Community awareness and usage of mental health resources

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COMMUNITY AWARENESS AND USAGE OF MENTAL HEALTH RESOURCES

A Project
Presented to the
Faculty of
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San Bernardino

In Partial Fulfillment of
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By
Carolyn Tjoland
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PROJECT ABSTRACT

This project is an exploratory study of the community's awareness and usage of mental health resources, patterns of help sought for specific emotional problems, and attitudes about seeking assistance for emotional problems. The study employed the use of a Community Awareness Survey designed by the researcher. The subjects of the telephone survey were 124 household respondents residing within the East Valley area of San Bernardino County. A historical review of the Community Mental Health Movement provides a theoretical orientation for the ongoing changes in the mental health delivery system. Needs assessment approaches, consumer input and control, and the implementation of surveys provides additional rationale for the methodology employed. Results of the study indicate that all of the mental health resources in the East Valley have low visibility in the community and suggestions for increasing community visibility are given. The patterns of help sought for specific emotional problems indicate the need for increased consultation to professionals not directly in the mental health profession. The results further indicate the need for education programs which would assist people in learning new ways of coping with stress,
building support systems, and decreasing the debilitating fear and stigma of mental illness. Further research on each of the three issues addressed is needed.
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CHAPTER 1

INTRODUCTION

Since February, 1978, I have been the director of an agency which does not provide traditional mental health services, but acts instead as an information and referral service, provides mental health education and training, provides consultation to other agencies, utilizes volunteers as support groups and task forces, serves as an advocate for individuals and the community as a whole, and in general, provides what is referred to as "indirect services." This experience, put together with my academic and clinical training, has awakened me to the preponderous amount of fear many people have of mental illness. People often hear the words "mental health" and automatically think "mental illness." Lacking the knowledge, they misunderstand themselves and others.

This fear of mental illness is not totally without a foundation. Since the beginning of time the mental health profession has not had a clear understanding of what mental illness is, and different people have defined it as being everything from possession by the devil to everyday problems in living with which some people are unable to cope (Szasz,
The ways in which people have reacted to those suffering from mental illness have been just as varied, from fear to tolerance to acceptance to rejection and isolation.

It has been my experience over the past few years that many of the attitudes toward mental health and mental illness have been a result of misinformation or a lack of information. This form of ignorance forms a cyclical pattern: the lack of information breeds fear, fear breeds distrust and non-acceptance, distrust breeds more fear. This pattern has an effect on not only people suffering from mental illness but also on the system that attempts to serve them. The guilt and embarrassment experienced by those seeking mental health services often keeps them away from the very thing that may be of help.

Given the trend of mental health services in the United States, from familial compassion to complete isolation to "community treatment," it is no wonder that the fear and stigma of mental illness remain. After a hundred years of "removing" the "problem" from the mainstream of society, it is of little surprise that the concept of "community mental health" is a little threatening and often misunderstood.

While the community mental health movement has had great impact on reducing the fear of mental illness, and while the community mental health centers have clearly
demonstrated their value as the most desirable approach to providing mental health services (Brandt, 1978), just what percentage of the population has knowledge of the mental health services available in their community? How many people know about the community mental health centers and other alternatives? How many people are aware of the crisis-hotlines in their community? Where do people "naturally" go when they experience emotional problems? And perhaps most importantly, how do people feel about getting help for emotional problems?

The foregoing questions are what this study attempts to explore and perhaps answer for the people of San Bernardino County Mental Health District #8 known as the East Valley, including Loma Linda, Bryn Mawr, Redlands, Mentone, Yucaipa, Oak Glen, Forest Falls, Camp Angeles, and Seven Oaks, a combined population of approximately 84,000 people.

It is not the intent of this project to make definitive statements but rather to discover patterns and trends that may be helpful in the planning, implementation, or improvement of mental health services designed to meet the mental health needs of the East Valley community. It is sincerely hoped that, by the very nature of becoming more aware of mental health issues, every person who takes the time to participate in the study in some way promotes her/his own or someone else's mental health.
CHAPTER II

HISTORICAL PERSPECTIVE OF THE COMMUNITY MENTAL HEALTH MOVEMENT

Fifteen years ago a tremendous "wave" formed in Washington, D.C., a "wave" which can be seen as the inception of the community mental health movement. This "wave" was the enactment of Public Law 88-164 (the Mental Retardation Facilities and Community Mental Health Centers Act of 1963) by the United States Congress on October 31, 1963. This one law would soon result in a community mental health approach that would challenge traditional mental health services as they never had been challenged before. While the challenge met with resistance from certain populations, the challenge was received with intrigue and excitement by others. Public Law 88-164 opened the door for mental health professionals to begin dealing with some of the dissatisfactions and frustrations of the traditional mental health system.

The Pre-Community Mental Health Era

In order to understand and appreciate the challenge posed by Public Law 88-164, it is useful to have some historical context for understanding previous approaches
to mental health. Psychosocial symptoms, whether in the form of mental illness, criminal behavior, or poverty, historically have tended to be treated on the basis of their etiology (Bloom, 1975). Therefore, during the pre-Christian era when psychiatric disorders were believed to be caused by supernatural forces, the treatment involved a variety of techniques designed to drive out the evil spirits. Even in cultures that believed insanity to be a natural phenomena rather than supernatural, treatment tended to be equally demoralizing and inhumane.

For Americans in the Colonial period, the question of the etiology of insanity was a comparatively new one (Rothman, 1971). Colonialists assumed that the cause of mental illness rested with God's will and thus responded sympathetically with little reflection of the precise nature of the affliction. During the Jacksonian period, however, many Americans changed their thinking, and insisted that the causes of crime, poverty, and insanity lay in the faulty organization of the community (Rothman, 1971). Jacksonians believed in a moral and humane solution, and the preferred treatment for these problems was that of changing a person's environment. Thus the notion of a "retreat" was born. The retreat seemed to be a logical response to scientific progress. After all, hadn't hospitals provided a place of restoration for the physically ill through bed rest, good nutrition, and
healthy environment? It seemed a little step to think that hospitals would yield comparable benefits for the mentally ill. These "mental" hospitals, or asylums, then would fulfill a dual purpose—one of reformation or rehabilitation and one of exemplification of the "proper" principles of social organization.

Over the next several decades, however, this "moral" treatment proved ineffective. State hospitals lacked sufficient funds. They became overcrowded as lengths of stay and rates of recidivism increased. Moreover, the sturdy walls of the asylum naively and puritanically created to "morally" treat the mentally disabled, in reality, served an unconscious motive—to isolate a problem which neither lay nor professional people understood nor knew how to treat (Rothman, 1971). Visibility of the mentally disabled in the community would have been a painful reminder of society's lack of knowledge and inability or unwillingness to take corrective social action.

It is feasible that the isolation of offenders served as a necessary "time out" period in American history which provided a foundation for further growth, that of the community mental health movement. Prior to World War II, little support of mental health services had been given by the federal government. Most states failed to appropriate sufficient funds to ensure high-quality care. In 1930 a federal Division of Mental Hygiene was created.
Notwithstanding the creation of this agency, the first piece of significant federal legislation did not appear until July, 1946, with Public Law 79-487 (the National Mental Health Act). This act created the National Institute of Mental Health (NIMH), encouraged each state to designate a mental health authority, and began a state financial assistance program.

