

RECENT FIELD APPLICATIONS AND EVALUATIONS OF BOSTI/PAK:
A MENTAL HEALTH PARTICIPATORY PLANNING PROCESS

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Abstract. The current federal posture towards local design and control of urban services generates the need for tools to aid community groups in priority setting, program planning and evaluation. BOSTI/PAK (The PLANNING AID KIT) is such a tool, developed in a mental health context, but adaptable to other uses. It is a structured process used to organize and aid the planning of community mental health programs and facilities, according to a prepared set of agendas, in meetings, by a group of service providers and service users. An evaluation is presented, as is a set of recommendations for improving this process. These recommendations are seen as generic for any community participation in planning.

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BACKGROUND

In the late sixties, social legislation started to contain the phrase, "maximum feasible participation" implying that the community should participate in decision making processes about how public moneys would be used to deliver services to them. The most basic decisions, of course, are those which describe which problems should be dealt with and in what order and what efforts should be made. These decisions have historically been the province of public policy makers and service deliverers.

"Maximum feasible participation" was intended to expedite a sharing of decision making by these interests with the service "consumer" community. Unfortunately, the legislation carried with it no models for "sharing behavior" for either the provider or consumer groups, and without such models, head-on confrontation was the model selected by one or both groups.

It was apparent that models embodying sharing behavior would have to be developed, tested, adopted, and diffused to assure creative participation between the "haves" and "have-nots" of urban service delivery systems.

BOSTI/PAK (The PLANNING AID KIT) is a process which attempts to provide a vehicle for sharing developed in a mental health context, although its basic principles seem applicable to all participatory planning and resource allocation situations. Work on this process was initiated by Michael Brill and Richard Krauss in 1968 while in Federal Service at the U. S. National Bureau of Standards. The work was supported by the National Institute of Mental Health, which has continued to support it. Other support (from County and State Governments and community groups) has been generated for its further refinement and field applications, for a total expenditure of some \$400,000 over a six year period. It is one of the few situations in which an adequate level of support has been generated over an extended period of time, with a core group of investigators "hanging in there" to develop and diffuse a process tool. The tool has been applied in 4 Catchment Areas (Mental Health Planning and administrative districts) in New York State and an analogous tool applied 4 times in Massachusetts. It has been modified and used for dormitory planning, prison planning, office planning and for health planning.

This paper will describe what BOSTI/PAK does and is, and then describe two recent applications of it, and the formal evaluation of these applications, and some lessons learned.

WHAT IT DOES

BOSTI/PAK is a formal systematic group planning procedure with six explicit goals:

1. To implement the group planning of mental health programs specifically tailored to local needs;
2. To implement the group planning of facilities which will support desired mental health programs;

3. To ensure community participation in the planning process;
4. To educate group members about mental health and planning;
5. To provide a mechanism for recording and disseminating the work done by each PAK group;
6. To facilitate "follow-up" through PAK group or community involvement in management and coordination of mental health programs.

The PAK group, assembled by the mental health agency or community group sponsoring the use of PAK, is generally a mixture of mental health professionals, community representatives, and local administrators, about fifteen members in all. To secure community representatives the initiators of PAK contact local organizations which reflect the racial, ethnic, socio-economic, and familial composition of the community, asking them to name delegates to the PAK group. Meeting initially for about twelve weekly sessions, the group will be responsible for developing a program of mental health services for the area it represents. Additional meetings will be required if facilities are also to be planned.

Aiding the deliberations of the group is a Discussion Leader, selected for his knowledge of mental health and of the dynamics of group process. A non-voting member, he is chosen by the sponsors of PAK to facilitate, oversee, and collate the information generated in the PAK proceedings.

As a planned set of steps, PAK may be followed either entirely or in part. The process is divided into four broad phases: Preparation, Problem Definition, Program Planning, and Facilities Planning. Instructions for the first three phases, including guidelines for decision making and methods of record keeping, are provided by a series of handbooks for the sponsors, the Discussion Leader, and the group members. The Facilities Planning phase has not recently been tested in use, and is not now included in the PAK "package".

