
Promoting Participation in Organizational Decision Making by Clients with Severe Mental Illness

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This qualitative study assessed clients' participation in organizational decision making in a public long-term psychiatric hospital. Numerous examples were found in which clients meaningfully participated in the decision-making process and achieved favorable policy changes. Three means of involving clients were found to be especially useful: (1) using a consumer council, (2) involving clients in the formal policy review process, and (3) including clients in the hospital's performance improvement system. The authors offer guidelines for mental health organizations wishing to promote client participation in organizational decision making. Implications for social work are discussed.

KEY WORDS: *administration; decision making; focus groups; mental illness; organizations*

People with severe mental illness (SMI) traditionally have been perceived by themselves and others as powerless (Carling, 1995; Williams, 1995). This perception occurred in part as a result of the provision of psychiatric treatment in large institutional settings, particularly before the 1970s, and the dominance of the medical model of psychiatric treatment, which minimized clients' roles in decision making (Bassman, 1997; Goffman, 1961). This is changing, however. Psychiatric treatment is being provided in less restrictive community-based settings. Psychosocial rehabilitation has emerged as a complement to medical treatment of mental illness, and a mental health consumer movement has taken hold, both of which emphasize client involvement in decision making in all aspects of their lives (Carling; Chamberlin, 1978, 1990; Cook & Hoffschmidt, 1993).

One aspect of this change is that people with SMI have increased their involvement in organizational decision making. They now are serving on boards of directors, task forces, and committees in agencies, as well as operating consumer-run programs (Carling, 1995; Pratt, Gill, Barrett, & Roberts, 1999; Vandergang, 1996). Despite this involvement, some argue that a lack of opportunity still

exists for most people with SMI to participate in organizational decision making (Beeforth, Conlan, Field, Hoser, & Sayce, 1990). In addition, few examples exist in the literature that detail efforts of mental health programs to involve clients in decision making (Vandergang). We address this void in the literature by describing the participation of clients in organizational decision making at a public psychiatric hospital and offering guidelines for mental health agencies that wish to increase such participation.

Strong arguments exist for social workers to promote the involvement of people with SMI in organizational decision making in the agency from which they receive services. Such involvement is consistent with ethical principles of the NASW *Code of Ethics* that call for social workers to challenge social injustice, respect the inherent dignity and worth of people, promote self-determination, and ensure access to decision making (National Association of Social Workers, 2000). Many also see participation in organizational decision making as a basic human right and reflective of the democratic process inherent in our culture (Croft & Beresford, 1992; Katan & Prager, 1986). Furthermore, client participation in decision making can

be empowering and aid in the process of recovery from mental illness (Pratt et al., 1999). Finally, client participation in organizational decision making can improve agency effectiveness by incorporating the viewpoints of clients as key stakeholders (Croft & Beresford; Katan & Prager; Salzer, 1997).

We report on the findings of a qualitative study of client participation in organizational decision making that was conducted at a public long-term psychiatric hospital. We operationally defined such participation as clients' involvement in the process of setting policies and procedures that governed operation of the hospital and applied to all clients. This study explored three primary research questions. First, what are the structures and processes through which clients can participate in organizational decision making? Second, how effective are these structures and processes in involving clients in organizational decision making? Third, what are the obstacles to participation in organizational decision making by people with severe mental illness? Based on the findings of this study, we offer guidelines for mental health organizations to promote client participation in organizational decision making and address implications for social work clinical practice, administration, and research.

METHOD

Setting

The site of the study was one of four public long-term psychiatric hospitals operated by the Missouri Department of Mental Health (MDMH). It is a 212-bed facility comprising four 25-bed wards and 14 eight-bed cottages located on hospital grounds. The hospital is usually at maximum census. The hospital is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and is certified by the Centers for Medicare and Medicaid Services (CMS). This hospital, along with the other three long-term hospitals, adopted psychosocial rehabilitation as its primary model in the early 1990s (Linhorst, 1995). Consistent with a growing number of public psychiatric hospitals in other states, MDMH long-term hospitals serve primarily *forensic clients*, defined in general terms as people with mental illness who encounter the criminal justice system (Linhorst & Turner, 1999). At the hospital in which the study occurred, the criminal courts had committed 10 percent of the clients following an adjudication of incompetent to stand trial and 70 percent as not guilty by

reason of insanity (NGRI). The remaining 20 percent of clients were nonforensic and were admitted to the hospital by their legal guardians.

