A MACRO LEVEL NEEDS ASSESSMENT FOR A COMMUNITY MENTAL HEALTH AGENCY

A Dissertation

Presented to

the Faculty of the Department of Psychology

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In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

By

Mary Alice Conroy

December, 1976

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ABSTRACT

The present study was designed to assess the mental health needs of children in a large urban area. This was done by contacting three groups of people connected with Children's Mental Health Services (CMHS) in Houston, Texas. Specifically, the investigator solicited the opinions of those served (or potentially served) by the agency, service professionals from the agency, and mental health professionals from the community at large. A two-step Focus Delphi technique was utilized to determine areas of agreement and disagreement among these individuals about important characteristics of mental health in children, mental health problems of children in Houston, and possible solutions to the existing problems. Specifically, this procedure involved contacting a total of 102 individuals and administering an open-ended interview soliciting their ideas about the three areas under investigation. Once these data had been gathered, all of the ideas were compiled and condensed into three lists, corresponding to the three major topics. These lists were then mailed back to the 102 subjects in the form of a questionnaire, asking them to respond to each idea on a scale and to indicate which ideas they considered to be most important.

Opinions from the entire sample indicated that self awareness and a positive self image were generally considered to be the most important elements of mental health in children. Other mental health characteristics stressed included independence, responsibility, and the capacity to form warm,

trusting relationships with family and friends. Least emphasis was placed upon caution, religiosity, ambitiousness, and good grooming.

Mental health needs eliciting greatest concern were lack of self awareness and negative self images among children. Also emphasized frequently were problems of physical and sexual abuse of children, as well as children feeling generally unloved. Relatively little concern was voiced about bedwetting, inter-racial strife among children, sexual acting out, financial difficulties in families, and a need for increased discipline.

An increase in convenient, low cost mental health facilities was most widely believed to be a necessary solution. Additional training for school personnel in dealing with problem children and mental health teams working in schools were also stressed. On the other hand, relatively few respondents emphasized more bilingual mental health services, family life education, better law enforcement, home and school visits by mental health professionals, censorship of media for children, or additional church activities.

All three areas evidenced some disagreement between mental health professionals and community parents. In terms of positive mental health parents stressed discipline, honesty, and industriousness more strongly while professionals were more concerned with fostering independence and a sense of responsibility. Parents were significantly more adamant

about problems of drug abuse, inadequate law enforcement, and poor school performance by their children, while professionals put greater stress on problems of parental awareness and understanding of children. In addition, parents place more emphasis on potential solutions which involved censorship and control, whereas professionals asked more often for family life education programs.

Four additional areas received brief treatment in the study: (a) an overview of opinions expressed by CMHS staff members, (b) a compilation of agencies and services actually utilized by respondents, (c) a critique of this particular method of needs assessment, and (d) specific program recommendations for CMHS based upon the present findings.

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CHAPTER I

INTRODUCTION AND STATEMENT OF THE PROBLEM

The term "program evaluation" is heard frequently today in groups of behavioral scientists, as well as among planners and practitioners involved in contemporary social action movements. Evaluation in this context can be loosely defined as the process by which one determines the value or amount of success one has achieved in meeting some predetermined objectives (Bloom, 1972). Such activities have come more into prominence over the last several years, as it has become increasingly difficult to obtain such things as renewed funding unless one can demonstrate some positive, verifiable results obtained by the program in question.

The strong association between program evaluation and community mental health services first came into being in May, 1963, when President John F. Kennedy delivered his message to Congress calling for the establishment of a program to meet the mental health needs of communities around the nation. The result of this was the Community Mental Health Centers Act of 1963 (Title II of Public Law 88-164), which mandated the federal government to supply two-thirds of the funding needed for construction of such facilities to serve catchment areas with populations between 75,000 and 200,000. To qualify for funds states were first required to survey the needs of communities and set priorities for meeting these needs. The underlying assumption expressed by the law

was that "mental health professionals are accountable to the communities they serve" (Roen, 1971, p. 777). By December 31, 1968, 351 programs had applied for funding, and by 1970, 245 centers were in operation ("Research Aspects," 1971). It should be further noted that these figures include only those programs funded under the Community Mental Health Centers Act and would be a gross underestimation of the total number of community mental health centers operating in the United States.

Given the speed with which the community mental health movement has developed, there is concern in some quarters as to its actual effectiveness in meeting community needs. Fried (1968) expressed some general feelings when he said that "the vast and rapid impact of community mental health programs suggests that the spread of interest was as much ideological as it was a realistic response to realistic gaps in services" (p. 42). Empirical data on actually analyzing and meeting community needs take on increasing importance when one considers, not only the cost in man hours, but the cost in dollars and cents to the tax payer. For example, in the state of Californaia the budget for direct mental health services increased an average of 12% per year between 1968-69 and 1972-73 (Rappaport, 1973).

Explicit in the original legislation is the idea that before any conclusions may be reached on whether some program is meeting community needs, it is first necessary to assess carefully exactly what those needs are in the particular

communities involved. Both the requirement for such assessment and methods to be used have been receiving increased attention among educational agencies throughout the United States. Formal educational needs assessments at the state level have been conducted in Washington, Wisconsin, Pennsylvania, Utah, Michigan, Alabama, Montana, Tennessee, Minnesota, and Colorado; in California virtually every county has conducted some formal delineation of needs. Researchers have employed methods ranging from questionnaires completed by teachers, educators, community leaders, and learners to the empirical measurement of learner preformance in specific areas.

Turning to the area of mental health, the researcher is frequently confronted with a much more amorphous area of study. Problems and needs are more difficult to define in concrete, measurable terms in many instances. Although the title "mental health services" is widely used, no generally agreed upon criteria of what constitutes "mental health" has yet been established.

Mental health planners all too frequently analyze and compare familiar "solutions" rather than analyzing "needs". Smith complained in 1974 that too "many organizations start out with solutions and find problems which fit them" (p. 58). For example, the proposition that a city "needs" another outpatient psychiatric clinic is really a statement of solution rather than of need. It suggests that there are certain

needs within the society, and the psychiatric clinic is one possible way they might be met. However, in defining the solution as the need, the planner precludes thinking about other possible solutions which might be more effective or desirable.

Kaufman (1972), in discussing a systems approach to evaluation and planning defines need in terms of some discrepancy which is known to exist:

> The identification of needs is a discrepancy analysis that identifies two polar positions of: Where are we now? Where are we to be? And, thus, specifies the measurable discrepancy (or distance) between these two poles. (p.23)

Needs, then, can be viewed as gaps between the way things are now and the way we would like them to be. Discovering the defining such gaps in mental health in a meaningful way requires looking very carefully at the population intended to be served.

Caro (1971) posed the question: Who do planners and evaluators serve? The practitioner? The recipient? The public? Mackler (1974) contended that program evaluation should be set up to serve the public and not the policy makers, who generally set the "official" goals. Kaufman (1972) considers it essential to look at a program from all three of these perspectives. To do otherwise is to risk serious bias in assessing significant aspects of the situation. Kaufman went on to make a comment concerning values, which is as applicable to mental health as it is to education:

> A fundamental assumption of educational system planning is that it is a human and humane process that starts in a context of values and valuing and derives its successes and failures in terms of the extent to which any plan is responsive to individual people with unique patterns of values. (p. 32)

If a community mental health service is to take into consideration the individual people and unique value patterns within the domain of its service, it must examine three components: the community at large, those in the community who are directly served, and those who render the service. For a needs assessment to be considered adequate, discrepancies must be investigated as they are perceived by all three segments, and some attempt must be made to resolve conflicts. In order to proceed, some agreement must be reached, not only on the content of various needs, but also on reasonable priorities. This is not to say that the researcher aims for any ultimate consensus, as different subpopulations realistically do have different needs. Rather the purpose is to discover areas of agreement where they in fact exist and to clarify points of significant difference.

Thus far in the discussion reference has frequently been made to a needs assessment, and this is actually a misnomer. Given the dynamic structure of contemporary society, needs assessment for a mental health service is never a single act occurring at one specific time. If the service is to be on-going, then the assessment of community needs must also be on-going. As Seigel and Cohn pointed out in 1974:

"Assessment is useful in established programs as part of a periodic examination of the relevance of existing service programs to changing mental health needs and priorities in given communities" (p. 9). Both the agency and the community are constantly changing and for information on needs to be current it must be continually re-collected and reevaluated. Such a procedure can be essential in answering such questions as: What problems are diminishing? What resources can now be freed? Weiss (1971) suggested that an annual needs assessment be conducted by community agencies for three purposes: (a) to gain feedback on previous findings, (b) to discover if needs are changing, and (c) to investigate new needs.