Phase 1: Preparation

Initially, PAK is presented to a prospective sponsor, usually a local mental health agency, which decides if PAK's capabilities will meet its goals. Once adopted, PAK guides the sponsors in selecting a competent and broadly-based PAK group. A profile of the community's demography, mental health, and power structure helps to determine which segments of the population ought to be represented. Other preliminary steps include the selection and training of the Discussion Leader and the allocation of PAK tasks.

Phase 2: Problem Definition

First, the group will be educated in the goals and operation of PAK, the history and philosophy of community mental health care, the demography and the specific problems of the Catchment Area, and the mental health services currently offered there. With this basic background, the group describes those problems seen as important in their respective areas. Starting with Problems, rather than existing services or funding categories places the process in a performance-based perspective. Precise problem statements

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are developed, problems are ranked by the group, and each high priority problem is explored in further detail.

Phase 3: Program Planning

Program planning proceeds in a carefully defined sequence starting with the problems ranked highest by the group. The group develops performance criteria for problem Effectiveness and Feasibility and then generates program alternatives in response to them. The most promising programs are developed to describe Program Objectives, Description, Activities, Best Point of Intervention and Evaluative Criteria. This phase ends with the group's decision about the "packaging" of, and dissemination of the program designs and a discussion of its own future status.

Phase 4: Facilities Planning

In this phase of PAK, the group develops criteria for selecting or designing environments suitable for the delivery of the mental health services it has programmed. Using a special set of Environmental Descriptors, the group determines and describes those environmental features which will best support each therapeutic activity within a program. Depending upon local conditions, these Environmental Descriptors may be used either to design new facilities or to remodel existing ones to serve as the setting for mental health activities. (The materials for this phase are only partially developed, and need further work before they can be used.)

WHAT IT IS

BOSTI/PAK is a structured process used to organize and aid the planning of community mental health programs and facilities. The planning is done according to a prepared set of agendas, in meetings, by a group of service providers and service users, led by a skilled Discussion Leader assisted by a Coordinating Secretary.

BOSTI/PAK is a system of planning aids which are precisely coordinated with the phases described above. The complete system, as it now exists, is described below.

1. An introductory 6-page mailing piece entitled PAK/Planning Aid Kit.
2. Planning for Better Community Mental Health Programs and Treatment Facilities -- a handbook intended to educate professionals or laymen about overall issues of mental health planning. The table of contents of this 57 page document follows:
 - a. Allocating sufficient resources to planning.
 - b. The planning process for community mental health programs and facilities.
 - c. Community participation in mental health planning.
 - d. Recurring problems in planning and how the Planning Aid Kit (PAK) helps solve these problems.

- e. How you might use PAK and the results of using PAK.
 - f. Your next steps in the planning process.
3. Preparing to Use PAK -- a handbook for groups who have decided to use the PAK program-planning process. It describes precisely, in "cookbook" form all tasks which must be completed before planning sessions begin. The table of contents of this 71 page document follows:
- a. Defining a local mental health context for PAK
 1. Describing the Local Mental Health Structure
 2. Defining PAK's Place Within the Structure
 3. Defining the Mandate and Role of the PAK Group
 - b. Assigning PAK Tasks
 - c. Selecting the PAK group
 - d. Gathering and processing information for the PAK group
 1. Catchment Area Description
 2. Funding Information for Program Planning
 3. Description of Existing Local Mental Health Services
 - e. Selecting and Training the Discussion Leader and Secretary
4. Discussion Leader's Manual for the PAK Process -- This manual contains both the Discussion Leader's instructions and the Participant's instructions organized in such a way that they are viewed simultaneously by the Discussion Leader.

