do is have Mr Schantz call and talk with you. Why don't you let me have Mr. Schantz call you and talk about the interview with you. He should be able to answer any questions you have and then you can decide if you want to do an interview. Would It'll be alright if David called you?" (if yes: caller record name and any questions and best times to call) (if no: caller responds) "Well, without your permission to have Mr. Schantz call you I don't know if there is any other way to get your question(s) answered. Maybe it would be best just to not participate in this survey, so unless you say otherwise we wont give your name to Mr Schantz. If there is any thing further that we at the Office of Consumer Affairs can do for you please let us know. OK? Thank you. Good by."
19. *** At this point there may be more questions for the caller about other matters other than the proposed interview the caller is to respond.
20. "I want to make sure you get a response to this so what I will do is take a message and make sure the right person from the Office calls you back about this." (Caller then takes message and then asks:) "Would it be OK for Mr. Schantz or one of his assistants to contact you for an interview?" **
21. *At any point in the interview if the caller digresses with questions about the survey the caller is to respond:
22. "You know, I don't know enough about this to be able to give you an accurate answer. I've got some more information here that may help with your questions. Why don't you let me finish and then we'll see if that answers your questions. If it doesn't then we'll talk. (Caller then resumes reading the script. If the subject resumes interrupting the caller repeats par. 22 then refers to place where they were interrupted.)

Appendix F

Informed Consent Format for Reading at the Beginning of Interviews

Verbal Consent for Interview
(Script to be read to subject at time of interview. 3½ minutes)

[Adjust script for in person consent or phone etc.]

Hi. Thanks for talking with me. I am working with the evaluation project for the Office of Consumer Affairs at the Mental Health Division in Olympia. It is an independent evaluation and the principal investigator is David Schantz who is a Ph.D. Candidate at the University of Washington School of Social Work. Your name was chosen from _____ (adjust for the subject) and I would like to interview you for this research. Anything you share will be confidential and is entirely voluntary. Declining to be interviewed or stopping the interview at any time will not effect any benefits or services that you receive. If you want to leave a message for Mr. Schantz he can be contacted by calling 1-800-446-0259 and he will get back to you. Or you can contact him at one of the other numbers on the top of the sheet I will make available to you. Are you interested in hearing more about this study? Is this a good time to talk?

Purpose and Benefits: The evaluation researchers are conducting interviews about the Office so the OCA and the state can do a better job providing services. Knowing what people from different groups think will help the office be more responsive. Also there has been no research done on an office like this any where in the country. So far there are about 16 offices like this in the country and they need information too. The results of this study will help them know what some of the issues might be from their interest groups too. The idea is to find out the extent of knowledge and the opinions of groups who have an interest in the Office. You have been selected because you are a member of one of these groups. By understanding what people think and feel about the Washington Office of Consumer Affairs, this office, the Mental Health Division and other offices around the country will have a better idea about how to be help the people they want to serve. Mental health consumers and other people that are interested in seeing improved services for mental health consumers will benefit by having better communication with people at the state level.

Procedures: This interview will be about your knowledge and opinions on the Washington Mental Health Division, Office of Consumer Affairs. It's OK if you don't know anything about the office. A couple of examples of questions that will be asked are: "What do you know about the Office of Consumer Affairs?" and "What would you most like to see the Office of Consumer Affairs doing?" There are also a couple of questions at the end that ask for some general information about your background. The most intrusive of these would be a question about how long you have been receiving services. We want you to be very comfortable and relaxed in this interview and to share only what you wish. Please remember that you are free not to answer any questions you do not wish to answer or which make you uncomfortable. This information will help the researcher understand all of the different types of people that have been interviewed. Depending on how much you know about the OCA and its activities, and how much you have to say about your opinions, the interview will take about twenty minutes to one hour. The plan is to write down your answers and to audio tape the interview [phone interviews will not be taped]. The risks to you are minimal.