From the foregoing it is clear that several very important benefits can be derived from a well conducted needs assessment: (a) the service or agency would acquire valuable information on the needs within the community it is to serve, (b) information would be made available on variations in perceptions of needs among sub-groups and what priorities various groups place upon these needs, (c) contacting community members directly would hopefully increase community participation in utilizing and improving mental health services, and (d) an initial needs assessment could result in the development of instruments and techniques which could be reapplied at different times and on larger segments of the population. Information obtained in such a study could be utilized by the agency in a number of ways, including: (a) determining

what additional services would be most valuable to the community, (b) deciding the best ways to revise or expand existing programs, (c) changing attitudes or emphasis within existent programs, (d) finding ways to establish stronger ties between the agency and the community, or (e) deciding upon community education programs concerning services offered.

CHAPTER II

REVIEW OF THE LITERATURE

To formalize an adequate plan for a community mental health needs assessment it is necessary to integrate concepts from several areas of thought. The review of literature will be divided into two major sections: (a) mental health needs assessment as it currently stands and (b) new techniques and approaches to the problem. The first section will cover general issues of defining mental health and mental health needs, research approaches which have been used, and problems still to be solved. The second section will examine a recently developed technique which holds promise in this area.

Mental Health Needs Assessment

A community mental health needs assessment, as it has been described, involves ascertaining what constitutes mental health (what ought to be) and then determining what gaps exist between mental health and the current situation. Although the term "mental health" is commonly used, its definition seems very elusive, even to the mental health professional. Sells (1968) conducted a symposium in which he asked ten renowned mental health professionals to define the term. He found that the majority were much more comfortable speaking in terms of mental illness, and only five of the ten were able to produce any definition of mental health. However, Schulberg and

Wechsler (1967) have pointed out that even mental illness is poorly defined, despite federal regulations which call for the assessment of need in terms of prevalence of mental illness and emotional disturbance. A review of studies espousing various concepts of mental illness carried out by Scott in 1968 found the concepts generally inadequate and mutually incompatible. The validity of the mental health/mental illness construct was again questioned by Seigel and Cohn in 1974.

Marie Jahoda, completing an extensive work on the concept of mental health in 1958, concluded that no one had the answer to the question of what characterizes mental health; yet she felt strongly that there was a need for a realistic definition of the concept to aid in the development of goals and techniques for achieving it. Three specific reasons for seeking such a definition were supplied by Sells: "(a) to recognize disordered function, (b) to devise more realistic goals for therapy than we have at present, and (c) also to take improved measures for prevention of illness" (p. 242).

Despite the advantages of a generally accepted definition of mental health, the feasibility of establishing a permanent or universal definition seems doubtful. Mental health is neither a unitary nor a static dimension (Clausen, 1968). A picture of mental health is rather a complex gestalt, which is subject to change with circumstances. The concept itself is seen as an inherently evaluative one. The criteria

for it have either the status of values or are derivatives of implicit values (Smith, 1969). As a value, mental health is also inherently culture bound (Jahoda, 1958; Scott, 1968; Sells, 1968; Smith, 1969).

Scott contends that contemporary criteria for mental hygiene are derived from the Protestant Ethic and very biased toward the middle class culture. But he admits that any other set of absolute norms would simply make the concept biased toward some other configuration. Given this dilemma, Smith concludes that,

> at least at the present stage of personality theory, "mental health" should not be regarded as a theoretical concept at all, but as a rubric or chapter heading under which falls a variety of evaluative concerns. (p. 181)

In the same vein Jahoda (1958) cautions that "the search for the values underlying mental health need not involve one in the megalomaniacal task of blue-printing the values of the distant future, or all civilizations" (p. 78). Finally, Sells (1968) points out that "data on normal mental function would be of greatest social value if conceived in the frame of reference of human living in characteristic human environmental relationships" (p. 242).

It would seem consistent, then, with each of these points of view to conceive of any culture or subculture generating its own set of elements which, given the time and circumstances, would be considered as characteristics of good mental hygiene. In order to promote mental health in a particular

setting it would first be necessary to determine what mental health is in that setting, and only then would it be possible to determine what is needed to maximize it.

The importance of allotting time to mental health needs assessment has become widely recognized in the last decade (Beigel, 1970a). Yet the situation which currently exists "may be described as the continual setting of priorities at every level of the educational decision-making hierarchy on the basis of information that is largely insufficient" (Sweigert, 1971, p. 316). This statement is equally applicable to the mental health field. Hochbaum (1969) contends that efforts have been concentrated on increasing services and increasing the general accessibility of these services. Goals include more services, which are more conveniently located, and which can be delivered at less cost. Bloom (1966), for example, developed a rather elaborate multivariate approach to social indicators in identifying "high risk" groups, principally for the purpose of determining <u>where</u> to put mental health facilities. In terms of needs assessment from a systems perspective this approach would be viewed as concentrating on solutions rather than determining real needs.

Health professionals frequently feel that <u>they</u> are the experts on people's mental health needs, and they know how to meet them, given the necessary resources (Hochbaum, 1969). Even with increasing emphasis on so-called "accountability"

the question remains: Accountable to whom? Freed pointed out in 1972 that "most schemes for promoting accountability attempt to make Center management more accountable to higher levels of bureaucracy, or to funding sources" (p. 762). There is some idea that in some sense these funding sources are in turn ultimately responsible to the public, but in reality, few avenues exist for the consumer to make his needs known to the mental health profession. Schneiderman (1968) expressed concern over what he termed the "inadequate knowledge base" which results when middle class standards are used in defining goals for services and would support moving away from such a base. Specifically, he said that,

> As students of human behavior and professionals living and working in a political democracy committed to services based on need alone, it is essential that we move away from the Ptolemaic assumption of the universality of our own middle class values. (p. 555)

The importance of assessing the needs as they actually exist in the community increases as the cultural gap between the server and the served increases. A mental health professional is much less likely to have a realistic understanding of the needs of members of another culture or subculture, than of the needs of his own community or cultural group. Barbara Lerner (1972), following a five year research project in which she worked primarily with Black ghetto residents, harshly criticized those who approach the lower socioeconomic classes by trying to impose their ideas.

> Ghetto institutions are generally administered by officials who are neither representative of nor responsive to the people they are supposed to serve. These officials are usually white "experts" who live outside the Black community and do not share decision-making with local residents, although nowadays, they sometimes ask selected residents to rubber stamp their decisions after the fact. This failure to share decision-making cuts off the possibility of open communication, and without open communication shared decision-making is impossible. (p. 8-9)

She went on to describe what she had observed to be the outcome of such practices:

> Officials feel maligned and mistreated, increasingly isolated in an unreasoning hostile world--after all, they are only trying to do what is "best" for the community; residents feel increasingly frustrated, deprecated, and enraged--after all, they are only trying to get some "decent" service. (p. 9)

The basic problem, as Lerner viewed it, was,

> Experts too often attempt to mold people into an elite image of what is desirable instead of serving them in their attempt to develop and implement their own image of themselves and the world. (p. 11)

An adequate needs assessment for a community mental health service requires collecting several types of information. Planners need to know how many and what types of people are to be served, specifically what their particular needs are, what impact existing provisions are having on those needs, and what needs are going unmet (Hailey, Wing, & Wing, 1970). Many of the methods employed by researchers to date have supplied only limited, and often very abstract, information on these issues.

One of the most basic methods which has been used in an attempt to assess mental health needs is that of examining demographic and census data. It has frequently been suggested that researchers need to pinpoint segments of the population which are at high risk for mental disorder (Gruenberg & Brandon, 1964; Pollack, 1968). Rosen (1974) explained how demographic characteristics of areas may be obtained from the National Institute of Mental Health Mental Health Demographic Profile System. This file, originally extracted from 1970 census data, offers catchment area profiles for regions throughout the United States. Profiles include information on socioeconomic class, ethnic composition, household composition and family structure, style of life, condition of housing, and community stability, as well as data on the age, sex, race, and marital status of area residents. Detailed methodology in this area has been described by Stewart and Poaster in 1975. Based upon this information high risk groups can then be identified in terms of problems most commonly found among these particular populations. It is also possible to estimate percentages of unmet needs by comparing the percentages of certain groups receiving service in an area to national averages for these groups.

It should be noted that demographic profile data lacks several elements essential to adequate needs assessment. Rosen herself has admitted that these are gross measurements and most useful in making decisions on where mental health facilities should be located rather than on what types of

services should be offered. In addition, Windle, Rosen, Goldsmith, and Shambaugh pointed out in 1975 that these data, although inexpensive "do not give a precise measure of the prevalence of mental disorders, nor are the 1970 data contained in the system fully up to date" (p. 75). These same authors further noted that "these data do not reflect local attitudes toward mental health problems and services, which are crucial to responsible planning" (p. 76).