At the time of the study, the average length of hospitalization was about six years. The majority of clients were men (80 percent), African American (60 percent), and in their mid-40s. Most had a primary psychiatric diagnosis of schizophrenia (70 percent), some had secondary diagnoses of personality disorders (50 percent), substance abuse (50 percent), or mental retardation (15 percent). Hospital clients had a range of functioning levels. NGRI clients tended to be higher functioning, on average, than nonforensic clients, because NGRI clients must demonstrate a higher level of functioning and psychiatric stability to meet discharge criteria that are much more stringent for forensic clients than nonforensic clients (Linhorst & Turner, 1999).

Data Sources

The findings we report were part of a larger qualitative study that examined client involvement in decision making at the hospital related to treatment planning, residential units, organizational decision making, and mental health policy making (Linhorst, Young, Eckert, & Hamilton, 1999). That study incorporated two data sources. We first reviewed hospital documents during the summer of 1998 to identify the formal structures and processes whereby clients should be able to participate in hospital decision making, to ascertain written evidence that clients had participated in hospital decision making, and to identify the outcomes of clients' participation. Documents we reviewed included the hospital mission, vision, and value statements; hospital policy and procedure manuals; JCAHO standards; various hospital planning documents and reports; and minutes from hospital committee meetings.

We also conducted focus groups with hospital clients and staff. We first asked clients and staff by what means they believed clients could influence hospital policies and to provide examples of when this occurred. We also asked about the structures and processes identified in the document review to determine participants' awareness of them. In addition, we asked staff to identify limitations to client participation. We informed potential focus group participants that we were interested in studying this topic because in recent years MDMH and

the hospital had sought to increase client participation in decision making. However, the extent to which client participation was occurring and factors related to participation had not yet been evaluated. We also told participants that the study could lead to recommendations for increasing client participation in decision making or setting more realistic expectations for participation if appropriate. We opened the focus groups to all hospital clients, clinical staff, and administrators. Participation was voluntary. We held focus groups with 17 groups of clients and 15 groups of hospital staff between October and December 1998. More than one-third of the clients participated, with some clients participating from each of the hospital's four residential treatment programs. Overall, 29 percent of the hospital's 389 clinical and administrative staff participated, including all eight executive staff (for example, medical director, superintendent), 76 percent of the 34 middle managers, 51 percent of the 95 professional clinical staff, and 13 percent of the 252 paraprofessional staff.

We selected the combination of document reviews and focus groups for several reasons. The review of mission statements, policy and program manuals, and similar documents allowed us to identify the level of involvement of clients in decision making that should occur. Other documents, such as committee minutes, were useful in verifying focus group results. We used focus groups because they permit an in-depth investigation of a topic, are more time-efficient than individual interviews, and have been used successfully with people with mental illness in other studies (Linhorst, 2002; Richter, Bottenberg, & Roberto, 1991). In addition, we chose focus groups over questionnaires because we were unsure what response sets to include for closed-ended questions. We also believed that discussion among participants would increase their understanding of the topic and generate more valid responses.

Data Analysis

In our review of focus group notes, we identified themes that were consistent across client and staff groups, as well as differences within and between each group. We used information gathered from document reviews in part to support or refute the opinions expressed by clients and staff in the focus groups. In presenting the focus group findings, we referred to the number of groups in which the

opinion was raised, not the number of individuals that raised the issues. In our judgment, when opinions were offered by an individual member, they usually were shared by most, if not all, other participants in that focus group. Furthermore, if, for example, only eight clients raised an issue but those eight clients were from eight different groups, this suggests that the issue or opinion may be widespread across the hospital. Opinions expressed in a limited number of groups were not dismissed as unimportant. Respondents in that single group may have a unique perspective or experience with that topic.

Study Limitations

One limitation of this study was that lower functioning clients and paraprofessional staff were underrepresented in the focus groups. Forty percent of the 68 clients in the hospital treatment program with the lowest functioning clients were ineligible to participate in the study because their legal guardians did not sign the required consent form. It was uncertain why participation was low among paraprofessional staff. We speculate that it was because their time was difficult to arrange because of their client-oversight duties; they traditionally have not participated in such research studies and may not have felt comfortable participating or believed they had anything to offer. Despite lower levels of participation, the program with the lowest functioning clients fielded a focus group with 11 clients, and at least one focus group was held with paraprofessional staff from each of the four treatment programs. Another potential limitation was the possibility that participants did not answer honestly. To promote open discussion, we held separate focus group with clients and staff so that clients would not fear retaliation from staff. We grouped staff according to the four levels of staff so that supervisors would not be present. We maintained confidentiality by asking participants not to repeat any discussion outside of the focus group, by not recording the names of any of the participants, and by reporting the data in such a way that the responses of any single client or staff or treatment program could not be identified. In our opinion these efforts produced open, valid responses from participants. Finally, the generalizability of this study to other mental health settings or to nonpsychiatric clients is questionable. For example, clients in acute psychiatric hospitals may not have

the time investment to participate in decision making, and different structures and processes may be required for clients to participate in community-based organizations.

