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THE DEVELOPMENT OF A COMMUNITY MENTAL HEALTH IDEOLOGY SCALE

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As psychiatric facilities move toward a community mental health orientation, it appears vital to understand and measure this new ideological perspective. A valid and reliable 38-item Scale has been developed for this purpose. The Community Mental Health Ideology Scale very effectively discriminates between groups known to be highly oriented to this ideology and random samples of mental health professionals. Other evidence of the Scale's construct validity is presented, and certain correlates of community mental health ideology are described. Further data on the validity of the Scale is required, and additional areas for future research are indicated.

The development of mental health theory and practice has entered a new period that has been labeled simply "the third phase" (GAP Committee on Medical Education, 1962), or more dramatically "the third psychiatric revolution" (Bellak, 1964; Hobbs, 1964). The early supporters of this new major movement have struck up a variety of banners for identifying themselves, including those labeled "community psychiatry," "preventive psychiatry," "public health psychiatry," and "community mental health." However the emergence of this development is heralded, there is consistent recognition of the existence of a growing collectivity of individuals drawn from a variety of mental health specialities. The collectivity is organized and mobilized on the basis of commonly held beliefs to redefine social action in the treatment of mental illness and the promotion of mental health. The members of this social movement are at once most articulate and most passionate about their shared set of ideas despite the present lack of adequate supporting scientific evidence.

Social scientists for some time have used the technical word "ideology" to refer to any systematically related set of beliefs held by a group of people, providing that the system of beliefs is sufficiently basic to the group's pattern of functioning. Although the term "ideology" was coined in the eighteenth century to refer to political beliefs, its usage has long since been extended beyond the narrow political arena and consequently has lost its former negative connotations of mendacity and illusion. Several recent articles (Levinson, 1964; Tomkins, 1965) have argued quite convincingly for more attention to ideological analysis in the study of social change.

This study is concerned with the ideological structure of the community mental health movement. Although we cannot here fully summarize its historical roots (see Caplan & Caplan, 1966; Rossi, 1962), the community mental health movement might be characterized briefly as an expression of, and a result of, changes in our society that began some years ago. Bockoven (1966) noted the congruence in values between the American mental health establishment and American political democracy and pointed

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to the emergence of community psychiatry as paralleling the emergence of a new moral mandate. Today we have a renewal of the awareness of identification with all human beings in a common effort to solve our collective human problems, a sense of communion and intimacy as the result of modern communication techniques, an active concern for the economic and psychological well-being of all citizens, and a desire to successfully control the social environment as man has managed so successfully to begin to control his physical environment. The interest in community mental health also parallels other current expressions of social consciousness, such as the civil rights movement and the antiwar movements, that have emerged in the more "open society."

Ideological differences have been present in the mental health professions for many years. The distribution and interrelations of the ideological positions of psychiatric "humanism versus custodialism" were studied in the 1950's (Gilbert & Levinson, 1957; Sharaf & Levinson, 1957). Sharaf and Levinson focused on psychotherapeutic versus sociotherapeutic orientations, both variations of the "humanistic" orientation. Hollingshead and Redlich (1958) distinguished two other types of psychiatric orientations—the analytical and psychotherapeutic versus the directive-organic. Dissatisfied with the limited exhaustiveness of these earlier typologies, Strauss, *et al.* (1964) formulated contemporary psychiatric ideologies as consisting of psychotherapeutic, somatotherapeutic, and sociotherapeutic orientations. However, even in this most recent work little attention is given to the major ideological battle now evident in psychiatric facilities throughout the country. As mental health programs assume a community orientation and are called upon to assume responsibility for total populations, our existing approach of concern for only those individuals who seek us out is becoming increasingly questioned. New treatment methods are being developed, and professional roles are being sharply altered and expanded.

As psychiatric facilities continue their change in direction and move toward a community mental health orientation, it appears vital to understand and measure this new ideological perspective. The specific purpose of this study was to develop a scale for measuring an individual's degree of adherence to community mental health ideology.