As an agent for the Division of Community Services of the Connecticut State Department of Mental Health, Cobb used demographic data to determine populations at high risk. He compiled profiles using statistics from the Rockland State Hospital data system, the U. S. Census Bureau, health and welfare departments, and University of Connecticut research studies (Cobb, 1971). In 1972, Fowler and Pullman developed an index of need for mental health services for the Los Angeles area. This was done by taking the 15 variables most frequent in epidemiological literature as need indicators (e.g. poverty, alcoholism, crowding) and computing a percentage for each region on each variable.

Other researchers have viewed the problem from the local level. In 1968, Levy, Herzog, and Slokin approached the problem by examining community statistics concerning (a) rates of extrusion (e.g. imprisonment, hospitalization), (b) rates of antisocial acts, (c) reduction in competence, and (d) rates of social disorganization (e.g. poverty, riots). Goldsmith and Unger have adapted this procedure for use in

identifying subpopulations at high risk in inner city areas.

Seigel and Cohn (1974) indicated some of the basic flaws in the social indicator method when they said:

> Correlations of social and health indicators with mental illness are not well established--and even when they are, what the correlations mean or indicate remains cloudy. For example, inspite of the fact that the role of social class and socioeconomic status in the etiology of mental illness has been studied so often, no firm assertion can be made regarding the relationship of social factors to mental illness. (p. 19)

Lapouse (1967) further remarked that until diagnostic criteria can be adequately standardized the validity of any type of prevalence study is highly questionable. Finally, Sorkin, Weeks, and Freitag, although themselves users of social indicators in measuring need, admitted in 1973 that,

> Until there are more sophisticated and valid measures of prevalency, especially in the field of mental health, indicators are best thought of as relative measures of a social condition--as a need for mental health services. (p. 5)

Some researchers interested in a broad statistical approach across populations have concentrated specifically on mental health service data for their information. In his description and defense of epidemiological methods for studying need, Kramer (1967) recommended thorough study of patient characteristics, state mental hospital discharge rates, national data on the utilization of mental hospitals and outpatient services, as well as the use of psychiatric case registers. Lemkau (1967) advocated the use of hospital and

institution statistics, as well as psychiatric case registers, to compare services from one community to the next, and from this comparison decide if services are adequately meeting needs. A very specific reason is given by Lemkau for preferring this mode of needs assessment: he feels that a basic problem of needs assessment comes in dealing with uneducated, unsophisticated people who do not understand their own needs. In 1975, Windle et al. alluded to "findings that minority races and the poor lack the skills to recognize and present their problems effectively to care-giving agencies" (p. 75).

The methods advocated by Kramer and Lemkau are actually among the most widely used for needs assessment purposes. Osterweil (1967) noted that the mental health indices used most frequently in state plans under the Community Mental Health Centers Act are (a) admissions to state hospitals, (b) resident patients in state hospitals, and (c) admissions to beds in psychiatric wards of general hospitals, as well as those receiving outpatient psychiatric care through these facilities. For example, Mesnikoff, Spitzer, and Endicott (1967) reported the use of admission statistics and demographic data gathered at the time of admissions as important indicators of need at the Washington Heights Community Service of New York State Psychiatric Institute. Temple University Community Mental Health Center in North Philadelphia studied mental health service utilization and basically defined "meeting needs" as "reaching with service"

(Berger and Gardner, 1970). The use of a psychiatric case register by a London mental health service supplied statistics on the current psychiatric population which were then used for forecasting future needs (Hailey et al., 1970). In 1970, Grenny completed a study of Solano County's mental health needs using hospital admission rates, statistics on the use of alternative services, and demographic data on the population as a whole. The major results reported were as follows: great disparity existed among various areas of the county in the use of public mental health facilities, greatest need was concentrated in areas of Vallejo adjacent to old down-town, more problems occurred among younger people then among older members of the population, and the number of alcoholics in the population was relatively high. These results are typical of those gathered by researchers using service statistics.

It seems clear that, with the possible exception of Grenny's information on alcoholism, the data generally indicate <u>where</u> the needs are rather than <u>what</u> the needs are. Although this is most certainly valuable information, more data would be required before the best course of action could be determined. A further question is raised by Schulberg and Wechsler (1967) as to what rates of hospitalization and outpatient service really mean in terms of community mental health needs. They pointed out that "the area may have low utilization rates because it has few facilities

or because currently existing facilities are not designed to meet the needs of the population" (p. 391). Seigel and Cohn summarized the case against service statistics well, when they said in 1974:

> If many more people are requesting specific services than service resources are able to provide, a prima facie case is made that there is a need for an increase in the delivery of those services. Likewise, a case can be made for the reduction of services that are under utilized. While we consider this technique an important element in a broader assessment strategy, there are a few caveats against using this approach alone to assess service needs. For example, a service, even though well utilized, is not necessarily addressing a high priority need in the community. It may be that the service is well publicized or inexpensive, or one of the only services available. Possibly the various professionals in the community are unaware of alternative services. Similarly, services addressing high priority problems may be under utilized because they are unpublicized or because client referral procedures are too cumbersome. (p. 51)

Whatever the real problems are, they cannot be determined from the study of utilization rates, and so the question of exactly what the needs are remains open.

Certain clinical methods have been used in combination with statistics in gathering information about mental health needs. As early as 1961, Pasamanick reported using a stratified sample of the population in question and administering thorough clinical evaluations. He then combined this data with studies on premature infants, rates of institutionalization, and Veterans' Administration statistics to derive a rate of impairment for the population, as well as ratings

on the severity of impairments. A much less complex study was reported by Henderson in 1972. Working in a very small community in northern Canada, Henderson extracted data on community needs from the reports and impressions of consulting psychiatrists who worked with the population over a number of years. One of the most ambitious projects of this type is currently being conducted by McGinnis, Schwab, and Warheit in a Southeastern county. In a progress report given in 1973 it was described as a four year epidemiological study to determine the mental health needs of the county. A random sample consisting of 2,333 members of the county's 37,000 population was selected, and each was administered a 317 item interview schedule concerning symptoms, functioning, interpersonal relations, and aspirations. Respondents were asked to rate both their physical and mental health on a five-point scale from poor to excellent (Schwab, Warheit, & Pennell, 1973). Each schedule was then rated by three psychiatrists, rates of impairment calculated, and the results subjected to regression techniques to determine the most positive predictors. As of 1973, the authors agreed that the instrument needed further revision.

The use of such clinical methods is not without its drawbacks. Although thorough, a study such as McGinnis et al. conducted which required four years would be impractical for any agency to repeat on a regular basis. It also appears that however complex and controlled the methodology, researchers

attempting to determine amount of pathology or degree of mental health in an area are still confronted with problems of definition. In 1965 Dohrenwend and Dohrenwend reviewed over 25 studies attempting to count untreated cases of psychological disorders in communities. Problems of validity inevitably arose concerning the definition of "psychological disorder". It was concluded that there were no generally accepted criteria for mental health or mental illness, even among professionals.

Researchers wanting more information than could be gleaned from statistics or clinical interviews finally came to asking community members about community needs. Obvious community leaders and professional agencies are frequently among the first to be consulted. For example, in the early phases of the Collier County Mental Health Clinic in Naples, Florida, workers questioned community leaders and care-givers to determine community mental health needs (Lombrillo, Wiresuk, & Sherman, 1973). Others have used more formal approaches. In planning for a community mental health center, Freed and Miller (1971) began by requesting representatives of four other major care-giving institutions in the area to participate on planning committees. Community leaders recommended by members of the planning committees were then approached and and asked for their views. These in turn were asked to recommend other important figures in the community for further contacts, and this process continued until a large body of opinion was amassed. A similar

sampling technique was employed by the Pima County Alcoholism Task Force in Tucson, Arizona, in an effort to identify alcoholics and their problems (Beigel, Hunter, Tamerin, Chapin, & Lowery, 1974). The Task Force began by contacting agencies felt likely to be in contact with alcoholics, and these in turn were asked to recommend other such agencies until over 200 had been tapped. In 1971, Grenny formally surveyed a sizable group of educators, doctors, counselling agency personnel, clinic workers, and other professionals in Solano County, California. The survey instruments consisted primarily of questions about needed or desirable services (e.g. consultation services) and a brief section which required the respondent to estimate concentrations of problems by formal diagnostic categories. Little space was allotted to open ended comment.

Some effort has been made to reach beyond professional agencies and designated leaders to seek input from the broader population. One technique often recommended by planners is the use of an advisory board composed of representatives of the community to be served (Beigel, 1970a, 1970b; Freed & Miller, 1971). When a needs assessment became necessary for funding, the Sound View - Throgs Neck Community Mental Health Center in the Bronx collected opinions from a group of community members who had been connected with the center in an advisory capacity for five years (Ahmed & Stein, 1974). Their ideas, along with those of the staff and a few

community agencies, were summarized for the final assessment. One of the most extensive uses of the community advisory board concept is to be found in the development of the Woodlawn Mental Health Center in Chicago (Kellam & Schiff, 1966; Lerner, 1972). From the very earliest planning stages an advisory board of 20 persons (representatives of political, religious, and social organizations) worked with the staff of the facility. The coordinators emphasized that the staff of the center was committed to the concept of on-going needs assessment. Lerner noted that although members of the board were generally poor and poorly educated they defined needs and set priorities which ultimately called for a program of primary prevention in the school rather then the more traditional therapy approach at first envisioned by the staff.