MEANS OF CLIENT PARTICIPATION IN ORGANIZATIONAL DECISION MAKING

Our review of documents identified five formal structures or processes that had the potential to involve clients in hospital decision making. These included the hospital's Consumer Council (CC), the policy review process, the performance improvement system, the client grievance process, and Missouri Protection and Advocacy (MPA). Clients and staff identified several informal means as well. Below is an assessment of each. (Table 1 summarizes the number of client and staff focus groups in which one or more members identified the means of client participation.)

The Consumer Council

The CC consists of approximately 10 hospital clients who are elected from each of the four hospital programs (Linhorst, Eckert, Hamilton, & Young, 2001). A staff member from the hospital's Quality

Management Department, who also chairs the Rights and Ethics Committee, facilitates it. According to the CC bylaws, its purpose "is to give clients a more active role when it comes to decision making that affects their environment. It is also the purpose of the council to give all the clients a voice in decision making" (p. 1). We found documentation that the CC participated in organizational decision making through meetings with the hospital superintendent and the Rights and Ethics Committee, and through the hospital's formal policy review process. We also found evidence that the CC played a significant role in achieving the following changes between 1997 and 1999: an increase in clients' spending budget, an extension of curfew time for evening grounds privileges, the purchase of patio furniture for outdoor areas, an increase in the diversity of pastoral services offered to clients, an increase in food choices in the cafeteria, a decrease in soda and canteen prices, and others. Despite its accomplishments, clients in just under half of the focus groups identified the CC as a means whereby clients could participate in hospital decision making, which is in contrast to all but one staff focus group.

Policy Review Process

A hospital policy outlines the process by which formal policies and protocols are developed and routinely reviewed. At the time of this study, the policy indicated that "Clients may ask for discussion of a policy suggestion at the CC. With the CC's approval, the suggestion will become a request to the quality management director, reported from the CC minutes." The policy has since been extended to include the CC in the review of all new policies and existing policies that directly apply to clients. Since 1997 clients' input into the policy review process has resulted in major content changes to four hospital policies—dietary issues, client access to medical records, availability of staff libraries on each residential unit, and photographing of clients with family members. With other policies, clients' input helped to provide a better match between policies and their actual practice, to change procedural timelines outlined in policies, to streamline procedures, and to write more clear and concise policies. Despite the inclusion of clients in the policy review process, no clients or staff identified this as a means whereby clients could participate in organizational decision making.

Table 1: Potential Means of Client Participation in Organizational Decision Making in a Public Long-Term Psychiatric Hospital Identified by Clients and Staff

Means ^a	Clients (n = 17)	Staff (n = 15)
Formal Means		
Consumer Council's interaction with committees and executive staff	8	14
Filing grievances through the client grievance system	7	9
Interactions with Missouri Protection and Advocacy	3	2
Participation in the hospital's performance improvement system	0	3
Participation in the hospital's policy review process	0	0
Informal Means		
Contact an executive staff member	3	7
File a lawsuit against the hospital	4	1
Contact a member of the treatment team	4	0
Write or call the main office of Missouri Department of Mental Health	3	1

^aListed is the number of focus groups in which one or more participants identified the means.

Performance Improvement System

JCAHO standards do not state directly that clients should participate in organizational decision making. They do, however, require that hospitals have a formal performance improvement (PI) system and that they seek client input to make improvements. The CC is part of the hospital's PI system and reports to the Rights and Ethics Committee. In enacting its role in this system, one or more members of the CC or clients it selects typically participate with staff on performance improvement teams, which are short-term task groups created to work on specific projects. Since the current PI system was created in 1995, clients have participated in several PI projects that resulted in changes to hospital policies or operating procedures. Examples include improving the scheduling of clients' medical appointments in the community, improving the safety of clients and staff working in the hospital's warehouse, minimizing the negative impact of clients being transferred from one residential program to another, reducing the cost of supplies used by clients, and improving clinical services in one hospital program. Clients' participation in organizational decision making through the PI system largely was unrecognized by clients and staff. None of the clients, and staff in only one-fifth of the focus groups, identified client participation in the hospital's PI system as a means whereby clients participated in decision making.