METHOD

Item Construction

On the basis of a careful examination of the relevant community mental health literature, 88 declarative statements were written that were thought to be representative of the beliefs common to the exponents of community mental health. To avoid possible response bias in later use of a scale, this initial pool of statements was worded in both positively and negatively oriented directions. The statements were constructed employing five conceptual categories to insure that major aspects of the ideology were covered. These categories were:

1. *A population focus.* The view that the mental health specialist should be responsible, not only for individual patients with whom he has contracted for treatment, but for the entire population of both identified and unidentified potentially sick members in his community.

2. *Primary prevention.* The concept of lowering the rate of new cases of mental disorder in a population by counteracting harmful forces before they have had a chance to produce illness.

3. *Social treatment goals.* The belief that the primary goal of treatment is, not to reconstruct the mental patient's personality, but rather to help him achieve social adjustment in an ordinary life situation as soon as possible.

4. *Comprehensive continuity of care.* The view that there should be a continuity of professional responsibility as the patient moves from one program to another in an integrated network of caregiving services.

5. *Total community involvement.* The belief that the mental health specialist is only one member of a group of community agents caring for the mentally ill and that he can extend his effectiveness by working with and through other people.

Content Validity

In an effort to insure the Scale's content validity, the 88-item preliminary questionnaire was submitted to a nationwide panel of 16 judges, composed of nationally known individuals from different disciplines who had been prominently identified with the community mental health movement through either their writings or their clinical programs. These judges were asked to rate, on a five-point continuum, the degree to which both an "agree" and "disagree" response to each item would reflect a respondent's endorsement of the community mental health orientation.

Items then were selected from the initial 88-item pool as having content validity on the basis of (a) a sufficient degree of agreement among judges on the meaning of both the "agree" and "disagree" responses, and (b) a distribution of item "extremity" to give a sufficiently wide and representative span to the full gamut of opinion. Some items were rewritten in accord with the judges' suggestions. The 64 items resulting from this assessment of content validity were arranged in Likert format with provision for respondents to circle one of six response categories for each item: strongly, moderately, or slightly agree; and strongly, moderately, or slightly disagree. On positively worded items, strong agreement is scored 7; moderate agreement, 6; slight agreement, 5; slight disagreement, 3; moderate disagreement, 2; strong disagreement, 1. Reversed scoring is used for negatively worded items. When no response is given, a score of 4 is given to that item.

Respondents

The final version of the Community Mental Health Ideology (CMHI) Scale was developed on responses from various criterion groups of mental health specialists comprising a total of 484 individuals.

The first category of respondents is composed of four criterion groups whose members were thought to be highly oriented to community mental health:

1. Graduates of the Harvard School of Public Health and Harvard Medical School Community Mental Health Training Program
2. Graduates of the Columbia University School of Public Health and Administrative Medicine, Division of Community Psychiatry Post-Doctoral Training Program
3. Members of the Harvard Laboratory of Community Psychiatry Visiting Faculty Seminar (a three-year program for professors in departments of psychiatry in 16 medical schools throughout the United States)
4. The participants in the 1965 Swampscott Conference on Training in Community Psychology

The second category of respondents consists of random samples from three national professional associations:

5. The American Psychological Association (Division of Clinical Psychology)
6. The American Psychiatric Association
7. The American Occupational Therapy Association (Psychiatric Occupational Therapists)

The third category consists of random samples of members from two other professional groups which, it was assumed, would include psychiatrists more negatively oriented to community mental health ideology:

8. The American Psychoanalytic Association
9. The Society for Biological Psychiatry

Questionnaire Administration

Questionnaires entitled "Mental Health Specialist Survey of Opinions" and containing the 64 items resulting from the study of content validity were mailed in the fall of 1966 to members of the preceding criterion groups. After one month, a follow-up letter was sent to nonrespondents. The rate of response for each of the nine groups is given in Table 1. Of the 784 questionnaires received by members of these groups, 484 were returned in usable form for an overall response rate of 61.7 per cent.