Risks: It is possible that in answering some of the questions you may become uncomfortable or it may raise an issue that you have been uncomfortable with in the past. We want you to be comfortable and able to share as fully as you wish, so please remember that you don't need to answer any question that makes you uneasy. You might be concerned that your individual answers could be of interest to someone at the mental health division or somewhere else, and that they might cause trouble for you. To prevent this, the researcher and interviewers are independent and all individual answers are confidential. If any question makes you uncomfortable just skip it and go on to the next. Please don't feel pressured to answer any question that you feel uncomfortable with. Nothing that you say will ever be transmitted in any way that will identify you to a Mental Health Division employee, another consumer, a service provider, advocacy group member or anyone else other than the interviewer and the researcher. If you want, we will not tape the interview. If the tape is ok but you want it shut off during the interview just wave your hand at it and it will be shut off. Once the tape has been transcribed it will be erased so your voice is not on record. In order to make sure that you haven't been selected twice for an interview, your name will be recorded on a separate sheet. Once we know no one is scheduled twice, All names will be destroyed so there won't be any way to tell who gave what answers. The information collected will only be shared as part of a group's answers. No one will be able to identify you.

If it is ok we will go ahead with the interview.

Appendix G

Informed Consent Handout for Face to Face Interview

University of Washington & State of Washington Mental Health Division
Verbal Consent for Interview
(To be given to subject at time of face to face interview)

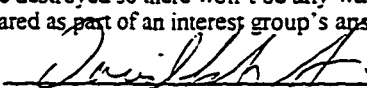
Washington Mental Health Division Office of Consumer Affairs Interest Group Member Interview

Investigator: David Schantz, Ph.C., ACSW: Ph.D. Candidate, School of Social Work, University of Washington, (206) 543-5640, messages (206) 883-9402; toll free messages 1-800-446-0259. Evaluator: Consumer Family Partnership Grant, State of Washington Mental Health Division.

Purpose and Benefits: This interview is part of the evaluation of the Office of Consumer Affairs (OCA) at the Washington State Mental Health Division. Nationally there are about 16 state level offices of consumer affairs. There has been no program evaluation carried out on any of these offices. This study will provide information to the state office and the National Institute of Mental Health and others about the Washington office. Because there have been no other evaluations like this, this particular part of the study is focusing on the knowledge and thoughts of different interest group members. By understanding what people think and feel about the Washington Office of Consumer Affairs, this study will make it more possible for the Washington OCA and the Mental Health Division to be more responsive to the people it has been designed to serve. Nationally this research will help other offices understand what some of the issues are that they may also need to address. Mental health consumers and other people that are interested in seeing improved services for mental health consumers will benefit as service providers know better how to respond to the desires of interested groups.

Procedures: This interview will be about your knowledge and opinions on the Washington Mental Health Division, Office of Consumer Affairs. It's OK if you don't know anything about the office. A couple of examples of questions that will be asked are: "What do you know about the Office of Consumer Affairs?" and "What would you most like to see the Office of Consumer Affairs doing?" There are also a couple of questions at the end that ask for some general information about your background. The most intrusive of these would be a question about how long you have been receiving services. We want you to be very comfortable and relaxed in this interview and to share only what you wish. Please remember that you are free not to answer any questions you do not wish to answer or which make you uncomfortable. This information will help the researcher understand all of the different types of people that have been interviewed. Depending on how much you know about the OCA and its activities, and how much you have to say about your opinions, the interview will take about twenty minutes to one hour. The plan is to write down your answers and to audio tape the interview [phone interviews will not be taped]. The risks to you are minimal.

Risks: It is possible that in answering some of the questions you may become uncomfortable or it may raise an issue that you have been uncomfortable with in the past. We want you to be comfortable and able to share as fully as you wish, so please remember that you don't need to answer any question that makes you uneasy. You might be concerned that your individual answers could be of interest to someone at the mental health division or somewhere else, and that they might cause trouble for you. To prevent this, the researcher and interviewers are independent and all individual answers are confidential. If any question makes you uncomfortable just skip it and go on to the next. Please don't feel pressured to answer any question that you feel uncomfortable with. Nothing that you say will ever be transmitted in any way that will identify you to a Mental Health Division employee, another consumer, a service provider, advocacy group member or anyone else other than the interviewer and the researcher. If you want, we will not tape the interview. If the tape is ok but you want it shut off during the interview just wave your hand at it and it will be shut off. Once the tape has been transcribed it will be erased so your voice is not on record. In order to make sure that you haven't been selected twice for an interview, your name will be recorded on a separate sheet. Once we know no one is scheduled twice, all the names will be destroyed so there won't be any way to tell who gave what answers. The information collected will only be shared as part of an interest group's answers. No one will be able to identify you.