The table of contents of this 194 page document follows:

- a. Meeting Agendas for PAK Program Planning with Notes to the Discussion Leader and Coordinating Secretary
- b. How to Use This Manual:

Material appearing in workbook #5, the Participants Manual is printed on the left-hand pages of this manual, while additional notes to the Discussion Leader are printed on the facing (right-hand) pages.

The Coordinating Secretary's instructions appear on yellow sheets, before and after each meeting.

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5. Discussion Leader's Manual for Group Process -- a compendium of information on group process, the PAK process, and leadership techniques, intended to equip a layman for the role of professional group leader in addition to participating in training sessions by NTL trainers.

The table of contents of this 121 page document follows:

- a. Why Have a Discussion Leader?
 - b. The Details of the PAK Process.
 1. PAK Goals and Rationale
 2. Preparing to Use PAK
 3. Participant Training
 4. Meeting Agendas
 - c. The Discussion Leader's Role
 1. Discussion Leader Training
 2. General Theory of Group Process
 3. Specific Problems You Will Encounter
 4. Alternative Decision-Making Models
6. Participants' Workbook -- instructions and forms for use by all the participants during the twelve meetings. It is both a workbook and a personal record of the process. The table of contents of this 74 page document follows:
 - a. Community Participation in Mental Health Planning
 - b. The Sequence of the PAK Process
 1. Pre-Planning
 2. Planning
 - c. Meeting Agendas
 1. Problem Definition and Analysis (Meeting 1-6)
 2. Program Design (Meetings 6-12)
 7. Slide Show -- A set of 30 slides, describing the PAK Process is used for orientation and training of the participants and the Discussion Leader.

THE EVALUATION

A team of social scientists (Charles Cosentino and Barry Fallon) with special skills in group process, was hired by BOSTI to design and apply an evaluation process. Their report, an excellent one, is now serving as the basis for a redesign of BOSTI/PAK by the multi-disciplinary team responsible for its continuing development and application.

Some of the following (in quotation marks) is text directly from their report. All identification of groups, places, and people has been deleted for this paper.

DESCRIPTION OF THE EVALUATION PROCESS

"The basic method used in the evaluation was non-participative observation. At least one observer was present at all meetings of both Catchment Areas. Observation was chosen as the basic method because of the nature of the task and because it was felt that this would create the least reactance on the part of the participants. This method relies heavily upon the expertise of the evaluators in the social-psychological areas of small group processes and leadership.

In addition to the weekly reports on each meeting developed from the observer's notes the other sources of data were:

a. Participants Reaction Form

This form had four seven-point rating scales and was completed by participants at the conclusion of Meeting #2 through #12. The ratings were concerned with (1) the individual's agreement with the decisions made at the meeting, (2) the usefulness of the PAK materials, (3) the satisfaction with his or her participation, and, (4) the satisfaction with the group progress toward final goal. Provision was made for the participants to make comments if they wished.

b. Initial Questionnaire

This questionnaire was handed to all participants at the first meeting. It included questions about the participant's perception of the reason for his selection, his role of representation and potential contributions to the PAK group, and his greatest concerns in the area of mental health.

c. Evaluation of Meetings Concerning Problem Definition and Problem Analysis

Since problem definition and problem analysis were considered by the PAK originators to be an integral phase in the process, a questionnaire was administered at the end of this phase before the group went on to program planning. A combination of seven-point rating scales and open-ended questions were used. The participants rated how well the high-priority items had been defined and analyzed, the importance of these high priority items to the

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CA and to themselves. Participants were asked to indicate possible modifications in the PAK process.

One of the aims of the PAK process was the education of the participants in the areas of mental health and program planning. The opportunity was taken at this point to ask the participants if they felt they had learned anything about mental health and about program planning, to whom did they attribute this learning, and what it was they had learned.