TABLE 1

RATE OF RESPONSE FROM CRITERION GROUPS

Group	Rate of Response		
	Number Received	Number Returned	Percent Returned
Harvard Post-Doctorals	63	57	90.5
Harvard Visiting Faculty	16	15	93.8
Community Psychologists	30	23	76.7
Columbia Post-Doctorals	48	25	52.1
Amer. Psychol. Assoc. (Div. 12)	98	79	80.6
Amer. Occup. Therapy Assoc.	47	35	74.5
Soc. for Biol. Psychiat.	50	29	58.0
Amer. Psychiat. Assoc.	332	175	52.7
Amer. Psychoanal. Assoc.	100	46	46.0

RESULTS

Item Selection

Items to be retained in the final version of the CMHI Scale were selected on the basis of joint consideration of item-total score correlations and the results of a principal-components analysis of the 64-item questionnaire. Thirty-eight items were found to have corrected item-total correlations of .44 or higher. The first latent root extracted by a principal-components analysis accounted for nearly a quarter (23.4 per cent) of the total variance of the 64 items, with a sharp drop of 5.2 per cent of the trace contained in the next highest latent root.

Factor loadings of the items on the first root closely paralleled the results of the item-total analysis. The same 38 items

TABLE 2

COMMUNITY MENTAL HEALTH IDEOLOGY (CMHI) SCALE

Item	Mean	S.D.	*F*-loading	Item-total *r*
1. Every mental health center should have formally associated with it a local citizen's board assigned significant responsibilities.	5.58	1.46	.59	.57
* 2. Our time-tested pattern of diagnosing and treating individual patients is still the optimal way for us to function professionally.	4.91	1.95	.61	.61
* 3. With our limited professional resources it makes more sense to use established knowledge to treat the mentally ill rather than trying to deal with the social conditions which may cause mental illness.	4.97	1.78	.68	.67
4. Our responsibility for patients extends beyond the contact we have with them in the mental health center.	6.01	1.27	.56	.54
5. A significant part of the psychiatrist's job consists of finding out who the mentally disordered are and where they are located in the community.	4.08	2.04	.44	.44
* 6. Such public health programs as primary preventive services are still of little value to the mental health field.	5.04	1.80	.51	.48
7. A mental health program should direct particular attention to groups of people who are potentially vulnerable to upsetting pressures.	5.70	1.51	.45	.44
* 8. The planning and operation of mental health programs are professional functions which should not be influenced by citizen pressures.	4.93	1.98	.49	.49
9. Mental health programs should give a high priority to lowering the rate of new cases in a community by reducing harmful environmental conditions.	5.46	1.66	.48	.47
10. The mental health specialist should seek to extend his effectiveness by working through other people.	6.48	.92	.55	.53
*11. A mental health professional can only be responsible for the mentally ill who come to him; he cannot be responsible for those who do not seek him out.	4.71	2.01	.66	.65
12. Our program emphasis should be shifted from the clinical model, directed at specific patients, to the public health model, focusing upon populations.	4.43	1.93	.61	.60
13. Understanding of the community in which we work should be made a central focus in the training of mental health professionals.	6.16	1.21	.57	.55
*14. The control of mental illness is a goal that can only be attained through psychiatric treatment.	5.75	1.58	.53	.51
15. A mental health professional assumes responsibility not only for his current caseload but also for unidentified potentially maladjusted people in the community.	5.16	1.86	.50	.47
16. Our current emphasis upon the problems of individual patients is a relatively ineffective approach for easing a community's total psychiatric problem.	5.03	1.94	.51	.51
*17. Our professional mandate is to treat individual patients and not the harmful influences in society.	5.31	1.81	.67	.65
*18. Our efforts to involve citizens in mental health programs have not produced sufficient payoff to make it worth our while.	5.58	1.52	.56	.54
19. The locus of mental illness must be viewed as extending beyond the individual, and into the family, the community, and the society.	6.38	1.16	.51	.50
*20. Mental health professionals can be concerned for their patients' welfare only when having them in active treatment.	5.92	1.48	.57	.55

*Negatively oriented disagree items.