 5/1/95

David Schantz, Evaluator

Appendix H

Executive Summary Report Submitted to the Mental Health Division

Washington State Mental Health Division
Office of Consumer Affairs Program Evaluation:
Executive Summary

Principal Investigator

David Schantz, Ph.C. ACSW

University of Washington

DESCRIPTION OF OFFICE OF CONSUMER AFFAIRS

The Washington State Mental Health Division (MHD) Office of Consumer Affairs (OCA) was funded by a 3 year Federal NIMH Consumer and Family Partnership grant. The OCA was stipulated in the grant to be staffed primarily by consumers and supervised within the MHD. It was fully staffed by October 1992. A limited program evaluation was required focusing primarily on outcomes. The following summarizes the grant and evaluation.

The OCA was created and placed in the state mental health division to accomplish 3 objectives. 1; place a consumer ear and voice in the day to day workings of the mental health division. 2; promote consumer representation at the mental health division and around the state by communicating with other consumers, and promoting the placement of independent consumers and advocates on boards and policy making bodies at state regional and local levels. 3; develop consumer communication, advocacy, and independence around Washington State by serving as an information, referral, and training resource.

The OCA was to develop and operate a 1-800 information and referral phone line, a resource library, a computer bulletin board system, and the Ad-hoc Consumer Affairs Advisory Committee that has since been changed to the Consumer Sub-committee of the Mental Health Advisory Board. This committee will be referred to here after as the Consumer Sub-Committee. Other activities were to be, from others, the production and dissemination of video newsletters and the production, collection and dissemination of technical assistance and informational materials. Other training and technical assistance services were to be provided to consumers, providers and family members in Washington.

RESEARCH METHODS

This evaluation focused on gathering information through two general avenues of inquiry. Participatory observation was utilized working closely with OCA staff and other stakeholders. OCA documents were collected for analysis and ongoing interviews were conducted with key stakeholders. Secondly, a comprehensive survey was developed to assess stakeholder views of the office, and its impact. Categorical and non leading open ended questions were incorporated. Stakeholders were included in the development of questions. Three hundred forty five (345) stakeholders were interviewed. Random representative samples, and where practical, population samples were included. Consumers (N = 173) constituted 50.1% of sample, consumer family members constituted 12.2% (N = 42) of the sample, and providers (N = 129) constituted 37.4% of the sample (please see appendix 1 for a table describing the distribution of stakeholder group samples). Extensive analysis of this survey data and other data collected throughout the evaluation has been made. The main points are described in the first paragraph below and then detailed.

FINDINGS

Evaluation findings can be summarized under five areas: 1) wide spread stakeholder

support; 2) different desired operational emphasis between stakeholder groups; 3) lack of knowledge on the part of many stakeholders particularly consumers; 4) a pattern of OCA ineffectiveness, diffuse unfocused activities, and disorganization, as related to implementation of grant goals; 5) evidence that the Consumer Sub-committee committee has been an effective tool in building consumer networking and empowerment through the growth of local and state level advocacy.

Data relating to stakeholder support is based on categorical material contained within the interview of the 345 subjects. Supporting material for the remaining questions is generated from volunteered responses to open-ended questions. Similar reports based on the this type of data are likely to represent lower response rates than would be expected if specific questions had been asked concerning the identified themes. This study was exploratory in that the intent was to find out what stakeholders most readily were thinking about. Common themes were identified and are presented below.

1. There is wide spread support among all stakeholder groups for the concept of the OCA as described above. No significant differences existed between groups. 75.5% (N=239) of all those responding to the question considered the OCA as very important. Another 15.6% (N=50) responded to the next highest response category that the mission was mostly important. Support was evenly spread between stakeholder groups with the strongest support coming from consumer and family members.