Kellam and Schiff clearly envision needs assessment as an on-going process, continue to consult regularly with members of the advisory board, and, upon recommendation, conduct needs assessments with specific subpopulations. These assessments are also considered baseline data against which to judge the effects of interventions.

Useful though they are, however, advisory boards have limitations if they are seen as representing the community as a whole. In 1973, Flynn studied advisory boards and local participants in planning for community mental health centers in Colorado. He found that those involved in planning and participation were a circumscribed group, not representative of the general population, and that this same group of people

tended to also be on planning and advisory boards for other community activities. This suggests the possibility that "advisory boards" form a specific population sub-group of their own, and therefore a cross-section of community opinion would require a much broader sample. Freed (1972) further suggested that a group of people working with an agency over a period of time naturally become a part of that agency, ingrained with many of its viewpoints, and therefore less representative of the community which has not had such contact. Seigel and Cohn (1974) noted from their own field experience with over 60 mental health programs that most advisory boards served principally as reactors to programs already developed by the staff and administration of the facility.

Efforts have been made on a few occasions to contact the community at large. A very informal approach was taken by Clausen and Elman in their work with New York's Mobilization for Youth Program in 1967. They began by setting up a series of neighborhood storefront centers in New York City's Lower East Side. These operated on a walk-in basis, and residents of the neighborhood were encouraged to come in and explain their problems (whatever they might be) to the staff. After some months patterns were seen in the problems being presented and an advocacy program was set up to meet these needs. A more formal study, utilizing more stringent sampling procedures was conducted by the Tucson East Community Mental Health Center (McWilliams & Morris, 1974). It was felt that

attitudes about mental health services could,

> Be directly utilized by the consultation and education component to encourage the center to meet the expressed needs of the public and to maximize citizen acceptance and utilization of the program (p. 237).

Sampling was done by randomly selecting residential block faces from 1970 census tapes. Respondents were asked 19 open-ended questions, including questions about most pressing social problems. Researchers concluded that the public was relatively well informed on existing problems, and the information generated formed the foundations for recommendations for public education programs.

Needs assessments for community mental health agencies have taken a variety of forms. They have involved the use of census statistics, demographic data, clinical evaluations, opinions of community leaders, and opinions of advisory boards; however, only the last effort (McWilliams & Morris, 1974) included any representative sampling of the community at large, those potentially or actually receiving service, to collect their ideas of what their needs really are or what priorities they should attach to them. Grenny (1971) described his results well when he said,

> The information we have gleaned over the past two and more years of studying Solano County has led to an interesting perspective about the problems served by professional counselors and mental health specialists (p. IIId-1).

He might also have added "as seen by professional counselors and mental health specialists". However, as McCurdy pointed

out clearly in 1975:

> Expert opinion is not synonymous with public opinion. The panel of experts approach does not involve the public in a review of policy issues, and may fail to consider significant facets of public receptivity and opposition to certain policy goals. (p. 24)

That expert opinion is not synonymous with public opinion in the field of mental health was aptly demonstrated by Polak in 1970 in a study of patients and staff at the Fort Logan Mental Health Center in Denver. It was found that the content of treatment goals differed between staff and patients, that patients' ranking of goals bore only random relation to rankings made by staff, and that the staff was unable to predict how patients would rank goals. Polak added that other research suggested "that a major contributor to treatment-goal discord between patients and staff is their different definition of the problem to be worked on in treatment" (p. 230).

Mental health professionals might well argue that they have been trained to diagnose psychiatric problems and that this is their legitimate realm of expertise. It would be short-sighted indeed to suggest that such professionals do not have an important contribution to make in this area; however, it would be equally shortsighted to contend that these professionals have the magic skills to make such "diagnoses" in deliberate isolation from the world that they purport to serve. Lerner (1972) provided insight into this issue when she said,

> Contemporary experts who attempt to mold rather than to serve their clients usually defend their right to do so in terms of their superior knowledge as a result of their scientific training. The fallacy in that defense is that decisions about what individuals <u>should</u> be, have, want, and do are decisions which involve values and in this area every man is a legitimate expert for himself and no man is a legitimate expert for others. (p. 11)

McCurdy (1975) reinforced the contention that the only way to explore needs as they are seen by the community is by asking the members of the community.

> Does the disappearance of pathological symptoms and the manifestation of improved functioning in relationship to the family and the rest of the world really indicate that the individual is living better? These are questions which cannot be answered mathematically. They may be explored qualitatively, however, if original policy allows for the use of human testimony from service recipients about the effects of a specific program upon their lives. (p. 14)

A final argument is noted by Beigel (1970b) involving the sophistication, of the population. For example, what if the general public being served has an orientation towards inpatient services from the past and demands more and more restricted inpatient facilities? First, given the systems analyst's definition of "need", the above question reflects concentration on solutions rather than on needs, and it is the researcher's responsibility to discover what problems or gaps underlie such a solution. Second, it would be inappropriate to assume that <u>only</u> potential service recipients would be contacted in a needs assessment or that any and all demands would be acted upon immediately

without further question. Finally, it seems possible that one very appropriate solution to the problem presented above would be an emphasis on community education programs in mental health.

An adequate community mental health needs assessment, then, is a complex undertaking. To be maximally useful it would have to meet the following criteria: (a) it would have to include the ideas of the three major segments of the population (the served, the servers, and the community at large); (b) it would have to have the capacity for studying "needs" and not merely solutions; (c) it would have to have the capacity for clarifying agreement and disagreement between groups in the population; (d) it would need some methodology for establishing priorities; (e) it should be open-ended enough not to dictate ideas, but at the same time thought provoking enough to elicit ideas; and (f) an initial needs assessment should provide the instruments or otherwise lay the foundations for an on-going process of assessing needs.

New Approaches to the Problem

Given the goals of (a) collecting ideas on community mental health needs from three segments of the population and (b) clarifying agreements, disagreements, and priorities, it would be tempting to collect representatives of these segments in groups so that issues might be discussed and clarified. However, Maier (1967) presented four important drawbacks to the use of group process in this type

of effort: (a) groups create social pressure and forces toward conformity, (b) solutions once determined establish a valence and members hesitate to reevaluate, (c) any leader is automatically placed in a dominate position, and (d) the goal of "winning the argument" can become a conflicting secondary goal.

Delbecq and Van de Ven (1971) proposed that the Program Planning Model (PPM) (which is currently used widely in business, industry, government, and education) surmounted many of the difficulties inherent in usual group process, while still facilitating group decision-making. This model involves the use of so-called "nominal groups", that is, groups in which individuals work in the presence of others but do not interact. The general format involves participants sitting in groups while individually writing a list of their needs and priorities and, only when finished, carrying on a group discussion of their lists. Delbecq and Van de Ven pointed to research which demonstrated "that creativity can often be facilitated by following specific group process" (p. 472). This model has obvious advantages but is still open to the danger of social pressure since participants are in close contact and are ultimately asked to reveal their thoughts openly to the group for review and criticism. The authors themselves noted that care must be taken to avoid low status clientele being forced into a passive position by professional staff. Ideally, the needs assessor is seeking a method which

eliminates social pressure entirely, while at the same time providing the stimulation of group feedback and preferably not requiring all participants to gather in the same place at the same time.

The Delphi Technique was developed for the Rand Corporation by Norman Dalkey and Olaf Helmer in the early 1950s for the purpose of collecting and focusing expert opinion and establishing some consensus without face-to-face contact among participants. The three major features of the Delphi Technique are: (a) anonymity, (b) controlled feedback, and (c) statistical group response. As described by Weaver in 1971 the original method involved a five-round survey (although the number of rounds has varied widely among users depending upon participants and objectives). In the first round participants were asked to generate ideas about what events were probable given a certain set of circumstances. In Round II, they were asked to estimate the probability of each event. Then in the third round each participant was shown the lists generated by other participants (anonymously) and asked if he wished to change or revise his list. Those whose lists from the third round deviated significantly from the average were asked in the fourth round to explain their opinions. The fifth round was used to gather ideas on what would enhance or reduce the probabilities participants had assigned to their lists.

In its purest form Delphi was used to forecast possible future events. In an early study by Helmer and his colleagues at Rand, six experts from six different areas were asked to predict events 50 years into the future, and reasonably satisfactory convergence was achieved by a four round questionnaire (Helmer, 1966). Anastasio (1974) reported success with 30 diverse specialists.