By 1950, three major developments began to influence emerging views of psychiatric hospitalization (Bloom, 1975). The first was the discovery of the effectiveness of psychopharmacology in modifying both the emotional and behavioral components of some psychiatric disorders. Not only did the use of these drugs accelerate recovery, but many patients were able to function in the community by continuing the use of these drugs at home. The second development was the concept of a "therapeutic community," a democratic process whereby the therapeutic potentials of patients as well as the staff were maximized, thereby increasing the effectiveness of the treatment.

The third development was the culmination of ongoing changes in the administrative organization of mental health delivery services. Prior to 1950, hospitals, as a result of increasing size, began to organize administratively around treatment modalities. Soon there were admitting wards, electric-shock-treatment wards, insulin-treatment wards, and alcoholism wards. The acute treatment and
admission services generally attracted greater numbers of better-trained personnel, while the chronic "back wards" sustained an aura of hopelessness, and resulted in a growing accumulation of patients. While the average length of stay in a mental hospital in 1870 had been about one year, by 1950 it had increased to nearly five years. Because of the growing patient population, geographic decentralization began. This third development resulted in working relationships between the hospitals and the communities they served.

Between 1955 and 1961, the state mental hospitals began to experience a decline in patient population. The decline was not a result of a decrease in admissions. In fact, admissions had increased. The average length of stay, however, began decreasing. Whether this decrease was a result of the previously mentioned developments or other factors is unclear, but the decline has continued up to the present time. During this same time period, 1955 to 1961, Congress authorized the National Institute of Mental Health (NIMH) to provide demonstration grants to mental hospitals as an incentive for improving hospital treatment. Congress also began to recognize the need for an "objective, thorough, and nationwide analysis and reevaluation of the human economic problems of mental illness" (Joint Commission of Mental Illness and Health, 1961, p. 301). These three factors, the decline in patient
population, the authorization of demonstration grants, and the realization of the need for evaluation of the human economic problems of mental illness, ensured continued government involvement in the mental health system and gave impetus to the enactment of Public Law 84-182. The Mental Health Study Act (PL 84-182) mandated the establishment of a Joint Commission on Mental Illness and Health. This Commission would become influential in illustrating the urgent need for improved mental health services and expanding federal funding of such services.

Until 1961, adequate resources had not been devoted to mental health research, prevention, or even an organized mental health delivery system. The focus of mental health services was on individual psychopathology and longterm psychotherapy. Services were not geared to meet the needs of the community, nor was the community involved in identifying mental health needs or developing services. In short, the mental health system was quite removed from the communities in which the patients lived.

The final report of the Joint Commission on Mental Illness and Health, released in 1961, had great impact on President Kennedy. His resulting message to the Congress of the United States was the first time in American history that a president delivered a message on the topic of mental health and mental illness (Bloom, 1975) These visionary words of J. F. Kennedy (1963) were typical of
the 1960's, a time of great change and challenge:

mental illness and mental retardation are among our most critical health problems. They occur more frequently, affect more people, require more prolonged treatment, cause more suffering by the families of the afflicted, waste more of our human resources, and constitute more financial drain upon both the Public Treasury and the personal finances of the individual families than any other single condition . . . .

The time has come for a bold new approach . . . .

We as a Nation have long neglected the mentally ill and the mentally retarded. This neglect must end, if our Nation is to live up to its own standards of compassion and dignity and achieve the maximum use of its manpower . . . .

We must act ---

to bestow the full benefits of our society on those who suffer from mental disabilities;
to prevent the occurrence of mental illness and mental retardation wherever and whenever possible;
to provide for early diagnosis and continuous and comprehensive care, in the community, of those suffering from these disorders;
to stimulate improvements in the level of care given the mentally disabled in our State and private institutions, and to reorient those programs to a community-centered approach;
to reduce, over a number of years, and by hundreds of thousands, the persons confined to these institutions;
to retain in and return to the community the mentally ill and mentally retarded, and there to restore and revitalize their lives through better health programs and strengthened educational and rehabilitation services, and to reinforce the will and capacity of our communities to meet these problems, in order that the communities, in turn, can reinforce the will and capacity of individuals and individual families.

We must promote—to the best of our ability and by all possible and appropriate
means—the mental and physical health of all our citizens. (pp. 1-10)

On October 31, only a few weeks before President Kennedy was assassinated, Congress enacted the Mental Retardation Facilities and Community Mental Health Centers Act of 1963.

The Community Mental Health Era

The Community Mental Health Centers Act of 1963 required the provision of five essential services: inpatient care, emergency services, partial hospitalization, and consultation and education. These mandates would eventually be extended to include diagnostic services, rehabilitation services, precare and aftercare services, training, and research and evaluation.

The Community Mental Health Centers Act of 1963 was not complete. While the law authorized funds for the construction of Community Mental Health Centers, additional money was needed for staff costs. Thus Public Law 89-105 (1965) authorized the appropriation of funds to support a gradually decreasing proportion of staff costs. Public Law 90-31 (1967) extended construction support for three more years and staffing support for two more years. The passage of Public Law

1 The following historical review was derived from U. S. Senate Committee on Labor and Public Welfare, 1973, and Bloom, 1975.
90-574 in 1968 recognized the problems associated with addictions (drug and alcohol) and authorized funds to support specialized programs addressing these social problems.

By 1970, the government was forced to look at its original idea of supplying "seed money" and modified its previous diminishing financial support policies by enacting Public Law 91-211. This law also identified children as being prime recipients of mental health care, and consultation and education as being prime preventative methods. Public Law 91-513, passed the same year, recognized the impact of psychological dependence on drugs and allowed for the expansion of the drug-abuse programs.

By 1973, another year's extension was granted (Public Law 93-45), but with skepticism. Even though Congress had authorized funds over the past five years, the Nixon administration was not allocating those appropriations. At the same time, the whole concept of community mental health was being questioned, and by 1974, an extension was vetoed by President Ford. Early in 1975 amendments were introduced again, vetoed again, but overridden by Congress. This new law, Public Law 94-63, again revised and extended the original Act for another two years.

The 1975 amendment did begin to address some of
the issues at debate. While the five essential services were still mandated, some were given new guidelines and some new services became compulsory. First, children and elderly were slated to receive specialized services, including diagnostic, treatment, liaison, and follow-up. Second, consultation and education services were defined in terms of objectives and recipients. Third, the mental health centers were mandated to serve as a screening mechanism for those requiring psychiatric hospitalization to determine if there were any appropriate alternatives. Fourth, follow-up services became mandatory. Fifth, if the Department of Health, Education, and Welfare deemed necessary, the drug and alcohol prevention, treatment, and rehabilitation programs could be mandated for specific catchment areas. Sixth, the 1975 amendment demanded better coordination with other mental health services and greater attention to overcoming cultural, linguistic, and economic barriers in the provision of mental health services. Seventh, the amendment required community citizen participation in the policy formulation of the agency and a continuous quality-assurance program for delivery of mental health services.