TABLE 2 (*Continued*)

COMMUNITY MENTAL HEALTH IDEOLOGY (CMHI) SCALE

Item	Mean	S.D.	*F*-loading	Item-total *r*
21. Mental health consultation is a necessary service which we must provide to community caregivers who can help in the care of the mentally ill.	6.40	.97	.51	.48
22. Caregiving agents who worked with the patient before and during his contact at the mental health center should be included in the formulation of treatment plans.	6.34	.95	.51	.48
*23. A psychiatrist can only provide useful services to those people with whom he has direct personal contact.	5.85	1.60	.53	.51
*24. Skill in collaborating with nonmental health professionals is relatively unimportant to the success of our work with the mentally ill.	6.17	1.26	.57	.55
25. The mental health center is only one part of a comprehensive community mental health program.	6.43	.83	.53	.51
*26. Mental health professionals should only provide their services to individuals whom society defines as mentally ill or who voluntarily seek these services.	5.30	1.90	.68	.67
27. We should deal with people who are not yet sick by helping them to develop ways for coping with expected life difficulties.	5.85	1.47	.59	.56
*28. We should not legitimately be concerned with modifying aspects of our patient's environment but rather in bolstering his ability to cope with it.	5.08	1.95	.48	.48
*29. It is a poor treatment policy to allow non-psychiatrists to perform traditional psychiatric functions.	4.88	2.02	.55	.55
*30. Since we do not know enough about prevention, mental health programs should direct their prime efforts toward treating the mentally ill rather than developing prevention programs.	5.47	1.71	.64	.62
31. The hospital and community should strive for the goal of each participating in the affairs and activities of the other.	6.11	1.21	.53	.51
32. Social action is required to insure the success of mental health programs.	6.30	1.11	.47	.44
*33. In view of the professional manpower shortage, existing resources should be used for treatment programs rather than prevention programs.	5.42	1.76	.51	.49
34. Each mental health center should join the health and welfare council of each community it serves.	6.33	1.01	.51	.48
35. The responsible mental health professional should become an agent for social change.	5.27	1.71	.68	.66
*36. We can make more effective use of our skills by intensively treating a limited number of patients instead of working indirectly with many patients.	5.06	1.84	.58	.58
*37. By and large, the practice of good psychiatry does not require very much knowledge about sociology and anthropology.	5.74	1.64	.44	.44
*38. Community agencies working with the patient should not be involved with the different phases of a patient's hospitalization.	5.90	1.36	.56	.53

*Negatively oriented disagree items.

derived from the item-total analysis received a factor loading of .44 or above on the first factor of the principal-components analysis, thus supporting the univocal nature of these items. The 38 items (19 positively and 19 negatively oriented) included in the CMHI Scale are presented in Table 2 with their item-total correlations,

F-loadings, and means and standard deviations based on the total sample of 484 respondents.

Reliability

Reliability for the CMHI Scale is quite high. The Cronbach Alpha (generalized Kuder-Richardson formula 20) for the total group of 484 respondents on the 38-item scale was .94 and the split-half reliability was .95 (odd-even corrected by Spearman-Brown formula). A test-retest reliability was computed on the basis of the September 1966 and May 1967 total scores obtained by 34 graduates of the Harvard Community Mental Health programs. In spite of the homogeneity of this group in regard to the ideology being studied and its extreme scores on the CMHI Scale, a quite high test-retest reliability of .92 was obtained.