Recently Delphi has been found to have other uses in addition to forecasting events. Martin and Maynard (1973) utilized it to determine opinions on appropriate roles for private institutions of higher education. This particular study used only two questionnaires, reducing 308 target statements from the first round to 45 generic statements for the second. A two-round questionnaire was also used by the Educational Testing Service in 1969-70 to facilitate planning for a new university in the Midwest (Winslead & Hobson, 1971). Judd (1970) used Delphi to collect opinion on curriculum for a branch campus and succeeded in consolidating opinion to the point of generating a highly innovative, experimental curriculum. A Delphi study by the University of Virginia School of Education sought a scientific assessment of need, desires, and opinions of its clientele in all walks of life. At the conclusion of the four round study, the authors commented that "besides giving the satisfaction of planning the future with the assistance of data, this survey made the influential persons in the commonwealth aware of the schools's existence

and gave them a vested interest in its future accomplishments" (Cypert & Gant, 1971).

McCurdy has recently completed a dissertation using the Delphi Technique to study social policy planning and the issue of drug abuse. In this work he makes explicit a distinction between what he calls "Classical Delphi" and "Focus Delphi", which he employs. Focus Delphi was developed by Stuart A. Sandow and his colleagues at the Educational Policy Research Corporation in Syracuse, New York, "specifically for the purpose of generating a more efficient medium for promoting communication between various public groups on questions of social policy" (McCurdy, 1975, p. 46). Focus Delphi is distinguished from Classical Delphi in three ways: (a) the emphasis is on planning goals rather than the predication of future events, (b) focus is on current values and attitudes and there is less emphasis on achieving convergence, and (c) the method is not restricted to experts but utilized with both "policy-affecting" and "policy-affected" groups. An "expert" becomes "anyone who can contribute relevant inputs" (McCurdy, 1975, p. 37). McCurdy's particular study involved a four-round survey sent by mail to a large sample of individuals. It began with respondents being asked to write two goals they considered important in the area of drug abuse prevention in the next five to eight years, and ended with some convergence on goal priorities, as well as comparisons among the various groups. Although he considered his four-round

study valuable, McCurdy strongly recommended that data be gathered in as few rounds as possible, noting that his rate of return fell off sharply in the last round.

The Delphi Technique offers obvious advantages to the researcher interested in community needs assessment. It can be used on a widely diverse sample, stimulating creativity by controlled feedback, without the social pressure characteristic of a group. At the same time, Anastasio (1974) contended that it eliminates problems of hasty and preconceived ideas, inclinations to close one's mind to novel ideas, and tendencies to be unduly influenced by loud and persuasive performers; while Martin and Maynard (1973) added that it forces participants to analyze choices.

Another distinct advantage of Delphi is its amenability to so many different types of questions and interview techniques. One possible example is the use of Flanagan's Critical Incident Technique (Flanagan, 1954). The first round might consist of direct application of the technique while succeeding rounds would be used to obtain convergence on issues which were raised by participants. Of particular importance to researchers attempting to obtain information on community concepts of mental health is an adaptation of Flanagan's technique created by Solley and Munden in 1962. The object of the study was to formulate some conception of what constitutes mental health by pooling the ideas of 14 mental health professionals, staff members at the Menninger Clinic. Each interviewee was asked

to describe a mentally healthy acquaintance. Following the description he was asked to give his reasons for the choice. Judges managed to condense the protocols of 14 staff members to five basic behavioral characteristics, with a reliability of .95 between the three judges. This technique could be of particular value when working with a population which may have difficulty dealing with abstract concepts.

The Delphi Technique, combined with carefully structured interview materials, could provide a valuable tool to the researcher concerned with community mental health needs assessment. It has the capacity to study both agreement and disagreement among the various groups in the community, while at the same time, giving some idea as to the priorities among community needs. At the same time it yields information which allows the researcher to make comparisons of the needs and values of any number of community sub-groups. It is also open-ended enough that specific interview techniques can be structured to fit the specific groups involved and the particular issues of that community. Finally, the combination of ideas about needs collected in this way can easily lay the foundation for creation of a more specific and objective instrument to be used with wider samples of the population for continuing needs assessment.

Given the importance of needs assessment for an effective mental health service, and considering the inadequacies of presently available methods, continued testing of new

methodology could prove very valuable. Delphi appeared to offer several advantages over other techniques and had not been employed in a formal community needs assessment. Therefore, it was decided to adapt the method for an initial survey of needs for a mental health agency in a large urban area.

CHAPTER III

METHODS

The Setting

Children's Mental Health Services of Houston (CMHS) is a United Fund Agency set up to serve the mental health needs of the children of Harris County, Texas. However, despite an official catchment area of over two million, CMHS does not realistically expect to meet the needs of all children in this community. Based upon statistics from the Houston police department, the Harris County Juvenile Probation Department, and the Harris County Child Welfare Unit, it is estimated that approximately 4200 children in this area each year develop problems requiring mental health services. Each year CMHS serves approximately 1200 of these children through direct services. The number of children served indirectly through program consultation and case consultation with other professionals has not been assessed.

CMHS is composed of five major divisions: Community Services, Emergency, Habilitation, Therapeutic Nursery, and Guidance. It is the Guidance Division which offers the most direct services to the broadest population, with the other divisions offering more specialized services. The Guidance Division is staffed by one psychiatrist, two psychologists, and four social workers. The staff is continually augmented by graduate students in psychology, social work, and medicine. Approximately 50 new families are seen each month, and approximately 550-600

cases are active at any given time. The division functions as an outpatient clinic for children and their families offering diagnostic, therapeutic, and consultative services. Treatment programs vary, ranging from individual child therapy to family therapy, group activity therapy, and parent education and counselling.

During the past two years, CMHS, and particularly the Guidance Division, have been engaged in an effort to revise its procedures for program planning and evaluation. Under the financial auspices of the Hogg Foundation for Mental Health, the agency began by compiling and computerizing a data bank of client/agency information from July, 1972 to August, 1974. As well as laying the foundation for a general revision of the agency information system, the data bank provided for a more thorough analysis of the population served and of the services offered. Children served by the Guidance Division most typically came from working class (36%) or poor families (32%) using the Hollingshead two-factor index (Hollingshead, 1957). Clients were predominately male (79.8%), with ethnic distribution of 65.3% white, 28.5% black, and 6.0% Mexican-American.

Given this information base, the Guidance Division is now interested in implementing more systems analytic procedures. The first step toward such a goal is a thorough needs assessment on both the micro and macro levels. Needs assessment procedures on the micro level will soon be implemented with

individual families coming to the center for service. However, the present study is concerned with a needs assessment on the macro level, involving the larger community.

Subjects

Subjects were selected to represent the three segments of the population: the servers, the served, and the community at large. Given the aim of the study (to generate ideas from the population) interviewing continued until no new ideas were forthcoming, with a total sample of 102 individuals being interviewed.

The servers included the six full-time and one part-time Guidance staff members, as well as three students, selected at random, from those working with the division as of July, 1975. Students form a large part of those providing services at CMHS along with those of permanent staff members. However, as individuals they are only with the agency for a short time, many are not from Houston and not familiar with the area, and they work under the direct supervision of a permanent staff member. Therefore, their ideas were not given equal weight with those of the permanent staff. To accomplish such a distribution, student representation was one less than half that of staff members.

The served were selected from two groups: 21 from among the families who had actually come in for service since September 1, 1974, and 30 from among families who had called to inquire but not actually come in for service during the

same period. Inclusion of representatives from both these groups was deemed important since the Schab et al. study of 1973 indicated that "needers" who are not "utilizers" may have different needs than utilizers. In 1974, Seigel and Cohn concurred with this position. All told, this resulted in a total of 51 served or potentially served members of the community, and was divided by the percentage of clients and inquiries serviced by the agency over the prior two years.

The particular time frame was selected for two reasons: (a) September 1, 1974, marked the end of an agency follow-up study, and therefore this would avoid sampling the same people twice and risking antagonizing them, and (b) previous studies with this population have indicated that going back farther than a year results in great difficulty locating individuals. Each case and each inquiry is automatically assigned a consecutive case number by the agency so that sampling could be random, using a table of random numbers. Finally, these two groups were stratified by the sex of the identified patient.