In essence, the task of the past 16 years, 1963 to 1979, has been to define and refine community mental health services. While varying definitions abound, certain characteristics are evident in each of them (Bloom, 1975):
1) emphasis on practice in the community as opposed to institutional settings;
2) emphasis on total community rather than on individuals;
3) emphasis on prevention;
4) emphasis on comprehensiveness and continuity of care;
5) emphasis on indirect services (consultation, education, and information);
6) innovative clinical strategies designed to meet the needs of larger numbers of people (brief therapy, crisis intervention, group therapy);
7) interest in identifying sources of stress within the community;
8) utilization of non-traditional resources (paraprofessionals, volunteers, networking with other agencies);
9) community involvement in identifying needs, designing and evaluating programs to meet those needs, i.e., citizen control; and
10) thoughtful and realistic planning, establishing of priorities, and coordination of services.

This paper will primarily address itself to the last three characteristics (8 through 10, above). It will seek to determine what kind of mental health resources
are utilized in a community, involve residents of that community in identifying mental health needs, and move from this information toward careful planning of priorities and coordination of mental health services.
CHAPTER III

EXAMINING NEEDS ASSESSMENT APPROACHES

Since the present study will result in citizen identification of mental health needs, various types of needs assessment approaches and consumer involvement in needs assessment will be discussed at length.

Types of Needs Assessments

There are essentially five different types of needs assessments, all of which have their respective shortcomings (NIMH, 1977). The least reliable is the key informant method in which certain people, because of the key positions they hold in the community, are selected and asked for their opinion on the specific issues being addressed. Its shortcoming lies in the fact that the people selected are usually chosen because of their special and sometimes invested interest; rarely, is an unbiased response possible.

The second method is that of a community forum whereby citizens have an opportunity to express their concerns, dissatisfactions, and suggestions to those who supposedly have influence on or the responsibility of planning. While much valuable information can be obtained
in this manner, an inherent danger is that one or two persons often become the "spokespersons," supposedly representing their community, when in reality, they have disguised their own or others' invested interests. Additionally, because of its voluntary involvement, the community forum method often leaves no concept of the magnitude of the problem or the need. What is known is that at least one person thought an issue was significant enough to raise. Sometimes, the issue discussed is not an unmet need, per se, but rather a phantom issue resulting from lack of information about available services.

A third method of assessing needs is by using current rates-under-treatment or "rate extraction." This method involves determining what percentage of a certain population is currently receiving a particular type of treatment and then this percentage figure is applied to the targeted population. For example, if the patient-care data of a community reveals that 30% of the community residents are currently receiving treatment for psychiatric disabilities, it is concluded that 30% of the target population is afflicted with psychiatric disabilities. Another way in which the rate extraction method may be utilized is using national statistical data and applying the percentage rate to the target population. In this case, a national survey may reveal that 40% of U. S. citizens sought
psychiatric treatment in a given year; thus, a certain community may conclude that approximately 40% of its citizens will suffer from psychiatric disabilities within any given year. The rate extraction method rests on the assumption that the original population from which the percentage figure was derived is, in fact, representative of the target population under study which, in reality, may not be true.

An example whereby the rate extraction method was not necessarily effective is a study (Morris, 1978) investigating the suitability of using national data for making local estimates of the need for family planning. The nationally accepted need formula for family planning has three components, and the results of the study indicated that the rate extraction method was only effective for two of the three components. Morris (1978) concluded that "there is a definite potential for misleading conclusions if an independent evaluation of the program used data on met and unmet need based on clinic reporting systems and regional estimates of private physicians use rather than the estimates based on local survey data" (p. 674).

Social indicators are the fourth source of information used in needs assessments. This method generally involves the collection of specified sociodemographic information over a period of time or a comparison of pre- and post-test
measures. It is generally inferential in character as opposed to descriptive.

As with the other approaches, some problems arise with social indicator studies. Social change indicators were examined over a 25-year period in a study by Gallagher (1977) to assess a community mental health program's impact on its target community. Three of the six indicators chosen were related to violent behavior—suicide rate, homicide rate, and child abuse rate. Three other indicators were related to state hospital use by tabulating the first admission rate, the average first year length of stay, and the annual patient turnover percentage. The generalizability of the study, however, was limited by the archival data on the social indicators thought to be most relevant. Second, the lack of randomization in design led to some possible selection bias. Third, there may be alternative explanations for the change in the social indicators measured other than the community mental health program.

The fifth method of needs assessment, which is usually the most expensive and time consuming but perhaps the most accurate method of need assessment, is the survey technique (NIMH, 1977). While the particular survey method may vary, the method is particularly valuable in identifying the special problems of community needs (Simons, 1977).

Perhaps the most effective strategy in assessing the
community's mental health needs is a combination of two or more of the available methods (Milord, 1977). One such example is a study by Simons (1977) which reported a needs assessment and outcome appraisal of a five-stage mental health program. Ten social indicators and seven survey indicators were combined, and the results indicated that mental health utilization rates can be predicted with considerable accuracy by combining social indicators and survey measures.

Need assessment information provides the contextual framework for evaluating the relevance or adequacy of the human services available within a community. The area of needs assessment is in its nascence (Attkisson, Hargreaves, Horowitz, and Sorensen, 1978), and no universally accepted methodology exists that will produce a comprehensive assessment of need.

Involvement of the Consumer in Needs Assessments

With the new trend in needs assessment has come an increasing involvement of citizens or consumers in the planning process. This is an age of "maximum feasible participation" wherein client, user, or consumer groups in public and private organizations wish to participate in program planning and administration (Delbecq, 1975). There appear to be two major rationales for this involvement. The first relates to political philosophy, and the
second, to studies of innovation.

In terms of political philosophy, the current trend of citizen participation is one of decentralization of decision-making. Within this framework, citizen participation is most concerned with making planning more responsive to the citizen by increasing her/his representation in the planning process, particularly in the establishing of priorities. In many instances, this trend represents more than a philosophy in that it becomes mandated as a requirement. In order for California counties to receive Short-Doyle funds, for example, Mental Health Advisory Boards must be established that are representative of the population.

The second impetus for citizen participation is the result of studies on industrial innovation, which seem to suggest that organizations making major innovations have a heightened awareness of consumer needs (Science Policy Research Unit, 1972). Through marketing research, organizations are able to "build in" provisions which may be easily overlooked by the developer but which are important to the consumer. In terms of mental health services, the implication is that successful planners will be those that design programs which incorporate features to meet unmet needs, resulting in greater user satisfaction. One such attempt in the mental health field is the utilization of Consumer or Community Input Meetings.
Much of the literature on innovation in human service delivery systems involves two processes. The first is the involvement of the consumers in defining unmet needs or inadequacies of present services. The second is the involvement of consumers in establishing priorities. Although consumers should be involved in both these processes, it is the opinion of some (Delbecq, Van de Ven, and Gustafson, 1975) that the consumer's most influential and unique role should be the identification of needs.