Validity

The nine criterion groups of mental health professionals described earlier were used to determine whether the CMHI Scale adequately discriminates known groups in their degree of orientation to community mental health ideology. The means, standard deviations, and ranges for the nine groups are presented in Table 3. The ordering of the groups according to mean total score is consistent with what one would expect if the hypothesized dimension were being measured. The four criterion groups with acknowledged commitment to community mental health have the highest means. The means of the random samples drawn from professional associations follow next, and the psychoanalysts have the lowest mean score. Only the mean of the Society for Biological Psychiatry appears out of its predicted lowest rank. When this group is examined more closely, however, one finds that it consists of a number of eclectically oriented psychiatrists with broader social orientations than might be thought from the name of the group.

TABLE 3

BASIC CMHI SCALE DATA FOR CRITERION GROUPS

Group	N	Mean Score	S.D.	Range
Harvard Post-Doctorals	57	239.79	19.48	165–262
Harvard Visiting Faculty	15	234.60	26.91	160–264
Community Psychologists	23	234.43	14.68	195–264
Columbia Post-Doctorals	25	221.96	24.06	173–260
Amer. Psychol. Assoc. (Div. 12)	79	217.89	22.19	159–258
Amer. Occup. Therapy Assoc.	35	207.69	21.07	161–243
Soc. for Biol. Psychiat.	29	206.28	32.97	131–258
Amer. Psychiat. Assoc.	175	198.93	37.02	92–265
Amer. Psychoanal. Assoc.	46	194.52	31.23	125–259

The results of an analysis of variance for the mean scores of the nine criterion groups are presented in Table 4. The obtained

TABLE 4

ANALYSIS OF VARIANCE OF CRITERION GROUPS ON CMHI SCALE

Source of Variation	Sum of Squares	df	Mean Square	*F*
Between Groups	113,905.76	8	14,238.22	16.00*
Within groups	422,583.75	475	889.65	
TOTAL	536,489.51			

*$p < .001$

F-ratio is significant well beyond the .001 level. The *t*-tests of all interpair differences between the means of the nine criterion groups are presented in Table 5. The matrix contains a pattern consistent with expectations regarding the criterion validity of the CMHI Scale. The means of groups expected to be adjacent on the continuum of orientation to community mental health ideology do not differ significantly, while those groups expected to differ do so to a statistically significant degree.

Support for the general construct validity

TABLE 5

t-TESTS OF INTERPAIR DIFFERENCES OF MEAN SCORES FOR CRITERION GROUPS ON CMHI SCALE

Group	Harvard Visiting Faculty	Community Psychol.	Columbia Post-Doctorals	Amer. Psychol. Assoc. (Div. 12)	Amer. Occup. Therapy Assoc.	Soc. for Biol. Psychiat.	Amer. Psychiat. Assoc.	Amer. Psychoanal. Assoc.
Harvard Post-Doctorals	.83	1.17	3.50†	4.93†	7.36†	5.84†	7.95†	8.90†
Harvard Visiting Faculty		.00	1.50	2.55†	3.72†	2.80†	3.63†	4.39†
Community Psychologists			2.10*	3.34†	5.21†	3.73†	4.53†	5.73†
Columbia Post-Doctorals				.77	2.40*	1.93	3.01†	3.77†
Amer. Psychol. Assoc. (Div. 12)					2.28*	2.07*	4.20†	4.83†
Amer. Occup. Therapy Assoc.						.20	1.35	2.12*
Soc. for Biol. Psychiat.							1.00	1.53
Amer. Psychiat. Assoc.								.73