Client Grievance Process

Clients can initiate a grievance if they believe their rights specified in Missouri law have been violated by the actions of staff or other clients or by hospital policies and procedures. Resolution of a grievance begins at the level it originated, which usually is the clinical program; if unresolved it can proceed to the hospital superintendent, the MDMH client rights coordinator, and the MDMH director, who has final authority. Grievances filed by individual clients have resulted in policy changes at the hospital. Examples between the years 1997 and 2000 include an increase in visiting hours and their standardization across all residential units of the hospital, clients being allowed to attend monthly continuing education presentations that previously were limited to staff, modification of the procedure for urine collection for drug testing, and a change in the security procedures so more clients could attend church services off the living units. None of

the clients identified the client grievance system as a means whereby they could influence hospital policy, although clients in two-fifths of the focus groups indicated that they could file a grievance if they disagreed with a hospital policy. Staff in more than half of the focus groups identified the filing of grievances as one means for clients to influence organizational decision making.

Missouri Protection and Advocacy

A fifth structure or process through which clients theoretically could participate in organizational decision making is MPA, a federally funded, not-for-profit agency that is part of a national network created by federal legislation to protect and advocate for the rights of people with disabilities, including those with mental illness. MPA can provide an array of services to clients, including investigation and mediation of problems expressed by clients; technical assistance to clients, attorneys, service providers, and other advocacy organizations; legal counsel to clients on selected issues; and community education and training. Although the potential exists for MPA to influence hospital policies as a result of working with individual clients, we could not identify any examples in which clients' involvement with MPA led to changes in hospital policies. Reflective of this apparent lack of influence on policy, clients in only three focus groups indicated they could contact MPA if they wanted to change a hospital policy, and in all three of these groups, clients added that they thought no change would occur. Staff in just two focus groups indicated that clients could contact MPA to influence organizational decision making.

Informal Means of Participation

In addition to the five formal structures or processes through which clients could (and in most cases did) participate in organizational decision making at the hospital, clients and staff identified four informal means of participation. The one identified most frequently was to contact a member of the hospital's executive staff. It is interesting to note that middle managers and clinical staff identified contacting executive staff as an informal means of participation more frequently than did either clients or executive staff. The other three means, which were identified more in client focus groups than staff focus groups, were clients filing a lawsuit, clients contacting their treatment team if they disagreed with hospital policy,

and clients writing or calling an upper-level MDMH administrator. We found no evidence that client lawsuits and communications directly with MDMH administrators influenced hospital policy. We also found no instances in which contacts with treatment teams led to policy changes, with the exception of treatment team members encouraging clients to present their concerns to the CC. We did, however, find one example in which an informal contact with an executive staff member resulted in a procedural change: Clients received permission to participate in the employee orientation of paraprofessional staff trainees.

OBSTACLES TO CLIENT PARTICIPATION

We asked staff in the focus groups to identify obstacles to client participation in organizational decision making. Staff identified four obstacles with the greatest frequency. First, staff believed that many clients lacked information about hospital policies, which policies were currently being debated, and how to provide input. They could not meaningfully participate in the process if they were not fully aware of it. Staff also indicated that many important policies that affected clients were made by MDMH or were established in Missouri law. At the time of the study, hospital clients had no connections with outside advocacy organizations to represent their interests in decision making at these levels. Next, some staff believed that the executive staff and program managers did not always seek client input on issues that affected clients. They believed that these individuals did not deliberately prevent client input; rather, in most cases, they apparently did not think to ask for clients' involvement in decision making. Moreover, staff indicated that the severity of mental illness prevented some clients from meaningfully participating in decision making. Their psychiatric symptoms made it difficult to concentrate or to process information required to engage in policy matters.

Staff offered five additional obstacles to client participation at less frequent levels. Some staff believed that some clients feared retaliation from staff for voicing their opinions, although they thought that many residential units of the hospital encouraged client participation. Also, the feedback loop to clients after they provided input was often incomplete. This lessened clients' motivation to participate in the future because they did not see the results of their efforts. In addition to psychiatric

symptoms, some clients lacked the skills to communicate information effectively or to participate in decision-making activities with staff. Next, negative attitudes about client participation held by some staff decreased their willingness to support client decision making. Finally, some staff believed that some clients were too apathetic to be involved in hospital decision making. (Table 2 summarizes the obstacles to client participation in organizational decision making offered by staff.)