As the participants were supposed to be representatives of the CA, questions were asked about whom they had spoken to "outside" and on what occasions they had spoken with others about what was happening in the PAK group.

d. Evaluation of Program Planning Meetings

A special questionnaire was designed for administration to CA IV participants as this was the only CA which did program planning. Once again a combination of seven-point rating scales and open-ended questions were used. The questions included satisfaction with the programs, usefulness of the forms and comments on PAK techniques. Questions were also asked about the packaging and dissemination plans. The participants were asked for their comments on the overall process, the number and length of meetings, the size of the group, the ratio of community representatives to mental health professionals, the Discussion Leader (DL) and the Coordinating Secretary (CS), and the strengths and the weaknesses of the process. This questionnaire was mailed to all participants.

The questionnaire method was used to obtain data from the participants about their evaluation of various elements of the process as well as to provide some check on the validity of the evaluators' observations. In most instances the evaluators felt that the participants' responses corroborated their own observations.

The evaluation focus was upon the match between the planned process/PAK materials and the groups' process and task needs. This means that certain issues are not addressed in this report -- issues which are of considerable importance and which would need to be assessed at some future point. Some of these views which were not addressed are: (1) selection criteria and process for PAK participants; (2) the "usefulness" of programs designed by the PAK groups; and (3) the training and familiarization of the Discussion Leaders within the total process and its implementation."

SOME LESSONS/RECOMMENDATIONS

Although the sample is so small as to be simply case studies, there are lessons to be learned from the Evaluation, from the 2 groups' output and from first-hand reports by the Discussion Leader.

The following recommendations are results of those evaluations, and seem generic enough to share with other researchers and practitioners:

- . Community Participants must clearly understand why they are chosen, and sense that they represent a very particular constituency whose concerns they will vigorously protect.
- . Professionals should see themselves as representing more particular constituencies than a "mental health system".
- . All Participants should be solicited and hired by a person of considerable status.
- . The Catchment Area's leadership or leadership-to-be should be part of the PAK group.
- . The larger mental health system should be officially represented.
- . The group which initiated PAK's use must be represented.
- . A clear, formal mandate for the group must be accepted and precede any deliberations. This should define exactly what power or status the PAK group has, and has not.
- . The task of educating PAK members about mental health should not be limited to classroom techniques (facts and numbers, lectures and discussion), but should include more active processes, such as visits, interviews with officials and service users, obtaining institutional reports, "quick and dirty" survey techniques, town meetings, etc.
- . The Discussion Leader must be sufficiently knowledgeable about and comfortable with PAK, and with the logic behind it, to know where and what kinds of changes can be made without compromising a carefully thought out process.
- . The "built-in" rules for fairness in BOSTI/PAK (i.e., everyone's highest priority becomes a high priority for the group and the "rule of the significant minority," or 1/3 of the group) is somewhat in conflict with the limited times allotted to each task.
NOTE: We don't know how to solve this yet.
- . Attitudinal and "mechanical" problems of existing services are very important to present consumers, even though the philosophy of PAK is one of performance and therefore concentration on the community's mental health problems rather than on problems of, or with, service deliverers.
- . PAK presently "assumes" a high degree of conflict because of the heterogeneous group engaged in what appears to be a zero-sum game. However, as group trust is built, concern increases for "the other guy's problems" and this is reflected in decreased use of the conflict based decision rules.
- . Participants who maintain a weekly contact with their constituencies develop very clear notions of special problems and are very effective in "marketing" PAK's results to those constituencies.

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- . Techniques must be developed to help the group maintain an overview of the process, their progress through it, and the linkages between activities and phases. This would make the process less dependent on the leader.
- . The process should not be cut loose from its inventors. They are an invaluable resource to the sponsoring group, the PAK group, and the Discussion Leader. Further, each group is a little different and the process needs "customizing". We must find a way to do this and yet make it widely and inexpensively available.
- . A "special" environment for PAK applications should be designed to go with the process. (Hospital Board Rooms are not the best places to do complex work.)
- . PAK's community representatives were paid \$25 per session, commensurate with our perception of them as professionals. Some resented receiving the money, arguing that their commitment (some 50 hours of real work over a 12 week period) was not based on financial considerations. Money appears not to be a significant motivator for community participants in such processes.