The two groups of the served provided a particularly relevant sample for a needs assessment for several reasons: (a) they were families known to have children, (b) they were known to have experienced some type of mental health problems within the past year and, therefore, were apt to have some ideas about needs, (c) they had conducted some investigation of possible resources for meeting their needs, and (d) they

were realistically apt to use the particular service. Although CMHS is open to all residents of Harris County, the agency in no way possesses the resources or capabilities to serve every child in this catchment area with a mental health problem. In reality, they serve a much smaller population. By sampling from a more specific population, the design eliminated several segments of the populus who were not likely to actually use the service, such as those who would see a private therapist, those who would use other professional services, those who would not use professional mental health services at all, those with special mental health needs more appropriate to some other services (e.g. the mentally retarded), and a large group of families who have no needs requiring service. Particularly in an initial assessment in which the aim is to generate original ideas from the sample, it seemed most productive to select subjects most apt to have such ideas. Once the initial study was completed, and a more objective instrument devised, it would be possible to survey a much larger and more diversified group.

The larger community was represented by the CMHS referral source network, and this was used as a guideline for sampling. A total sample of 41 persons was used so that this group was slightly less than the served group. The exact breakdown for the study was as follows:

Referral Source	Percentage	Representatives
Schools	26.7%	14 (34.2%)
Doctors	8.1%	4 (9.8%)
Juvenile Probations	7.4%	5 (12.2%)
Welfare	4.2%	3 (7.3%)
Family Service	4.2%	3 (7.3%)
Other Agencies	22.0%	12 (29.2%)
Unknown or self	27.4%	0

Sampling was kept as random as possible, given the dictates of each agency involved.

These community professionals were salient to the study for several reasons: (a) as Kaufman points out, a needs assessment is biased if it ignores the community sector, (b) these individuals are also users of CMHS services in the context of their work, (c) they are in positions of some influence with regard to mental health services in the community, and (d) they have had direct contact with groups of troubled families and individuals not seen by CMHS. It was never the intention to suggest that professionals do not have a unique and important contribution to make in assessing mental health needs, but only to see that this is not the only or over-riding consideration.

Procedures

Once the sample had been selected, the first step was to contact these individuals, give them information about the study, and ask them to participate. In this initial contact

perspective participants were given information on the questions to be asked and told that the study would involve two separate contacts. Of the total 27 former clients contacted by telephone only three refused to participate; this small group included two whites and one black. Of the 56 persons contacted from the non-client group, 16 (9 white, 6 black, and 1 Mexican-American) refused to participate. No one in the professional group declined, either from the community or from the staff of CMHS. Reasons for non-participation varied widely, and no principal explanation was evident.

In all cases, once a subject agreed to assist in the study an appointment for a personal interview was arranged. Generally these were held at the home or office of the interviewee. Of former clients who agreed to the interview, three persons (all white) failed to meet the appointment. In the non-client group, this number was 10 (6 white, 3 black and 1 Mexican-American). In each case, a person who would not participate was replaced randomly from the subject pool.

At the time of the interview, subjects were again told that a second part of the study would be presented to them later, and its importance was emphasized. Each person was asked for an address and telephone number where they could be reached for the remainder of the summer. They were also assured that their responses would remain anonymous.

Questioning began by attempting to elicit the respondent's concept of the important elements in a mentally

healthy child. As can be seen in the sample interview schedule in Appendix A, the first two questions employ an adaptation of the Critical Incident Technique. Following the initial question, the interviewer ascertained what particular child the person had in mind and talked briefly about how they happened to know the child. If the subject had difficulty grasping the question, other phrasing was used such as "a child who is well adjusted", "a child who gets along well in life", or " a child who is the way you think children ought to be." Remarks were made to encourage the subject to go on or obtain clarification, but the giving of clues to particular traits was carefully avoided.

The second two questions on the interview schedule attempted to discover what people saw as pressing mental health needs in the community. In each instance the respondents were asked to describe these needs in terms of "how things are now as opposed to how you would like them to be." On Question #4, the interviewer began by gathering general ideas, and then prompted the subject to analyze needs more carefully by focusing on specific groups of chidren. Again, synonyms were avoided. If the respondent initially suggested solutions rather than needs, inquiry was made as to why he thought the particular solution was needed.

The final two questions of the interview did invite participants to suggest solutions to problems and to discuss various solutions which they had explored. Following completion

of these final items, respondents were asked to fill out a brief personal data sheet (see Appendix B).

Once the interview data had been gathered, they were content analyzed by two independent raters. When this was completed the raters examined each other's categories and continued to work until basic categories could be agreed upon. This same process was repeated until the raters were satisfied they could narrow the statements no further. The final instrument is included in Appendix C. The questionnaire is composed of three sections: (a) statements of important elements in mental health for children, (b) statements of important mental health needs of children in Houston, and (c) statements of needed solutions.

Subjects were first asked to respond to each of the statements in a section on a five-point Likert scale ranging from "Very Strongly Agree" to "Disagree." Following this rating, they were instructed to check the five statements in that section they considered to be most important.

Each of the 102 respondents were mailed or handed their second questionnaire in mid-August. This packet included a cover letter (see Appendix D) urging them to complete this instrument and return it in the stamped envelop which was enclosed. An additional incentive to the professional community was a form enclosed asking if they would like to see a summary of the results. By the end of September, a total of 55 questionnaires had been returned, one of which was not

completed and therefore not usable. At that time, a telephone call was made to each person who had not returned their questionnaire, again urging them to do so and offering to mail an additional questionnaire in the event that one had been lost. This resulted in the gathering of 15 additional responses.

Once all data had been collected, the second stage of analysis was begun by comparing those who returned questionnaries with those who did not to determine differences in these groups. Then the total sample of returned instruments was combined to determine the most widely held agreement and priorities through frequency counts. Services actually used were also recorded and a count made. Next, the sample was divided into a professional and non-professional group. From the frequency counts regarding priorities, a ranking of priorities was made for both the professional and non-professional groups on each of the three issues. A Kendall Coefficient of Concordance (Kendall's $\underline{W}$) was used to determine the extent of correlation in the priorities of the two groups. Finally, chi square analysis was employed to investigate significant differences between these groups on each of the statements in the three areas, as well as on priorities.

CHAPTER IV

RESULTS

The Total Sample

The total sample can be described as ranging in age from 23 to 63, with a median age of 34. A total of 20 males, 75 females, and 7 couples were interviewed. (Couples resulted from home interviews in which both parents were present and wished to participate jointly). The ethnic distribution was: 77 white, 22 black, 2 Mexican-American, and 1 French Creole. Socio-economic classification included people from the full range of the Hollingshead Scale. Professionals tended to be grouped in the upper middle class and upper class area; otherwise there was considerable scatter. In the realm of experience, professionals interviewed ranged from less than one year to 30 years, with a median experience of 7 years.

Questionnaire Return

Those who returned the second questionnaire were compared with those who did not on the variables group, age, sex, ethnicity, socio-economic status, and professional experience (for the professional group only). Chi square analysis was used, with a median test being applied to age, socio-economic status, and experience. No differences were found between the two groups on age, sex, or experience. There was found to be a significant difference among the four groups (clients, non-clients, community members, and CMHS staff) as to whether the second questionnaire was returned, $\underline{X}^2$ (3) = 17.85, $\underline{p} < .001$.

This appeared due in great part to the difference between clients and non-clients, with 35.7% of former clients returning questionnaires and only 36.7% of non-clients doing so. Differences in ethnicity were also significant. On this variable, $\underline{X}^2$ (2) = 9.49, $\underline{p} < .01$, with a much higher percentage of whites (75.3%) than blacks (40.9%) returning questionnaires. Finally, significant differences based upon socio-economic status indicated that individuals of higher socio-economic class were more apt to complete the instrument than those in the lower classes, $\underline{X}^2$ (1) = 5.34, $\underline{p} < .05$. From these data it is clear that persons most likely to participate in a second round effort are white clients or professionals in the upper middle or upper socio-economic classes.

Statements Checked as Priorities

For each individual statement in the three sections a frequency count was made to determine how many individuals felt which characteristics, problems, or solutions were among the five most important. A rank ordering of all the statements in each section can be found in Tables 1, 2, and 3.

Mental Health Characteristics Given Most Priority. Of the 26 mental health characteristics, the three marked most often were:

1. Being able to understand oneself, like oneself, and feel confident in oneself. (42)

2. Being independent, thinking for oneself, and working toward being able to care for oneself. (33)

TABLE 1

Mental Health Characteristics
Rank Ordered by Priority Checks
by the Total Sample

Xs[a]	Mental Health Characteristic
42	Being able to understand oneself, like oneself, and feel confident in oneself.
33	Being independent, thinking for oneself, and working toward being able to care for oneself.
33	Being able to form warm, trusting relationships with other people.
29	Being sensitive toward other people and being able to show loving concern for them.
28	Having close relationships with family members and being happy at home.
23	Being able to take responsibility for his or her decisions and chores.
21	Being flexible and able to deal with new situations, even when there is stress.
18	Being honest and truthful.
16	Being generally curious, interested in trying new things in the world.
14	Being well disciplined, behaving, and respecting authority.
14	Being able to express feelings and ideas freely in words.
14	Being able to reasonably control emotions in dealing with frustration and conflict.
7	Being bright, alert, clear headed and having common sense.
7	Being christian and active in church.
7	Obeying the law.
6	Being happy, carefree, fun-loving, and enjoying life.
5	Having goals and planning for the future.
4	Being even-tempered and agreeable rather than tense and nervous.
4	Being interested, motivated, and able to succeed in school.
4	Being able to relate well with people of other races.
2	Being involved in activities (for example: sports, clubs, etc.).
2	Being polite and well mannered.
2	Being ambitious, hardworking, and industrious.
1	Being outgoing and friendly.