Citizen participation in the identification of mental health needs, however, must go beyond Mental Health Advisory Boards and Community Input Meetings as there are inherent problems with both of these approaches. Relatively few people are expected to represent the community. This level of responsibility is unrealistic. Can any person really be "representative" of the average citizen? How well-informed is that representative on all the relevant issues? Can that representative remain autonomous without taking on the identity and perceptions of the group? How well can the representative articulate the position of her/his representative group, and does the representative really communicate back to the reference group?

Delbecq (1975) points out that successful human service agencies must design programs which incorporate
features to meet unmet needs, resulting in greater user satisfaction. In many instances, however, social service agencies which did include nonprofessionals in program planning and policy-making met with little success. Cohen (1975) suggests that perhaps such failures are a result of mistrust and a feeling that the agencies and their programs have little relevance to the problems faced by most people in that community. He suggests an alternative way of developing resident participation in community action programs by moving the planning and decision-making process away from the trained experts associated with the formal institutions to the residents within the neighborhoods themselves. The people living within a defined community would decide which programs they wish to address, and then use resources available within the community to solve them. The problem of citizen participation from this perspective is not so much participation in decision-making for professionally run bureaucracies, but rather participation for the development of indigenous support groups and the identification of other resources which residents see as relevant to their current concerns and needs.

A study by Homma-True (1975) also supports the effectiveness of indigenous support groups and programs. Within a Chinese-American community, Homma-True conducted door-to-door interviews in 100 households selected by
stratified random sampling. He compared an indigenous community program as an alternative to traditional psychiatric care with a county mental health service and found that the Chinese-American residents were accepting of help provided the program was attuned to their needs.

With the trend of increased citizen participation and the importance of indigenous support groups, then, it is important to look at the level of citizen involvement in the needs assessment processes. Methods utilizing the least amount of citizen involvement are social indicators and rate extraction. Survey techniques usually involve greater citizen participation, but one must take into consideration whether or not the survey is directed towards a specialized population, such as institutionalized or incarcerated patients or minority groups. The needs assessment methods involving the greatest amount of citizen involvement are generally those that utilize open-ended modalities, such as community forums and the key informant method, allowing for maximum community impressions and opinions. When two or more of these methods are chosen, it may be useful to select methods involving different levels of citizen involvement, thus lowering the probability of bias.
CHAPTER IV

UNDERSTANDING SURVEYS

In as much as the present study is based on the survey method of needs assessment, this method and its attendant problems will be discussed at length.

The Nature of Surveys

Surveys can have a variety of purposes (Warren, 1965). They may be primarily for information of for action. They many times stimulate awareness of community conditions and/or stimulate remedial programs to correct deficiencies. Often times surveys are designed to canvass a particular need in hopes of improving a particular program or to set up a new one.

Generally speaking, survey research is done to meet one of three objectives (Babbie, 1973). The first objective is to offer some type of description about a population. The second objective is that of offering an explanation. This type of survey usually investigates relationships and usually requires a multivariate analysis. The third objective of survey research is exploration or the beginning of an inquiry. This latter type of survey tends to be loosely structured and many times contains open-ended
questions. The researcher may have an idea or a premonition about a certain thing but does not want to overlook other factors which may have an impact on the question being addressed. The intent is not to describe or explain, but to explore, offer possibilities, and formulate ideas for further research.

Often surveys address a certain population, such as institutionalized patients, incarcerated persons, minority groups, parents, children, or households. For a household survey, as the present study is utilizing, three separate strategies may be applied—mail, telephone, or home interview. An initial method of approach may be chosen with the intent to follow-up with one or both of the other strategies in order to reach initial nonrespondents.

Siemiatycki (1977) found that strategies employing the telephone achieved the highest response rate and were overall the cheapest and most effective. Mail responses elicited greater validity (more representational sampling) but yielded a lower response rate. Additionally, Siemiatycki found that little was lost by omitting home interviews if a telephone or mail survey was the first line of strategy.

In order to maximize the response rate in a survey, attention should be given to why people respond to surveys. The theory of social exchange proponents, namely Homans, Blau, and Thibaut and Kelley (Dillman, 1978) assert that
the actions of individuals are motivated by the return those actions are expected to bring. It is different from a monetary exchange in that the nature of the return is diffuse and unspecified. The theory of social exchange assumes that people engage in any activity because of the rewards they hope to reap, that there will be incurred costs, and that people will attempt to keep the costs below the rewards. Based on this theory, then, three things can be done to maximize survey responses: minimize the costs for responding, maximize the rewards for doing so, and establish trust that those rewards will be delivered.

Rewarding the respondent may be done in several ways, most of which are attitudinal on the interviewer's part. By showing positive regard for the person and supporting her/his values, the respondent will feel valuable. The interviewer can imply that the respondent is, in essence, serving as a consultant. Of course, the questionnaire must be interesting in order to hold the respondent's attention. Tangible rewards may be offered, and if this is not feasible, then verbal appreciation needs to be expressed more often.

Eliminating any direct monetary costs for the respondent is crucial, but the researcher should also be aware of possible emotional costs to the respondent for taking part in a survey. The task should be as brief as possible and require as little physical and mental effort as
possible. Again, if the respondent feels she/he is "consulting," then the survey designer has eliminated any implication of subordination. Perhaps the most important feature is eliminating any chance for embarrassment through careful design of the questions and by allowing a "way out" if the questions make the respondent feel uncomfortable.

Establishing trust is perhaps the most difficult task in a survey interview. When feasible, a token of appreciation may be offered in advance. The interviewer may want to build on other exchange relationships whenever possible, and identify with a known organization that has legitimacy.

While the tenets and implications of the social exchange theory are offered as guidance, no guarantee can be offered. Essentially, the researcher is left to establish a rapport with the respondent that will facilitate maximum survey response, which is no simple task.

Special Considerations for Telephone Surveys

Since the present study is based on a telephone survey, this method has been given special consideration. In constructing the telephone questionnaire, Dillman (1978) suggests that consideration of additional factors may prove beneficial. Research by Dillman (1978) has shown that when other facets of her design method are incorporated
with minimizing the costs of responding, maximizing the rewards for responding, and establishing trust that those rewards will be delivered, telephone response rates for both the specialized and general public populations in 31 surveys was 17 percentage points higher than the average response rate for mail surveys.

The telephone questionnaire must serve the needs of three audiences—the respondent, the interviewer, and the coder. Special problems arise that may not be present if the questionnaire were in written form before the respondent. The questions may be too long. Response categories may be too numerous, and the respondent may experience difficulty in rank-ordering. The number of items in a series may be confusing; and, of course, maps, diagrams, and pictures are not feasible.

To facilitate ease on the respondent's part, the questionnaire must have a smooth and flowing sense which may not be necessary with the mail questionnaire. Generally it is useful to order the questions starting with less detail and requiring less in-depth answers and progressively move to those questions with more detail and requiring more personal answers. Response categories can sometimes be incorporated into the wording of the question, rather than delineated as response categories at the end of the question.