GUIDELINES TO PROMOTE CLIENT PARTICIPATION

Develop Formal Structures and Processes for Client Participation

Formal structures and processes need to be developed and institutionalized to provide ongoing, systematic opportunities for clients to participate in organizational decision making (Means & Smith, 1994). Without this, client participation is likely to be haphazard and dependent on the will of individual administrators, if it occurs at all. Having multiple structures and processes allows more clients to participate and ensures that clients are exposed to a range of decision-making opportunities. The most important means of influencing decision making at the hospital were through the CC, the

Table 2: Obstacles to Client Participation in Organizational Decision Making Identified by Staff (N = 15)

Obstacle*	
Clients' lack of knowledge about hospital policies and how to provide input.	7
Some important policies that affect clients are made at the MDMH or legislative levels.	7
Executive staff and program managers did not always seek client input.	6
The severity of mental illness prevented some clients from meaningfully participating.	6
Some clients feared retaliation from staff for voicing opinions.	2
The feedback loop after clients had provided input was often incomplete.	2
The inability of some clients to effectively communicate information.	1
Negative staff attitudes about client participation.	1
Client apathy toward involvement in hospital decision making.	1

Note: MDMH = Missouri Department of Mental Health.
*Listed is the number of focus groups in which one or more participants identified the obstacle.

policy review process, and participation in the hospital's PI system. Each mental health setting needs to adopt structures and processes unique to its situation. Community-based mental health organizations, for example, may not have as ready access to clients as residential programs. Thus, to engage clients, they may, for example, need to pay clients' transportation costs to participate on committees or conduct telephone surveys of clients' opinions.

Inform Clients about Current Policy Issues and Mechanisms for Participation

If clients are to participate meaningfully in organizational decision making, they need information about current issues, policy options, and mechanisms for participation, among other things (Means & Smith, 1994). To increase clients' knowledge of hospital activities, clients are now invited to attend the hospitalwide updates presented by the superintendent, which previously were available only to staff. To increase client and staff knowledge of the CC, the CC meeting minutes are now routinely distributed to all living units for review by staff and clients. In addition, a client newsletter was recently started, and the orientation to the hospital received by new clients was modified to include more information about the CC, the client grievance system, and opportunities for participation in the hospital's PI system. Another dimension of information sharing is publicizing the positive contributions clients already have made to organizational decision making. We found that many clients and staff were unaware of clients' contributions. Such awareness is important for clients and staff to build credibility for clients as legitimate participants in decision making and to institutionalize their role in the process. Community-based mental health organizations face logistical challenges in communicating with their clients compared with residential programs. They likely need multiple forms of communication, such as mailed newsletters, information sharing by case managers, e-mail for clients with computers, and open meetings with staff at central locations.

Research studies such as this one can inform clients and staff about opportunities for clients to participate in organizational decision making. In our final report of findings, we included recommendations for increasing participation. As we expected, executive staff and the CC acted on several of our recommendations to make meaningful sys-

tem changes. A positive unintended consequence of the study was that studying client participation promoted client participation. The discussion among focus group participants created an awareness of the opportunities for client participation in decision making and the positive aspects of such participation. As a result, well before we issued the final research study report, more clients asked to participate and were granted the opportunity, and staff asked for client membership on performance improvement teams at a higher rate.

Listen to Clients and Respect Their Opinions

Once mechanisms are established for client participation in decision making, it is critically important that staff listen to clients. Executive staff indicated that they made a concerted effort to listen to clients' opinions and suggestions, to carefully consider them, and to explain reasons for not enacting their suggestions when they chose another policy option. Others, too, have highlighted the need for staff to listen to clients carefully and respectfully and acknowledge their contribution (Carling, 1995; Smith & Ford, 1986; Winship, 1996). Carling emphasized this point: "The major strategy for building consumer involvement in policy and planning is to listen, listen, and listen some more" (p. 281). It can be a challenge to develop an organizational culture in which staff at all levels are willing to accept client participation in organizational decision making. Such a culture was promoted at this hospital by the adoption of psychosocial rehabilitation as the primary treatment approach, the emphasis on client choice in its mission, vision, and value statements, and strong leadership by executive staff and selected middle managers. The culture developed incrementally as staff and clients began to see clients' positive contributions to organizational decision making. Most staff now see the positive value of client participation, as it has resulted in more effective services and provided clients with additional outlets through which they can express their concerns.