Table 1 (continued)

1	Being relatively clean, neat, and well groomed.
0	Being quiet, subdued and cautious.

[a]Numbers in this column represent the number of times this characteristic received an X from respondents.

TABLE 2

Problems Rank Ordered by Priority Checks
by the Total Sample

Xs[a]	Problems
29	Children need to better understand themselves and feel good about themselves.
25	Physical and sexual abuse of children in families needs to be stopped.
24	Children need to believe more strongly thatthey are loved and that parents are concerned about them.
23	Children need to be able to communicate more freely, being able to listen and express feelings.
22	Parents need to be better able to solve their own problems and conflicts without involving their children.
21	Parents need to be more effective parents (for example: using more moderate and consistent discipline).
21	Parents need to better understand how children develop.
19	Drug abuse needs to be controlled.
16	Children need help in adjusting to divorces, broken homes, and new step parents.
16	Parents need to better supervise children and spend more time with them.
14	Children need more encouragement to be motivated and have reasonable goals and ambitions in life.
13	Children need help to become more independent and responsible.
13	Children need to have better family relationships so there will be fewer runaways.
12	Children need to be better able to behave, accept discipline, and respect adults.
12	Children who are somehow different (handicapped, overweight, retarded, etc.) need understanding and the ability to be happy with themselves.
11	Children need to be able to form better, more trusting relationships with other people.
10	Children need help in dealing with hard life situations.
9	Children need help to succeed in school and achieve all that they can.
8	Children who are hyperactive need help and understanding in dealing with the world.
7	Children need to be more motivated to try in school, attend and finish school.

Table 2 (continued)

5	Children need to stop breaking the law and have more respect for authority.
3	Children need better control over negative feelings (for example: aggression, anger, wanting to fight).
3	Families need more financial aid in order to care for their children.
2	Sexual acting out and unwanted teenage pregnancies need to be stopped.
2	Children need to be more happy, easy going, enjoying life.
1	Race relations among children need to be improved.
0	Bedwetting in older children needs to be stopped.

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[a]Numbers in this column represent the number of times this problem received an X from respondents.

TABLE 3

Solutions Rank Ordered by Priority Checks
by the Total Sample

Xs[a]	Solutions
33	More low cost, conveniently located mental health services with transportation and convenient hours.
31	More training for school personnel in how to see problems in children and handle them early.
22	More mental health teams in schools to work with unmotivated, problem children and help curb truancy and drop outs.
19	More residential (live-in) treatment centers for children, which both diagnose and treat problems.
18	More immediate services for crises.
18	School classes on values, emotions, and self knowledge.
17	More educational programs for children and adults in parenting, family life, relationships, and family planning.
17	More public information on what service is available and a central agency to make referrals.
16	More vocational training and jobs for youth.
15	Inexpensive day care in local areas for both normal children and problem children.
14	More community understanding and support for mental health services.
13	More treatment available for learning disabled and hyperactive children.
12	More family centered approaches used by agencies and emphasis on family activities.
11	More free recreation in local areas which is supervised by interested adults.
10	More living placements (both permanent and temporary) for hard to place children (retarded, delinquent, less intelligent, etc.).
10	Less waiting time for all services.
9	More drug abuse prevention centers.
8	The law putting children's needs first rather than seeing children as parents' property.
7	More careful control of what movies and books children see.
7	More volunteer men and women to work with individual children.

Table 3 (continued)

6	Use of television and radio to teach important things about mental health.
5	Agency follow up of families that do not return for service.
5	Discussion groups providing support for parents (both single and couples).
4	More financial and social aid for needy families.
3	More church activities for youth.
2	Home and school visits by mental health teams.
2	Better law enforcement, control of problem youth.
1	More bilingual services with staff members from several races and cultures.

[a]Numbers in this column represent the number of times this solution received an X from respondents.

3. Being able to form warm, trusting relationships with other people. (33)

Mental Health Characteristics Given Least Priority. The three receiving the fewest votes were:

1. Being quiet, subdued and cautious. (0)

2. Being outgoing and friendly. (1)

3. Being relatively clean, neat, and well groomed. (1)

Problems Given Most Priority. In the category "most" important problems of children in Houston," the following were checked the most:

1. Children need to better understand themselves and feel good about themselves. (29)

2. Physical and sexual abuse of children in families needs to be stopped. (25)

3. Children need to believe more strongly that they are loved and that parents are concerned about them. (24)

Problems Given Least Priority. Problems receiving least response were:

1. Bedwetting in older children needs to be stopped. (0)

2. Race relations among children need to be improved. (1)

3. Sexual acting out and teenage pregnancies need to be stopped. (2)

4. Children need to be more happy, easy going, and enjoying life. (2)

Solutions Given Most Priority. Among solutions, those marked most often included:

1. More low cost, conveniently located mental health services with transportation and convenient hours. (33)

2. More training for school personnel in how to see problems in children and handle them early. (31)

3. More mental health teams in schools to work with unmotivated, problem children and help curb truancy and drop outs. (22)

Solutions Given Least Priority. Solutions stressed least were:

1. More bi-lingual services with staff members from several races and cultures. (1)

2. More educational programs for children and adults in parenting, family life, relationships, and family planning. (1)

3. Better law enforcement, control of troubled youth. (2)

4. Home and school visits by mental health teams. (2)

General Levels of Agreement

Statements were next examined on the basis of strong agreement and disagreement. Summaries of all results in this area are included in Tables 4, 5, and 6.

Strong Agreement on Mental Health Characteristics. Of the mental health characteristics listed, those most often marked "Very Strongly Agree" were:

1. Being able to understand oneself, like oneself, and feel confident in oneself. (43)

2. Having close relationships with family members and being happy at home. (36)

TABLE 4

Levels of Agreement with Mental Health Characteristics by the Total Sample

Levels of Agreement[a]					
VSA	SA	A	NS	D	Mental Health Characteristic
16	10	28	9	6	Being well disciplined, behaving, and respecting authority.
8	8	31	8	12	Being polite and well mannered.
12	15	31	3	5	Being bright, alert, clear headed, and having common sense.
19	26	20	3	1	Being generally curious, interested in trying new things in the world.
32	19	15	1	1	Being independent, thinking for oneself, and working toward being able to care for oneself.
34	20	14	1	0	Being able to take responsibility for his of her decisions and chores.
11	21	26	6	3	Having goals and planning for the future.
8	11	23	9	17	Being ambitious, hardworking, and industrious.
0	3	4	9	51	Being quiet, subdued, and cautious.
4	11	38	7	7	Being outgoing and friendly.
31	21	14	3	0	Being able to form warm, trusting relationships with other people.
30	23	11	2	2	Being sensitive toward other people and being able to show loving concern for others.
19	25	17	4	4	Being able to express feelings and ideas freely in words.
13	26	24	4	0	Being able to reasonably control emotions in dealing with frustration and conflict.
43	16	10	0	0	Being able to understand oneself, like oneself, and feel confident in oneself.
9	12	36	4	7	Being happy, carefree, fun-loving, and enjoying life.
10	18	28	5	6	Being even-tempered and agreeable rather than tense and nervous.
20	27	22	0	0	Being flexible and able to deal with new situations, even when there is stress.
6	9	34	7	13	Being relatively clean, neat, and well groomed.
8	6	15	16	24	Being christian and active in church.

Table 4 (continued)

36	16	12	3	2	Having close relationships with family members and being happy at home.
8	21	33	6	1	Being interested, motivated, and able to succeed in school.
7	9	32	8	12	Being involved in activities (for example: sports, clubs, etc.).
11	14	37	4	3	Being able to relate well with people of other races.
24	15	25	4	1	Being honest and truthful.
17	12	31	5	4	Obeying the law.

[a]Numbers in these columns represent the number of total respondents marking this level of agreement on the item.