The construction of the telephone questionnaire should
also take into consideration the needs of the interviewer and recorder. One of the most useful tools is to list most of the expected responses even though these are not given to the respondent. Distinction between questions and answers can be facilitated by the use of lower case letters for the questions and upper case letters for the answers. Any precoding of questions, screening questions, or answer categories is useful. Arrows to the next appropriate question depending on whether preliminary questions were answered "yes" or "no" also facilitates smoothness, time restraints, and ease for the interviewer. The interviewer should freely use explanatory material or other transitional material, and if it eases the interviewer's task, "break" pages or tabs may be incorporated into the questionnaire.

The telephone survey contrasts sharply with the mail questionnaire because it is "heard," never "seen." While the telephone survey need not be visually attractive and contain every detail, it is more rigorous, as the words must totally compensate for the lack of visual display and/or visual cues from an in-person interviewer. Each word must be delivered and comprehended simultaneously, as the respondent cannot "look back." Once the crucial differences between telephone surveys and mail surveys are compensated for, some other general principles apply—ordering the questions, pretesting, not leaving
anything to chance, making the questionnaire interesting, reducing costs to respondents—all of which utilize to the fullest extent the implications of social exchange theory.
CHAPTER V
IMPLEMENTING THE SURVEY

Subjects

The subjects of the telephone survey were 124 household respondents within the East Valley area of San Bernardino County, California (Loma Linda, Bryn Mawr, Redlands, Mentone, Yucaipa, Oak Glen, Forest Falls, Camp Angeles, and Seven Oaks). The approximate age range of the respondents was 18 to 83.

Instrument

A questionnaire (Appendix A) was designed by the researcher to elicit responses which would allow the researcher to assess the respondents' awareness of mental health services (questions 1 and 2), usage and satisfaction of specific mental health services (questions 4 and 5), patterns of help sought for specific problems (question 3), and opinions as to whether the general public is aware of mental health services available and feels comfortable seeking needed services (questions 6 and 7). Questions were open-ended to minimize the possibility of false familiarity with resources. Debriefing questions or comments by the respondent were also recorded.
**Procedure**

Telephone numbers were chosen by random digit selection to offset some of the shortcomings of published lists of telephone numbers, specifically, exclusion of unlisted numbers, the outdatedness of published telephone directories, and duplication of respondents. Subpools were determined by selecting 5-digit numbers from a table of random numbers. Different first digits were represented in direct proportion to the percentage of the total population living within that prefix area (i.e., 9% of the total population resides within the 796- prefix area; therefore, 9%, or 18, of the 5-digit numbers began with 6-).

Two pre-screening procedures were employed. The 795-prefix is also used for Calimesa residences which are outside the East Valley area; therefore, any respondent not residing within the East Valley area was rejected from the original sample and another 795- prefix number was selected. The second pre-screening measure was the elimination of any business or office telephone numbers to avoid any duplication of respondents.

All telephone interviewing was completed by one interviewer during a randomly assigned time period. Time periods were defined as daytime (any weekday between 10 a.m. and 12 p.m. or 2 p.m. to 5 p.m.), evening (any weekday evening between 7 p.m. and 9 p.m.), and weekends.
(Saturday and Sunday between 2 p.m. and 5 p.m. or 7 p.m. to 9 p.m.). Each household was contacted up to six times (two attempts during each of the three time periods) before that household was declared unreachable. The person first answering the telephone was considered an eligible respondent unless that person was under 18 years of age, in which case that person was asked to call either of her/his parents to the phone.

An introductory statement (Appendix B) to each respondent included the name of the researcher, appropriate affiliation information, the nature of the study, and the approximate time needed to complete the survey. If the respondent was unavailable at the time called, another time at the respondent's convenience was offered. Additionally, each respondent was given the opportunity to decline answering any questions with which she/he felt uncomfortable answering.

Debriefing (Appendix B) included a simple explanation of how the information obtained might be used, and a copy of the summarized results was offered to each participant. Respondents were also given the opportunity to ask questions or make comments, and each respondent was thanked for participating in the study.
CHAPTER VI

RESULTS OF THE SURVEY

Out of the original sample of 200 households, 124 respondents answered the survey, 58 persons refused to participate, and 18 households were unreachable. Approximately 58% of the persons answering the telephone were women and 42% were men. Using a method of response rate calculation which allows for the exclusion of noneligible and nonreachable respondents from consideration (Dillman, 1978), the overall response rate for this survey was 68%.\textsuperscript{2} The difference between response rates of women and men was minimal, 69% and 67% respectively. The two prominent reasons given for non-participation in the survey were lack of interest in survey subject and lack of available time.

The data suggest that of the 124 people who agreed to participate in the study, 68% of the respondents were aware of at least one mental health resource, 37% were aware of at least two mental health resources, and less than 9% were aware of three or more mental health resources.

\textsuperscript{2}The 95% confidence level for the response rate is $0.68 \pm 0.02143$. 
Women were more aware of mental health resources than men by 10 percentage points.

The most frequently mentioned community mental health resource within the East Valley area was the Redlands-Yucaipa Guidance Clinic Association. The most frequently mentioned county or state mental health resource was the Outpatient Program of the San Bernardino County Department of Mental Health. Table 1 indicates the percentage of respondents who were aware of specific mental health resources.

The data in Table 1 reflect the respondents' familiarity with mental health agencies. The second question in the survey elicited information about a different type of mental health resource, the crisis-hotline. Approximately 52% of the respondents indicated no knowledge or awareness of the crisis-hotlines available. Approximately 40% knew that there were hotlines in existence but did not know any of the telephone numbers or the names of any hotlines. Only 8% of the respondents were able to give specific numbers or names of hotlines.

Patterns of help sought for specific problems are illustrated in Table 2. Family-related problems were defined as problems with children, parents, marital conflicts, divorce, or widowhood. The three most frequently sought sources of help for family-related problems were a minister or church, a counselor or psychologist, and dealing with
### TABLE 1

Percentage of Respondents Familiar with Various Mental Health Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Percentage of Respondents Familiar with Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redlands-Yucaipa Guidance Clinic Assn.</td>
<td>31</td>
</tr>
<tr>
<td>Private Psychologists/Psychiatrists</td>
<td>19</td>
</tr>
<tr>
<td>Loma Linda University Medical Center</td>
<td>13</td>
</tr>
<tr>
<td>Department of Mental Health, Outpatient</td>
<td>13</td>
</tr>
<tr>
<td>Family Service Association in Redlands</td>
<td>11</td>
</tr>
<tr>
<td>High School/College Counselors</td>
<td>10</td>
</tr>
<tr>
<td>Department of Mental Health, Ward B</td>
<td>6</td>
</tr>
<tr>
<td>East Valley Mental Health Assn.</td>
<td>5</td>
</tr>
<tr>
<td>Hospitals</td>
<td>5</td>
</tr>
<tr>
<td>Ministers</td>
<td>5</td>
</tr>
<tr>
<td>Health Clinics</td>
<td>3</td>
</tr>
<tr>
<td>Physicians</td>
<td>3</td>
</tr>
<tr>
<td>Patton State Hospital</td>
<td>2</td>
</tr>
</tbody>
</table>

**Note.** Column totals more than 100% because respondents could give more than one response.
TABLE 2

Percentage of Respondents Identifying Specific Resources for Help with Three Types of Problems