2. There are significantly different emphasis in expectations between consumers and providers related to how the OCA carries out its mission. Consumers, and to some extent family members, tend to expect the OCA to be involved in direct personalized individual help, advocacy and intervention in the lives of consumers (advocacy is defined here as personal intervention with a local service provider to assist a consumer in overcoming provider erected obstacles to obtaining services). Providers on the other hand feel the focus of the OCA should be on supporting the development of advocacy capacity at the local level. These differences can be seen in the following findings.

- ▶ Family members (40.5%) and consumers (23.1%) called for the OCA to be involved with individualized helping activities such as provision of resources or individual advocacy. Only 5.4% of providers presented the same view.

These differences are important to note. If the OCA does engage in direct forms of helping, such activities will likely generate support from family and consumer stakeholders but not from providers who's support is also needed. Additionally the engagement in direct helping activities will subtract form other activities that may be viewed by parties as more important - such as the development at the local level the capacity for consumers to find advocacy and support activities independent of the formal mental health system.

- ▶ Providers (32.6%, N = 42 of 129) were most likely to volunteer that the OCA should *not*

be involved in advocacy. Consumers least likely to state that the OCA should not be involved in advocacy were day treatment clients (5.3%, N=4 of 173) and consumer club house members (3%, N=1 of 173).

Differences on this issue are also important to note. If the OCA engages in direct advocacy, providers are likely to tend to view this activity as interference and detracting from the educational, developmental mission of the office. Provider views of interference on the part of the OCA will likely generate barriers to OCA access to agencies, boards, and staff. Lack of access will make more difficult the tasks of training, educating, and organizing. Conflictual relationships do not generate the type of atmosphere that will bring an agency to request technical assistance to assist them in developing environments conducive to consumer empowerment. Individual advocacy will detract from limited staff time to do educational, developmental tasks. Consumers *not* presenting the same negative view of OCA individual advocacy efforts may be an indication that these activities are needed state wide - hence one reason for the call for advocacy capacity development activities by the OCA.

- ▶ Providers significantly favor OCA efforts being directed toward policy development 85% (N = 110 of 129), and education and training 83% (N = 108 of 129). Consumers were significantly lower in their expressions supporting these activities by the OCA, but still supported policy development, and education and training; 69% (N = 120 of 173) and 68.2% (N = 118 of 173) respectively. Family members were lower than consumers in volunteering that the OCA should participate in policy development 64% (N = 27 of 42). Family members suggested at a higher rate than consumers that the OCA should be engaged in education and training 81% (N = 34).

These high numbers indicate that all stakeholder groups understand that policy development and education and training on the part of the OCA are the best route to effectively utilizing the efforts of the office. The development of stakeholder understanding of consumer rights and empowerment, and advocacy capacity development at local, regional and state levels of the mental health system most effectively utilizes the limited resources available. The role for the OCA thus becomes one of facilitation to these ends.

- ▶ Providers (37%) and family members (38%) recommended that the OCA be engaged in starting advocacy groups around the state. Consumers spoke of this as a desired OCA activity 25% of the time.
- ▶ The majority of providers 55.8% (N = 72) and one half of family members 50% (N = 21) recommended that the OCA be engaged in information and referral activities. Consumers recommended this course of action in 37% of interviews.

The support for the above two activities once again indicates the wide support for the OCA to be spending its energy in development activities.

3. Knowledge of the OCA among all stakeholders, particularly consumers, is highly limited. Of 293 stakeholders not directly associated with the MHD or Consumer Sub-committee, 14% (N = 42) of these individuals were able to demonstrate reliable knowledge of the OCA and its activities. Executive administrative personnel from agencies and RSNs (N=5, or 50% of executives) were most likely to demonstrate knowledge of the OCA or Consumer Sub-committee. Day treatment and consumer club house members were least likely to know. Two day treatment consumers (N = 2, or 2.7% of day treatment consumers) and 2 consumer club house members (6.1% of consumer club house members) were able to demonstrate knowledge of the OCA. Overall 14 (9.9%) of all 142 consumers in this sample were able to describe the OCA or Consumer Sub-committee.