*$p < .05$
†$p < .01$

of the CMHI Scale is derived from the responses supplied in the general background questionnaire that all 484 respondents completed together with the Scale. Each individual was asked to indicate how strongly he identified with each of four psychiatric orientations on a continuum ranging from "very strongly" through "average" to "not at all." The four orientations were: (a) somatic (organic), (b) psychotherapeutic, (c) sociotherapeutic (milieu), and (d) community mental health. Total score on the CMHI Scale was significantly correlated ($r = .55$, $p < .001$) with self-rating of degree of identification with a community mental health orientation. There was also a highly significant correlation ($r = .41$, $p < .001$) between CMHI Scale score and identification with a sociotherapeutic orientation, a not surprising finding since community mental health concepts are generally thought to include sociotherapeutic elements. The correlation between CMHI Scale score and strength of identification with a somatic orientation was $-.18$ ($p < .001$), and the correlation with a psychotherapeutic orientation was $-.09$ ($p < .05$). Although the absolute values of these last two correlations are small, they suggest that high-scoring respondents on the CMHI Scale have a somewhat negative identification with the somatic and psychotherapeutic orientations.

Respondents in the upper quartile (N= 127) of scores on the CMHI Scale differed from those scoring in the lower quartile (N = 121) in their responses regarding the substantive areas in which they felt enough interest to keep up with new developments. Twice as many of the high scorers (87 per cent) indicated that they kept up with new developments in community mental health as did low scorers (43 per cent), a difference significant well beyond the .001 level. High scorers reported significantly more frequently that they kept up with new developments in culture and personality, social psychiatry, epidemiology, group psychotherapy, and milieu therapy. Low scorers indicated more frequently that they kept up with developments in individual psychotherapy, biochemistry, genetics, neurology, and neuropharmacology.

Evidence of the CMHI Scale's construct validity is seen also in respondents' preference for attendance at simultaneous symposia. People were asked to rank-order their choices of a symposium on recent advances in: (a) community mental health, (b) milieu therapy, (c) psychotherapy, and (d) somatic therapy. The rankings obtained indicated that the highest-scoring quartile on the CMHI Scale preferred a symposium

on community mental health, then milieu therapy, psychotherapy, and finally somatic therapy. The bottom-scoring quartile on the CMHI Scale most preferred the symposium topic of psychotherapy, followed by community mental health with the other two choices receiving lowest ranks.

Ratings by respondents in the criterion groups of the concept "Community Mental Health" on a 19-scale semantic differential supports the construct validity of the CMHI Scale. As described elsewhere (Schulberg and Baker in press), all respondents in this study were asked to rate the concept on 19 seven-point, bipolar adjective rating scales. On each adjective scale, high scorers on the CMHI Scale differed from low scorers at a level of significance beyond .001 in defining the meaning of community mental health as more good, effective, relevant, timely, new, progressive, wise, complex, right, sophisticated, broad, considered, realistic, needed, important, strong, productive, cooperative, and active. Low scorers on the Scale, conversely, defined community mental health in a less positive light, thought it to be less active, and attributed less potent characteristics to it.

Evidence for the validity of the CMHI Scale may be summarized as follows:

1. The Scale successfully discriminates groups known to have positive community mental health views from random samples of mental health professionals.

2. CMHI Scale scores relate significantly to self-reported responses on degree of: identification with a community mental health orientation; interest in keeping up with new developments in community mental health; and preference for a symposium on recent advances in community mental health. CMHI Scale scores also relate significantly to the connotative meanings assigned community mental health on a 19-item semantic differential rating form.

CORRELATES OF COMMUNITY MENTAL HEALTH IDEOLOGY

How does adherence to community mental health ideology relate to other characteristics of mental health professionals? A beginning answer can be obtained from the general background data available on the 484 individuals who completed the CMHI Scale.

Respondents indicated what percentage of their work week was spent in each of a variety of activities. Respondents in the upper-scoring quartile on total CMHI Scale score spend a significantly greater proportion of their time in administration, consulting with community agencies, and in teaching than do respondents in the lowest-scoring quartile. The members of the high group spend an average of over 50 per cent of their time in these activities as compared to those in the low group, who spend a quarter of their work week engaged in these three types of activities. Those in the lowest-scoring quartile spend significantly more of their work week in treating patients than do the respondents in the upper-scoring quartile—an average of 54 per cent compared to only 22 per cent. There were no significant differences between the two extreme quartiles with regard to the proportion of time spent in research or in supervising others in their facilities.