<table>
<thead>
<tr>
<th>Resource Sought</th>
<th>Family-related</th>
<th>Personal</th>
<th>Physically-related</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>14</td>
<td>24</td>
<td>53</td>
</tr>
<tr>
<td>Counselor/Psychologist</td>
<td>27</td>
<td>17</td>
<td>5</td>
</tr>
<tr>
<td>Self</td>
<td>17</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Minister/Church</td>
<td>29</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Family</td>
<td>15</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td>Friends</td>
<td>11</td>
<td>17</td>
<td>-</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>5</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>Shick Center/Spa/Gym</td>
<td>-</td>
<td>-</td>
<td>9</td>
</tr>
<tr>
<td>Alcoholics Anonymous</td>
<td>-</td>
<td>-</td>
<td>7</td>
</tr>
<tr>
<td>Dept. of Public Soc. Services</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Don't Know</td>
<td>10</td>
<td>10</td>
<td>16</td>
</tr>
</tbody>
</table>

Note. Columns total more than 100% because respondents could give more than one response.
the problem themselves. Personal problems were defined as feelings of depression, nervousness, anxiety, or job/school/friendship difficulties. The three most frequently sought sources of help for personal problems were a physician, a counselor or psychologist, and a friend. Physically-related problems were defined as difficulty with sleeping, weight control, smoking, having sexual problems, and over-use of alcohol or drugs. Over half of the respondents chose their physician as the most likely source of help for these physical problems, 10% chose to deal with the problem themselves, and 9% would utilize programs such as Chick Centers for the Control of Weight/Smoking, health spas and gyms.

Some interesting sex differences occurred in the patterns of help sought for specific problems. Over 34% of the women chose a minister or church as their first resource for family-related problems, yet only 12% of the men made this same choice. A counselor or psychologist was the most frequently cited resource for family-related problems for 27% of the men; only 17% of the women stated a counselor or psychologist as their first resource for family-related problems. When faced with family-related problems, 19% of the men chose to deal with the problem themselves rather than seeking outside help while only 3% of the women indicated that they would prefer to deal with family-related problems themselves.
Utilizing a physician as the first resource for personal problems, such as feelings of depression, anxiety, nervousness, or job/school/friendship difficulties, was much more frequent for women than for men, 28% and 12% respectively. For these same personal problems, 23% of the men, as compared to only 11% of the women, chose a family member as their first resource.

For physically-related problems, such as difficulty with sleeping, weight control, smoking, having sexual problems, and over-use of alcohol or drugs, there were no sex differences. Both 53% of the men and 53% of the women indicated that a physician was their first resource for help with these physically-related problems.

Of the almost 47% of the respondents who had sought help from both traditional and non-traditional sources for emotional problems, roughly two/thirds were satisfied with the services received. Women in this study had sought assistance for emotional problems more frequently than men (53% vs. 38%). Table 3 shows the resources sought and the number of respondents who were satisfied and dissatisfied with the services received.

The next set of data analyzed was to assess whether people had difficulty finding the resources they needed. Only 17 respondents, or 14%, had either been unable to get help for a specific emotional problem or didn't know of a resource that could help with a specific problem.
**TABLE 3**

Frequency of Respondents' Reporting Satisfaction or Dissatisfaction from Utilization of Mental Health Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Number of Respondents Satisfied with Service</th>
<th>Number of Respondents Dissatisfied w/Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians/ Kaiser Hosp.</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Redlands-Yucaipa Guidance Clinic</td>
<td>12</td>
<td>0</td>
</tr>
<tr>
<td>Private Psychologists/Psychiatrists</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Family/Friends</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Minister/Bible/Prayer</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>Family Service Assn. of Redlands</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>DMH-Outpatient</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>DMH-Ward B</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Health Clinic</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>College Counselor</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>L.U.K.E. Hotline</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>792-TALK Hotline</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Senior Information and Referral</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

**Note.** The total of both columns is greater than the number of respondents who sought mental health services because some of the respondents had received services from more than one resource.
One respondent felt he had been given the "runaround" and finally discontinued looking for assistance. The other 16 respondents did not know where to seek assistance for specific problems ranging from job-related difficulties to coping with an emotional crisis on the weekend.

Securing mental health services often depends on how people feel about seeking assistance for emotional problems. Over half of the respondents, 56%, felt that most people were not comfortable seeking assistance for emotional problems. The most frequently cited reason for that discomfort was fear, including fear of the unknown as well as fear of being "crazy." Embarrassment and the inability to admit one's emotional problems were the second and third most frequently cited reasons for not seeking professional help with emotional problems. The stigma attached to mental illness, making the securing of mental health services "taboo," was the fourth most frequently cited reason for not seeking help with emotional problems. Substantially less important to the respondents were considerations such as shyness, lack of trust, and feeling admission of emotional problems to be a sign of weakness. Approximately 23% of the respondents felt that most people were comfortable seeking mental health services and another 21% were either uncertain or unwilling to make a statement of their opinion about how people feel about seeking assistance for emotional problems.
Approximately 56% of the respondents did not feel that most people are aware of mental health resources available for assistance with emotional problems and felt that advertisement and other mass media coverage should be increased. Approximately 19% of the respondents believed that most people were aware of mental health resources, and 25% were uncertain or were unable to give an opinion. Of those who were uncertain, 19% felt the educational level of the person seeking assistance would be positively correlated with that person's knowledge of mental health resources.

In summary, approximately two-thirds of the respondents were aware of at least one mental health resource but only 8% were aware of any crisis-hotlines. Women were slightly more aware of mental health resources than men by 10 percentage points. Approximately 53% of the women and 38% of the men had sought help for emotional problems. Of the 47% of the respondents who had sought help for emotional problems, roughly two-thirds were satisfied with the services received. The most common sources of help sought for emotional problems, including family-related, personal, and physically-related problems, were a physician, a counselor or psychologist, dealing the problem themselves, and a minister or church. Family and friends were the fifth and sixth most frequently cited sources for help with emotional problems. Resources for specific
types of problems varied greatly, but as a whole, women tended to seek help from ministers and physicians more frequently than men, and men sought counselors and family members more frequently than women. Only 14% of the respondents had experienced any difficulty in obtaining appropriate mental health services. Over half of the respondents felt that most people were uncomfortable seeking assistance for emotional problems and were unaware of mental health resources available.
CHAPTER VII
DISCUSSION AND IMPLICATIONS

The results of this study could be used for a variety of purposes. My primary interests, however, lie in providing information and in discussing any action implications that may be of benefit to the residents and mental health resources within the East Valley. Given the trend of environmental change and increased psychosocial stress (Coelbo and Stein, 1977), it is increasingly important that people recognize indicators of stress and emotional problems and learn new methods of coping when their basic emotional and psychological needs are severely frustrated under conditions of rapid sociocultural change. Because of this almost daily frustration, it would be instructive for the reader to know what services are available in the East Valley before considering issues centering on their utilization.