4. The fourth finding relates to stakeholder and researcher observations of an ineffective OCA, predominantly viewed by those closest to its operations as being unhelpfully overly assertive in its direct advocacy activities, generally unavailable, disorganized, generally unprepared, not focused on grant activities and in need of a defined focus that is centered in original grant objectives and tasks. There is also a recognized pattern of continuing internal and external conflictual relationships related to power and control issues. This conflict is viewed by stakeholders to have negatively impacted OCA effectiveness.

Of the entire stakeholder sample, including those directly associated with the MHD and Consumer Sub-committee, 84 stakeholders exhibited demonstrable knowledge of the OCA and/or the Consumer Sub-committee (see appendix 2). Of this group, there were 38 consumers including: 24 associated with the Consumer Sub-committee, 7 family members, and 39 providers. Of the providers 15 were associated with the MHD. The following survey material for finding # 4 has been developed from interviews with these 84 persons.

- ▶ Thirty-one percent (31%) of consumers, 28% of family members, and 41% of providers volunteered that they did not feel the OCA was carrying out the tasks of the grant.
- ▶ Thirty-four percent (34%) of consumers 14.3% of family members and 12.8 percent of providers discussed conflictual relationships between OCA staff and between OCA staff and others outside of the OCA. These same individuals considered these conflictual relationships to be one of the greatest failings of the OCA.

The above two themes can be contrasted with the fact that no one in this same group volunteered information that the OCA was doing its job as defined by the grant. No one shared a view that the OCA had been able to resolve conflict either internally within itself or the MHD, or externally with stakeholders outside of the MHD, or that the OCA had begun working in partnership with both consumers and providers.

- ▶ Forty-five percent (45%) of the 84 persons discussed problems with access of outside persons in contacting the OCA or getting them to return calls or respond to requests.
- ▶ Thirty-five percent (35.7%, N = 30) of this overall 84 person sample considered that the OCA was doing a poor job considering the resources that had been provided. There were no significant differences between consumer, family member or provider groups on this point. Seventy-two percent (72%) of those associated with the MHD volunteered this information. On the other hand 9.5% of the sample shared that the OCA was doing a positive job. These persons were exclusively consumers comprising 21.1% (N=8) of the 38 consumers in the 84 person sample of those who know the OCA.

The above information is consistent with findings reported to the MHD at the mid-point report of this evaluation. Data generated by the non-survey method of this evaluation research also support the observations of the above stakeholders. Key grant described activities of the OCA have been left undone or inadequately completed. OCA staff continue to be involved in direct committee work and other peripheral activities in the MHD and elsewhere. Staff have been described by stakeholders as an additional "MHD labor pool" Activities such as ongoing involvement in national consumer efforts, and direct individual advocacy are not central to the OCA mission and defined activities. The primary grant intended role of OCA staff can be seen to be that of a facilitative, developmental, technical assistance, and educational role. This has not been the primary focus of the OCA during this evaluation.

The following points are from the first phase of the evaluation lasting through the conduction of the 345 stakeholder survey. They assist in illustrating some of the internal OCA problems referenced above.

- There is no listing of consumers qualified to serve on a speakers bureau.
- There is no listing of consumers who can serve on state or local committees.
- There is no organized method of promoting consumers as speakers or committee members.
- Beyond taping of Consumer Sub-committee meetings there have been no video newsletters produced.
- Stakeholders report there has been no appreciable compilation or dissemination of technical assistance materials other than those owned personally by the present consumer director.
- There was no brochure describing the OCA or its activities available to distribute to

- stakeholders for the survey phase of this program evaluation.
- The BBS was allowed to not function for months at a time.
 - Computers that were promised to Consumer Sub-committee members were not delivered, nor was there an explanation for why they had not been.
 - Independent consumers and advocates to accomplish many of the tasks of the OCA have not been recruited.
 - The data base of consumer complaints and information and referral calls continues to be collected in paper form and there is no provision for feed back to the rest of the MHD as to problem areas in the state.
 - Additional general disorganization can be seen in the lack of an ability to generate a listing of Consumer Sub-committee members and former members for the purposes of this evaluation.