Treat the Mental Illness and Provide Decision-Making Skills

Mental health organizations need to acknowledge that psychiatric symptoms may prevent some clients from meaningfully participating in decision making during certain times, as was the case in this study (Gutiérrez, GlenMaye, & DeLois, 1995; Torrey,

1994). In addition, many clients do not have the skills or experience to participate in the decision making process (Croft & Beresford, 1992; Dillon, 1994; Hagner & Marrone, 1995; Penney, 1994; Sundram, 1994). Thus, some clients require psychiatric treatment and skill building before they can meaningfully participate. Client education should include assertiveness training, functioning in groups, and communicating orally and in writing. Vandergang (1996) extended the need for training to staff and agency board members on how to work effectively with clients in organizational decision making.

Clarify the Extent of Client Decision-Making Power

Finally, and perhaps most important, organizations should be honest about the extent of clients' decision-making power. Means and Smith (1994) argued that "people need to know the scope and limits of the contribution they can make. If they are to contribute effectively, they need to know what it is they are expected to contribute and what the outcome will be" (p. 90). To do otherwise is dishonest and invalidates the entire process. At the hospital, it was clear to both staff and clients that clients' final decision-making authority rested with the hospital's executive staff, or, in some cases, with the MDMH director or the Missouri legislature. To provide clarity on clients' decision-making authority, some mental health organizations have written agreements with client groups that specify the areas in which clients make the final decision and those in which they make recommendations that administrators are not obligated to follow (Glasman, 1991).

IMPLICATIONS FOR SOCIAL WORK

This study has implications for social work clinical practice, administration, and research. Social work clinicians play a vital role in promoting client participation in organizational decision making. They can treat clients' mental illness and help clients develop decision-making and social skills necessary to meaningfully participate in decision making. They also may provide an informational role, particularly regarding the structures and processes for decision making and current hospital issues. In addition, they may be in a good position to recruit clients to serve on decision making committees. Finally, social work clinicians may find themselves working with clients and other staff on committees

and thus have the opportunity to model attitudes and behaviors that support client participation in decision making.

Social work administrators also play an important role. They can help create an organizational climate that supports client involvement in decision making and establish decision-making structures and processes that routinely involve clients. In addition, they may have the opportunity to work with clients on committees and therefore model inclusive attitudes and behaviors. Furthermore, they can promote meaningful client participation by sharing decision-making power and respectfully considering and acting on clients' preferences.

Finally, this study provides support that focus groups can be conducted successfully with people with SMI and with staff of mental health organizations. It also creates awareness of unintended consequences of conducting focus groups, which in this study were positive. To add to the body of knowledge about focus groups, such unintended consequences should be observed and reported in research findings. In addition, it provides an agenda for future research in at least two areas. First is the generalizability of this study's findings to other mental health settings. How do the structures and processes, obstacles, and guidelines for client participation in decision making differ for this hospital compared with other long-term psychiatric hospitals, versus acute psychiatric hospitals, versus community-based mental health organizations? Second, it provides a structure for conducting research on participation in organizational decision making by other client populations, such as welfare recipients, elderly people residing in nursing homes, victims of family violence, and people who abuse substances. This study calls attention to the identification and importance of having established structures and processes through which clients can participate in decision making, the identification of limitations to client participation in decision making, and the development of guidelines to promote client participation in organizational decision making in the programs from which they receive services.

CONCLUSION

A limited number of hospital staff believed that clients were apathetic about participating in organizational decision making. Some of this apathy can be a periodic characteristic of having a severe

mental illness. It is more likely, however, that apathy is a function of the barriers that people with mental illness have faced in providing meaningful input for the organizations from which they receive services. We believe that many clients will choose to participate in organization decision making if they are taught decision-making skills, if formal structures and processes exist for participation, and if their opinions are respected and acted on by decision makers. The participation of clients in organizational decision making is consistent with the ethical obligations of the social work profession to promote social justice and client self-determination. Given the knowledge, values, and skills of the profession, social workers, more than any other professionals, may be in the best position to promote client participation in organizational decision making. **SW**

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Original manuscript received January 24, 2001
Final revision received April 8, 2002
Accepted August 6, 2002