Conceivably, a respondent could have mentioned all of the mental health services available in the East Valley area. The Redlands-Yucaipa Guidance Clinic Association (RYGCA), established in 1969, is the only community mental health center in the East Valley area as defined by the
Community Mental Health Centers Act of 1963. RYGCA provides marriage and family counseling, child and adolescent services, geriatric services, crisis intervention, drug detoxification and counseling, drug counseling/education/information for adolescents, a school-based counselor program, psychiatric evaluation and consultation, and community mental health consultation. The Family Service Association of Redlands provides a variety of supportive services to families in need, counseling services being only one of their services. The Loma Linda University Medical Center, as its name implies, is a university and a medical center. Mental health services through the Departments of Psychiatry and Marriage, Family, and Child Counseling are available to the community. The Johnston Centre is a training program for graduate students in Humanistic and Transpersonal Psychology which offers counseling and personal growth-oriented services, many times utilizing the arts and humanities, such as music, art, dance, and movement, as therapeutic modalities. The Christian Counseling Service offers counseling services with the basic philosophy that the resolution of emotional problems must take into consideration the physical, emotional, and spiritual components of the person. The Women's Resource Center of the YWCA offers paraprofessional counseling for women experiencing transitions in their lives and who
could benefit from the support of other women. Two local crisis-hotlines, 792-TALK and L.U.K.E., are available to East Valley residents, as well as other hotlines based in San Bernardino.

There are essentially two indirect service providers within the East Valley. The East Valley Mental Health Association provides information and referral services, education programs, consultation to other agencies, and other services designed to prevent the onset of debilitating emotional problems and promote a higher level of wellness for persons in the community. The Coalition for the Prevention of Abuse to Women and Children provides the same type of indirect services for victims of domestic violence and to agencies/organizations concerned with domestic violence.

In addition to the aforementioned community mental health resources, respondents could have mentioned private psychologists and psychiatrists (either by name or title), county and state agencies, and numerous other resources which are not exclusively mental health resources.

The data reported in Chapter VI suggest that over half of the residents within the East Valley area are aware of at least one mental health resource in their community and that another 15% are aware of a resource that, while perhaps not usually thought of as a mental health resource, could serve as a referral source for a
more conventional mental health service. At first glance, this level of awareness of mental health services looks impressive; however, when consideration is given to the number of people who are aware of various alternatives, the original optimism is diminished. For example, imagine a city with approximately 84,000 people and 15 to 20 restaurants, all of which serve different types of food. For each ten people in the community, only one person knows of three or four of those restaurants, three people know of two restaurants, another three people know of only one restaurant, and the last three people don't even know there are any restaurants in town! Only one person out of ten really has much choice as to what type of food she/he would like to have if she/he would like to eat out. This lack of choice, or lack of knowledge about alternatives, parallels the limited awareness of alternatives in mental health services among East Valley residents. If the emerging trend of this sample is true of other parts of the nation, then relatively few people in our nation are aware of the different types of mental health services available for help with emotional problems.

The data suggest that the community's awareness of crisis-hotlines is substantially less than the awareness of mental health facilities. Since many agencies are only open 8 to 12 hours per day on weekdays and are often closed on weekends and holidays, the person experiencing problems
during the non-business hours is left with minimal resources. For those having severe emotional crises during these non-business hours, the most frequently used resources are the emergency rooms of hospitals which serve as screening devices for those needing psychiatric hospitalization. However, there is little recourse for the person experiencing emotional difficulties who does not require psychiatric hospitalization. Crisis-hotlines can be a viable resource, but only if the public is aware of the hotlines' existence. In the present sample, 52% of the respondents had no knowledge of the existence of any hotlines. Approximately 40% of the respondents knew there were hotlines, but were unable to give a telephone number or name or to mention key words, such as suicide, crisis intervention, or rape, which would give the respondent some clue as to how to locate the hotline number in the telephone directory. Only 8% of the respondents were able to give specific numbers or names of crisis-hotlines. Since emotional problems and/or crises can occur at any given point in time, and not just during regular business hours, it seems crucial that people have some knowledge of where they can receive help during non-business hours.

The community's lack of awareness of the variety of mental health resources seems to indicate that most mental health resources have rather low visibility. It is reasonable to think that some mental health resources
within the East Valley, such as the Family Service Association of Redlands and the Loma Linda University Medical Center, are not easily recognized as providers of mental health services because mental health services are not their primary focus. For other resources, such as the East Valley Mental Health Association, the Coalition for the Prevention of Abuse to Women and Children, Johnston Centre, and the Christian Counseling Service, all of which have been established within the past two years, their newness may be responsible for their low visibility among people seeking help with emotional problems.

Perhaps another reason why some resources were not originally mentioned by the respondents was user dissatisfaction with the mental health services received. Approximately one-third of the respondents who indicated they had sought help for emotional problems were dissatisfied with the help they received. All four of the respondents that had received care at the Department of Mental Health, Ward B, expressed dissatisfaction with the care they received. Reasons for the dissatisfaction included feeling frightened, being mistreated, and not being informed by the staff as to what was happening to them. Reasons given for dissatisfaction with services received through the Family Service Association of Redlands and private psychologists and psychiatrists were feelings that the therapists did not really care about the respondents
and that the problems for which they were seeking help did not cease. Reasons for dissatisfaction with crisis-hotlines were generally that the hotline counselors were not helpful. While any broad conclusions or implications about the dissatisfaction of mental health services received is limited due to the small sample size of those respondents who indicated dissatisfaction, the data may suggest that the services previously mentioned may need to upgrade the quality of service provided. However, the reader is cautioned to the fact that dissatisfaction with services rendered may also be an indication of client irresponsibility.

The data strongly suggest that the community's lack of awareness of mental health resources is a result of low visibility. One of the most effective means of increasing an agency's visibility is through the mass media. A mass media campaign might include news articles, radio/TV spots, the placing of posters in strategic locations, media interviews, and mass mailings. One community mental health center decided to use the newspaper as a means of increasing the center's visibility and conducted a street survey to determine the effect of the publicity (Morrison and Libow, 1977). Before any newspaper publicity was initiated, the researchers developed a Visibility Survey Instrument and selected a sample of 105 people who were by chance on the main street of the
community at the time the survey was given. During this initial phase of the research, 28.6% of the sample had heard of the center, 17.1% knew of the center's location, and 13.3% had knowledge as to what services the center provided. Phase Two of the study involved newspaper publicity about the center and another "accidental sample" of 100 persons. The percentage of people who had heard of the center during Phase Two increased to 53%; 33% knew of the center's location, and 27% had knowledge of the services offered. Six weeks later the researchers entered Phase Three and again surveyed a street sample of 106 people and found that 49.1% knew of the center, 22.6% knew of the center's location, and 27.4% had knowledge of the services offered by the center. The results of the Morrison and Libow study indicate that community mental health centers with low visibility in the community can drastically increase that visibility through the use of the media and that the publicity effect on visibility is generally quite stable. It is reasonable to speculate that media publicity would result in increased visibility for other mental health resources as well. Accordingly, I intend to suggest to various agencies the benefits that may be derived from increased media publicity.