Illustrations of observed or reported effective activities and actions of the OCA follow:

- Creation of the agenda and training was turned over to the Consumer Sub-committee.
- Leadership of the Consumer Sub-committee was turned over to the members.
- Reporting mechanisms were put in place for Consumer Sub-committee members to provide feedback as to their community efforts.
- The BBS was the first of its type set up in the national MH arena.
- Continuing willingness to provide an assertive voice resulted partially in the redirection of MH policy both at state, regional, and local levels.
- Anti Stigma Campaign preformed in conjunction with AMI received very positive reviews and continues to have an impact.

Provider stakeholders who had experienced contact with the OCA at the regional or local level were very careful in their descriptions. It was occasionally shared that while the OCA had been of assistance to a consumer in need, the *nature* of the assistance was preformed in an abrasive manner rather than one of partnership that generally left the consumer in a continuing conflictual or resentful position with the provider, and the provider reluctant to seek out the OCA for assistance. These same providers shared that they felt that with a different, non-adversarial approach, conciliation with the consumer would have been possible. Providers also repeatedly called for the availability of training opportunities for their boards and staffs to help facilitate a working partnership with consumers they serve as well as the advocacy groups.

5. The last finding is that the Consumer Sub-committee has been an overall positive force and has been a key to the impact that the grant has had on the state consumer movement. While the specific name of the Consumer Sub-committee was generally not recognized, consumers and providers continually mentioned Consumer Sub-committee members and former members as knowledgeable resources to the community. While there were many suggestions for improvement in the qualitative data, there was only one individual making negative comments about the overall mission concerning the Consumer Sub-committee. Consumer Sub-committee performance received 20 positive comments from the sample of 38 consumers (52%) in the sample of 84 stakeholders described above. One specific case can best

describe the indicated impact. In one agency one of the Consumer Sub-committee members was reported repeatedly by stakeholders to be of great assistance to the consumer movement in their area, yet there was no recognition of the Consumer Sub-committee. In agencies where these individuals were not present on an ongoing basis there was no mention of names or the Consumer Sub-committee. Consumer Sub-committee members repeatedly mentioned constraints on their roles due to the inability to pay for long distance telephone charges or to have "gas money" to get to different agencies and services in their area.

CONCLUSIONS

The OCA is a potentially valuable resource for the state of Washington Mental Health System. There is wide spread support for the concept among all stakeholder groups. This potential is not being realized due to a misdirection of OCA energy. Among the wider consumer population around the state there has been no discernable impact as can be observed by the clear lack of knowledge or understanding regarding the OCA or its mission. There is a particularly strong sense of ownership and also frustration at the perceived lack of OCA performance on the part of advocacy group members, consumers and professionals who are aware of its existence and functioning. The OCA has experienced an initial period of diffusely focused energies that has in part been due to outside organizational pressures from within the mental health division as well as the lack of experience, appropriate levels of education and desire for a role of participatory involvement in the 'action' of advocacy and MHD policy making, national meetings and other public roles, rather than the developmental facilitative roles needed to foster development of advocacy capacity at the local level. The Consumer Sub-committee is a developing group that has assisted in the generation and increasing levels of sophistication of consumer advocates around the state. These individuals, already of some prominence in their local communities, have had their ability to positively impact services and develop networks enhanced by their participation on the committee.

RECOMMENDATIONS

1. Continue the OCA.
2. Recommit to the original OCA mission emphasis of: developing advocacy capacity at local levels; educating consumers, providers and family members; establishment and enhancement of advocacy networks; and developing and insuring a voice for consumers at all levels of the mental health system. Place primary emphasis on: providing information and referral services; developing, gathering and disseminating technical assistance materials; providing training and educational activities related to consumer abilities, respect, non discrimination, and advocacy group development/ improvement. Support advocacy groups and service providers in their efforts to insure quality services for chronically mentally ill consumers. Place an emphasis on identifying and developing consumers (other than OCA staff) who are capable of serving in an advisory role to the MHD, regional and local agencies in the formulation of policy.