From these lessons, modifications are now being made to BOSTI/PAK. In addition, work is ongoing to adopt the process to uses other than in mental health planning. Moving "up the scale", it seems a particularly useful process for a community's priority setting deliberations under revenue sharing and block grants. Moving "down the scale", we are exploring its use for particular groups (the elderly) and/or for particular problems (alcoholism). Because it has many of the characteristics of a generic participatory planning process, these are legitimate explorations.

APPENDIX -- SAMPLE OUTPUT

(From a recent application in a Catchment Area of 200,000 people in Western New York State. These are offered to demonstrate the format and quality of output achievable with BOSTI/PAK by a planning group consisting of 5 professionals and 10 lay people. Some 15 programs were developed.)

Problem Topic:

"A need exists for a range of services and facilities adequately staffed to meet the needs of parents and children who are experiencing emotional problems that show up in varying kinds of symptoms. Special emphasis must be given to developing flexible foster homes, group living situations and day care (as well as short term in-hospital care)."

1. Complete Description

These children may be between the ages of 4 and 20. During their initial development, the children may not demonstrate "acting out" behavior but be passive. Later, these children may display violent or abnormal sexual behavior. In the above, a special group may be young girls who physically mature early. These children are not mentally retarded but present behavioral problems. They require either outpatient services while still being at home or removal from the home. In the latter situation, children may have "allergies to their homes"; i.e., their homes are unstable and chaotic. Further, the parent-child dyad may be one in which the child is gratifying the parent. These relationships may be destructive symbiotic ones. Boys are more difficult to work with and service alternatives for boys are more difficult to find in that jail or detention homes are often seen as the alternatives.

2. Causes

The differentiation of causal factors which necessitate outpatient versus group living is largely a matter of degree. The causes are mostly familial in nature:

- a. family disruptions
- b. family interaction breeds learning which is based on lack of coping (normal) behavior
- c. in some cases, parents who do not know how to be good parents
- d. parental abandonment
- e. unwanted children
- f. in some cases, parents also drink and like to party
- g. parents who sexually abuse their children
- h. sexual problems between parents

Non-family causes may include: peer group pressure, the court system where cases of both mental and physical abuse are difficult to negotiate and finally the fact that the problem in general has been given little priority.

3. Best Place and Time to Deliver Service

In the case of the lesser involved child, the suggestions are to deliver services in schools perhaps with the child and his family. Educational and vocational counseling are important service adjuncts. Another suggestion is for services to be delivered in day care facilities in the Catchment Area. Public awareness of this problem must be developed. Also, work must be done with families as well as peer groups. Responsive environments must be developed.

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In the case of the more involved child, night care services might be a good development. In these situations, children would have a large degree of freedom in decision making. The night care facilities would provide a structured family unit. Group living would provide for learning about peer and family adjustment.

Finally, in some cases, short term hospitalization may be desirable. On the other hand, facilities and hospital staffs should be out in the community.

4. Special Factors

Children with these problems may be embarrassed. Foster homes may have criteria which are more concerned with cubic feet than parental child rearing skills.

Legal problems further complicate these problems. For example, courts make it difficult to remove children from their homes. The judges themselves, because of their attitudes, are difficult persons on whom to make an impact regarding mental health concerns. Finally, the criteria for eligibility for group living facilities should be reviewed.

5. Current Attempts to Deal with Problem

- a. State Hospital Day Care (16 years and over)
- b. Citizens Committee for Children (child advocacy)
- c. Father Baker's
- d. Child Care Center (ages 6-12)
- e. Gateway (teenagers)
- f. Hope Vale
- g. Immaculate Heart
- h. Protestant Home
- i. Boys Town

Foster homes were discussed the most. However, two types are needed: one with the services aimed at those who will be returning home and the other foster home plan to keep the child removed from the home.