The results of the study also seem to indicate that there is a need for increased provision of indirect services, i.e., consultation, education, and information.
Due to the large percentage of people who seek physicians and ministers for help with emotional problems, a program designed to inform physicians and ministers of mental health issues and the numerous alternatives in mental health resources could prove effective in assuring that the person needing the mental health services received an appropriate referral. The data also suggest that people in need of mental health services frequently seek out friends, family, and often choose to handle the problem themselves. In fact, the results of this study may even be an underestimate of the frequency of friends, family, and self as mental health resources because of some respondents' lack of perception of these resources as "help for emotional problems." The data suggests a need for education programs designed to teach people new methods of coping with stress, methods of helping friends and family members in periods of crises, and how to build natural support systems that could help them deal more effectively with their problems. Kaplan (1974) emphasizes the importance of support systems and describes them as the health-promoting forces at the person-to-person and social levels which enable people to master the challenges and stresses of their lives.

Further evidence of the need for escalated consultation, education, and information services is the finding that fear is one of the primary reasons why most people
do not feel comfortable seeking assistance for emotional problems. Not only is fear a factor, but also embarrassment, inability to admit one's emotional problems, and the stigma attached to mental illness. The impetus of the community mental health movement was to provide the most appropriate care in the least restrictive setting, allowing people to live at home and receive outpatient treatment in the community. Adequate attention was perhaps not given to preparing the community for the de-institutionalization of mental patients. Lacking the appropriate knowledge, the community's fear of mental illness and "crazy" people increased. The implication is that in order to decrease people's fear and uncomfortableness about seeking help for emotional problems, education and information about mental health and mental illness must be more readily available.

Any broad implications as a result of sex differences found in the study are extremely limited due to sex differences being specifically related to the type of emotional problem and/or type of resource. However, the consideration of one general tendency may be instrumental in the designing of programs. While women tend to seek assistance for emotional problems more frequently than men, women also tend to seek physicians and ministers more frequently than men. This may be an indication of women's tendency to not see emotional problems as
psychologically based, but rather related to physical and spiritual aspects of their lives. This finding may also be an indication that women still tend to seek out external strength through the advice and guidance of the "fathers" of our society rather than build internal strength and guidance with the assistance of a counselor. Further research is required of differences in women's and men's perceptions of emotional problems before any definitive statements can be drawn.

Subjectively, I would like to make a few comments about my interviewing experiences. As a whole, the interviews were pleasant and rewarding. One unexplained phenomena was the high incidence (80%) of men answering the telephone from the 796- prefix area. To my surprise, elderly respondents were generally cooperative and interested in the survey. Some respondents were very open and intimate and sought answers and/or referrals for some of their emotional problems. I am extremely appreciative of those respondents who took the risk of expressing skepticism, intrigue, and concern.

One of the "fall out" benefits of this study arises from my being in a position to carry out some of the implications of the study. As Executive Director of the East Valley Mental Health Association, a non-profit, volunteer organization concerned with promoting mental health, preventing mental illness, and working towards
the improvement of mental health services, I am in a position to advise under-utilized agencies of their lack of visibility in the community, especially as that visibility relates to men and women and certain problems. Additionally, the association will be able to design some of its education and information programs to meet some of the needs identified by this project.

For every human service program, there are several parties to consider, each with different interests and concerns. Any research into human services must take into account the clients, staff, management, sponsors, and the community. To do so requires an untraditional methodology, that of a second-person or communal research party, which can balance the considerations of intrusions against those of bias (Krause, 1976). Considering the action implications of the data, sequentially staging the research, or even publishing the findings, becomes a highly political process "often unlikely to be logically decisive about intervariable relationships, to yield generalizable results, or even to be completed." (p. 291). This project was only one small step in researching community awareness and utilization of mental health services, patterns of help sought for specific emotional problems, and current attitudes about seeking assistance for emotional problems. Each of these three issues needs to be a separate research project within the near future.
APPENDIX A

COMMUNITY AWARENESS SURVEY

<table>
<thead>
<tr>
<th>TIME PERIOD:</th>
<th>D</th>
<th>E</th>
<th>W</th>
<th>D</th>
<th>E</th>
<th>W</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviewed by</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>M</td>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Do you know about any of the places in this area where people can go to get help for emotional problems?

   - RYGCA
   - DMH, OUTPATIENT
   - FAMILY SERVICE ASSN.
   - DMH, WARD B
   - LOMA LINDA UNIV.
   - PATTON
   - EAST VALLEY MHA
   - HOSPITAL
   - JOHNSTON CENTRE
   - CHRISTIAN COUNSELING
   - PRIVATE PSYCHOLOGISTS/PSYCHIATRIST

2. Do you know about any of the crisis-hotlines in this area?

   - 792-TALK
   - 88-MITTY
   - L.U.K.E.
   - OTHER

   YES, BUT DON'T KNOW
   # OR NAME
3. If you wanted help with any of the following problems, who do you think you would see or talk to?

| Family-related problems (such as problems w/ children, parents, marital, divorce, widowhood) | COUNSELOR | PSYCHIATRIST | PHYSICIAN | MINISTER | FAMILY | FRIENDS | SELF | OTHER |
| Personal problems (such as feelings of depression, anxiety, nervousness, job/school/friendship difficulties) | | | | | | | | |
| Physically-related prob. (such as difficulty sleeping, weight control, smoking, having sexual prob., over-use of alcohol/drugs) | | | | | | | | |

(RANK ORDER IF APPLICABLE)

4. Can you tell me if you have ever received help for emotional problems, and if so, how do you feel about the services you received?

__Satisfied__ DISSATISFIED

RESOURCE ________________________________

5. Have you ever had an emotional problem

__NO

A) YOU WERE UNABLE TO GET HELP FOR or
B) DIDN'T KNOW WHERE TO GO FOR HELP?

Type of problem ________________________________
6. Do you think that most people feel okay about getting help for emotional problems?

___YES  ___NO → Do you have any thoughts as to why?

___UNCERTAIN

___AFRAID     ___STIGMA

___EMBARRASSED ___

7. Do you think most people know where to get help for emotional problems?

___YES  ___UNCERTAIN  ___NO

COMMENTS________________________________________________________

_______________________________________________________________

DEBRIEFING QUESTIONS OR COMMENTS:

MAIL SUMMARY TO:

_______________________________________________________________
APPENDIX B

INTRODUCTORY AND DEBRIEFING COMMENTS

Introduction to Respondents

Hi, my name is Carolyn Tjoland, and I'm a graduate student from the State College in San Bernardino. I'm doing a study on how people get help for emotional problems, and I wonder if you have about 3 or 4 minutes to help out with the study?

YES → NO Is there another time that might be more convenient for you?

Okay, thank you. I have seven questions I would like to ask you and if at any time you would like to pass on any of the questions, please feel free to do so, okay?

Closure and Debriefing

I really want to thank you for taking the time to answer the questions and for sharing your opinions. Are there any questions you would like to ask or comments you would like to make? (RECORD)

We hope that the results of this study will be useful in improving the services available in our community. Would you like to receive a summary of the results? (GET ADDRESS FOR MAILING)

Thanks again for participating in our study.
REFERENCES