3. Administrative support for mission/grant focused activities is critical. Limiting outside demands emanating from within the MHD as well as the OCA staff itself is needed to regain and maintain mission focus based on grant formulated guidelines. Additional administrative ground work is needed including education of the broader MHD, senior supervisory support, and technical assistance to create adequate informational and record keeping systems is needed from the MHD to improve the OCA operating environment. Assure management and supervisory oversight and accountability based on clear measurable goals and objectives. Monitor outcomes and provide technical and supervisory assistance and support where needed. Conduct in-house ongoing education both formally and informally with a focus of improving communication, respect, and trust between the OCA staff and others.
4. Open the position of director of the OCA. Stipulate that a masters degree or equivalent and mature successful experience in community organization, agency administration and program development be part of the selection criteria. A masters degree is recommended because it is at the masters level with specific training related to the above issues that one receives the depth and level of instruction and skill building necessary to carry out the intended tasks of the OCA. This level of training is not found at lower levels of education. Insure that the person hired understands the focus on capacity development and facilitation. The position of director requires a trained seasoned professional leader who is able to objectively carry out policy and implement programmatic features while creating an environment of respect, trust and collegiality with persons both within the division and stakeholders without. There are consumers that can fulfill these criteria. Seeking a consumer to fill this position should be a priority. Search efforts should take place at local, statewide and national levels. Nominations should be sought.
5. Policy decisions consistent with MHD ethics, statutes, organizational vision and values are needed concerning what is appropriate information and traffic for the bulletin board system/ world wide web site (BBS/WWW). The primary intent and direction of the BBS/WWW site as well as the OCA is to promote consumer voice and meaningful participation in the decision making process regarding individual services as well as overall policy. Support this mechanism as a centralized focal point of communication and an informational tool for consumer and family advocates to increase networking, support, and education. Consistent with the MHD statewide coordination and facilitation role, the BBS/WWW goal should be to enhance consumer empowerment through involvement in policy change and advocacy development. Regardless of the effectiveness of staff employed to develop the site, policy decisions are needed to insure clarity as to appropriate material to be shared, and to open the flow of material from the division and other sources that can be posted.
6. To enhance stakeholder ownership, engage and assure OCA stakeholder involvement in partnership for selection of their representatives in OCA and Consumer Sub-committee. Include individual consumers and organizational representatives from advocacy groups. Lift the decision making capacity onto an objective group of experts and stakeholders. Invite scheduled,

ongoing input to MHD management and the OCA regarding OCA performance and accountability. Include consumers, (including the Consumer Sub-committee) family members, and community stakeholders in this feedback.

7. Continue and expand support for the Consumer Sub-committee in its new form. In addition to engagement in meaningful activities the Consumer Sub-committee can serve a role in the self perception of empowerment on the part of the broad range of consumers and family advocates in the state. There is a direct link between viewing a member of one's group as empowered and representing the larger group and feeling personally empowered.

Maintain both training and policy feedback activities. In addition to ongoing training, an emphasis should be placed upon assisting members both individually, and as a group in operationalizing community and state level consumer empowerment activities. Money for expenses is needed to enable Consumer Sub-committee members to have broader consumer and community contact. Create Consumer Sub-committee membership terms based on 1/3 rolling tenure. Institute a mentoring system for new members. Facilitate constructive involvement of ex-members in the MH system at all levels to insure an expanding resource pool of informed educated consumers.

Local support for technical assistance and educational activities is needed. Increased financial commitment is needed from local providers to enhance local development. Communities where this is happening are producing effective, respected consumer advocates. The OCA statewide role should link national, MHD, and local level efforts to identify and procure resources. Use these resources in the continuing development of consumer empowerment activities in local, regional, and state arenas that promote partnerships for systems change.

Vita

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PUBLICATIONS

Schantz, D. (1996). A State Mental Health Division Office of Consumer Affairs Program Evaluation: Stakeholder Views, Efficacy and Desired Directions. Doctoral Dissertation, University of Washington.

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