A related factor was the type of work setting in which respondents spend the majority of their professional work week. High- and low-scoring quartiles differed significantly on this matter as well. More community mental health oriented professionals work in universities and medical schools, general hospitals, community clinics, and school systems than do less community mental health oriented individuals. More of the low-scoring group work in mental hospitals, and three times as many members of this group spend the majority of their professional work week in private practice as compared to the high-scoring group (44 per cent compared to 14 per cent).

Total score on the CMHI Scale is correlated to a significant degree with age ($r = -.16$, $p < .001$), indicating that those supporting community mental health beliefs tend to be younger. Likewise, there is a significant correlation between high total scale score and date of highest degree ($r = .23$, $p < .001$), indicating that in-

dividuals receiving their advanced training more recently are more likely to have been socialized to a community mental health orientation.

DISCUSSION

Now that the statistical elements central to the Scale's construction have been described, it is important to consider once again its conceptual basis. Although in first constructing items for the Scale, five conceptual categories had been used to insure adequate coverage of the beliefs of community mental health, these were not thought to be independent subscales, nor do the results of the factor analysis support such a view. Rather, the Scale is largely a single-factored measure of community mental health beliefs.

It is to be noted that proportionally more successful items were retained in the CMHI Scale from the original pool of statements in these three conceptual categories: population focus, primary prevention, and total community involvement. Relatively fewer items were retained from the conceptual categories of comprehensive continuity of care and social treatment goals. It would appear that what is more unique to the ideology of community mental health is its focus on the total population, the prevention of mental illness through environmental intervention, and the involvement of a variety of community resources in working with the mentally ill.

This success in constructing a community mental health ideology scale of better than average reliability and validity, as compared to the attitude scales described by Shaw and Wright (1967) in their exhaustive review of the literature, supports the hypothesis that there exists a relatively coherent belief system that differentially characterizes today's mental health professionals. The extent of a group's adherence to this belief system is measurable through use of the Scale described in this paper.

The Scale successfully discriminates between groups of mental health professionals holding different attitudes toward community mental health and thus should be useful for a variety of research purposes. One possible use is in evaluating the effectiveness of specialized training programs in community mental health in modifying the participant's theoretic persuasion.

Another major use that is envisioned for the CMHI Scale is in research on the development and functioning of community mental health programs. Mental health facilities, like other organizations, are influenced by cultural values or belief systems that may affect the changing goals of the organization. For example, community mental health concepts imply extension of a hospital's traditional goals of patient care and treatment to include improvement of a population's mental health through programs of primary and secondary prevention. These new goals will produce changes in the hospital's task hierarchy. It is thought that staff resistance to, or advocacy of, organizational change will be a function of its degree of orientation to community mental health ideology. The CMHI Scale allows examination of the relationships between the ideology of staff groups and their participation in the development of community programs. The Scale already is being used for this purpose in a study of Boston State Hospital, an institution undergoing the change from state mental hospital to community mental health center (Baker, 1966; Schulberg, Caplan, & Greenblatt, in press).

The correlates of community mental health ideology offer additional areas for interesting research. What are the characteristics of people strongly oriented to community mental health? The data presented here indicate that they spend more of their work week in administration, teaching, and community consultation and are relatively less involved in direct patient treatment. They are more likely to work in academic institutions, general hospitals, community clinics, and school systems than in private practice. They also are likely to be a bit younger than other mental health professionals and to have received their advanced training more recently. Other characteristics of high scorers on the

CMHI Scale that bear research are relevant personality characteristics and specific training and educational experiences.

Further research in the appropriate applications of the Scale is desirable. The Scale was developed on psychiatrists, psychologists, and occupational therapists. Data for nurses, social workers, and other mental health specialist populations are still needed. Further evidence of the Scale's convergent and discriminant validtiy should also be gathered. The relation of the CMHI Scale to other psychiatric ideology scales offers future research possibilities.

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