TABLE 5

Levels of Agreement with Problems
by the Total Sample

Levels of Agreement[a]					
VSA	SA	A	NS	D	Problems
15	6	24	5	16	Children need to be better able to behave, accept discipline, and respect adults.
31	21	15	1	1	Parents need to better understand how children develop.
26	26	16	1	0	Parents need to be more effective parents (for example: Using more moderate, consistent discipline.)
28	20	12	4	5	Parents need to be better able to solve their own problems and conflicts without involving their children.
29	22	18	0	0	Children need help in adjusting to divorces, broken homes, and new step parents.
38	20	8	2	1	Children need to believe more strongly that they are loved and that parents are concerned about them.
28	14	23	3	1	Parents need to better supervise children and spend more time with them.
21	19	25	4	0	Children need to be able to form better, more trusting relationships with other people.
8	16	28	8	8	Children need better control over negative feelings (for example: aggression, anger, wanting to fight).
20	19	27	2	1	Children who are hyperactive need help and understanding in dealing with the world.
9	9	34	7	8	Children need to stop breaking the law and have more respect for authority.
25	28	16	0	0	Children need to be able to communicate more freely, being able to listen and express feelings.
29	19	19	1	1	Children who are somehow different (handicapped, overweight, retarded, etc.) need understanding and the ability to be happy with themselves.

Table 5 (continued)

22	14	27	4	2	Children need more encouragement to be motivated and have reasonable goals and ambitions in life.
33	15	16	1	3	Children need to have better family relationships so there will be fewer runaways.
38	18	11	2	0	Children need to better understand themselves and feel good about themselves.
12	10	30	8	8	Sexual acting out and unwanted teenage pregnancies need to be stopped.
9	8	35	8	8	Children need to be more happy, easy going, enjoying life.
17	14	30	2	5	Children need help to succeed in school and achieve all that they can.
16	20	29	2	2	Children need to be more motivated to try in school, attend and finish school.
16	28	19	2	2	Children need help to become more independent and responsible.
15	29	23	0	2	Children need help in dealing with hard life situations.
32	13	19	0	5	Drug abuse needs to be controlled.
49	7	11	1	1	Physical and sexual abuse of children in families needs to be stopped.
8	14	36	3	8	Race relations among children need to be improved.
8	9	16	19	17	Families need more financial aid in order to care for their children.
4	6	31	13	13	Bedwetting in older children needs to be stopped.

[a]Numbers in these columns represent the number of total respondents marking this level of agreement on the item.

TABLE 6

Levels of Agreement with Solutions
by the Total Sample

Levels of Agreement[a]					
VSA	SA	A	NS	D	Solutions
27	10	19	10	3	More residential (live-in) treatment centers for children, which both diagnose and treat problems.
22	17	21	7	2	More living placements (both permanent and temporary) for hard to place children (retarded, delinquent, less intelligent, etc.).
42	13	11	2	1	More low cost, conveniently located mental health services with transportation and convenient hours.
26	20	19	2	1	More immediate services for crises.
26	22	16	3	2	Less waiting time for all services.
22	19	23	4	0	More treatment available for learning disabled and hyperactive children.
30	20	15	3	0	More community understanding and support for mental health services.
30	15	17	4	3	More public information on what service is available and a central agency to make referrals.
27	15	19	5	3	Inexpensive day care in local areas for both normal and problem children.
12	14	23	13	7	More financial and social aid for needy families.
38	20	9	2	0	More training for school personnel in how to see problems in children and handle them early.
34	20	11	1	3	More mental health teams in schools to work with unmotivated, problem children and help curb truancy and drop outs.
23	18	24	3	1	More free recreation in local areas which is supervised by interested adults.
23	19	22	4	1	More vocational training and jobs for youth.
18	16	19	11	3	More drug abuse prevention centers.

Table 6 (continued)

13	14	27	9	3	More bilingual services with staff members from several races and cultures.
27	15	20	5	2	More educational programs for children and adults in parenting, family life, relationships, and family planning.
9	9	19	14	18	Better law enforcement, control of problem youth.
13	19	29	8	0	Discussion groups providing support to parents (both single and couples).
16	22	22	9	0	More family centered approaches used by agencies and emphasis on family activities.
19	13	11	20	5	The law putting children's needs first rather than seeing children as parents' property.
11	12	14	10	21	More careful control of what movies and books children see.
12	15	27	13	2	Home and school visits by mental health teams.
18	19	22	7	3	Use of television and radio to teach important things about mental health.
8	12	24	16	9	More church activities for youth.
8	17	30	9	4	Agencies following up families that do not return for service.
15	8	36	8	2	More volunteer men and women to work with individual children.
27	11	21	6	2	School classes on values, emotions, and self knowledge.

[a]Numbers in these columns represent the number of total respondents marking this level of agreement on the item.

3. Being able to take responsibility for his or her decisions and chores. (34)

Disagreement on Mental Health Characteristics. Those most often marked "Disagree" were:

1. Being quiet, subdued, and cautious. (51)

2. Being Christian and active in church. (24)

3. Being ambitious, hardworking, and industrious. (17)

Strong Agreement on Problems. Turning to problems, more people very strongly agreed that:

1. Physical and sexual abuse of children in families needs to be stopped. (49)

2. Children need to better understand themselves and feel good about themselves. (38)

3. Children need to believe more strongly that they are loved and that parents are concerned about them. (38)

Disagreement on Problems. Those most often disagreed with were:

1. Families need more financial aid in order to care for their children. (17)

2. Children need to be better able to behave, accept discipline, and respect adults. (16)

3. Bedwetting in older children needs to be stopped. (13)

Strong Agreement on Solutions. Very strong agreement was voiced most often on the following solutions:

1. More low cost, conveniently located mental health services with transportation and convenient hours. (42)

2. More training for school personnel in how to see problems in children and handle them early. (38)

3. More mental health teams in schools to work with unmotivated, problem children and help curb truancy and drop outs. (34)

Disagreement on Solutions. Most disagreement occurred around the following solutions:

1. More careful control of what movies and books children see. (21)

2. Better law enforcement, control of problem youth. (18)

3. More church activities for youth. (9)

Services Utilized

A frequency count was made of answers to Question #4: "What additional agencies/services have you personally used?" A total of 88 different agencies and services in (or accessible to) the Houston area were mentioned by respondents. Twelve persons stated they had utilized or contracted no other services. Table 7 contains a listing of the 15 most mentioned services and their frequency of mention by both lay and professional groups.

Comparison of Responses by Professionals and Non-Professionals

Following completion of the frequency counts, statements in each of the three sections of the second questionnaire were rank ordered by the number of priority checks given them by professionals in the mental health field. This procedure was then repeated for the non-professional group. A Kendall

TABLE 7

Major Agencies and Services
Utilized by Respondents

Group[a]		
Professionals	Non-professionals	Agency
38	12	Texas Research Institute of Mental Sciences
21	8	Family Service Center
7	16	School counselors
11	5	Private psychiatrists/ psychologists
10	2	Hope Center
8	4	Texas Children's Hospital
5	6	Ben Taub Hospital
10	1	Harris County Mental Health and Mental Retardation Association
10	1	Baylor
3	6	Juvenile Probation Department
6	3	Big Brothers of Houston
8	0	Blue Bird Clinic
7	1	Texas Rehabilitation Commission
7	1	Cambio House
8	0	Palmer Drug Abuse Program

[a]Numbers in these columns represent the total number of professionals and non-professionals who mentioned personally utilizing or making a referral to the particular agency.

Coefficient of Concordance showed a significant agreement between professionals and non-professionals on priority mental health characteristics, $W = .8528$, $X^2 (25) = 42.64$, $p < .05$. Identical analysis on the problem and solution priorities revealed no significant correlation.

Mental Health Characteristics. In the area of desirable mental health characteristics, there were no significant differences between laymen and professionals on 12 out of the 26 items. On four of the items, however, these two groups differed on both general level of agreement and priority. On item #1, "Being well-disciplined, behaving, and respecting authority," laymen were significantly more likely to check it as a priority, $X^2 (1) = 7.84$, $p < .005$, as well as tending to agree more strongly with it, $X^2 (4) = 12.97$, $p < .01$ (see Table 8). Professionals were more apt to strongly agree with the importance of "Being independent, thinking for oneself, and working toward being able to take care of oneself," $X^2 (4) = 9.28$, $p < .05$, and also more apt to give this characteristic priority, $X^2 (1) = 4.55$, $p < .05$ (see Table 9). Professionals were also significantly more apt to give priority to "Being able to form warm, trusting relationships with other people," $X^2 (1) = 16.70$, $p < .001$, and to agree strongly with this, $X^2 (4) = 12.85$, $p < .01$ (see Table 10). On item #20, "Being christian and active in church," the professionals were significantly more likely to disagree, $X^2 (1) = 4.27$, $p < .05$ (see Table 11). Finally,

TABLE 8

Discipline as an Element in Mental Health

Group	Level of Agreement					
	VSA	SA	A	NS	D	X^2
Professional	4	5	18	8	5	12.97*
Non-professional	12	5	10	1	1	

*$p < .01$

Group	Priority[a]		X^2
	Yes	No	
Professional	3	37	7.84*
Non-professional	11	18	

*$p < .01$

[a]The "yes" column represents the number of respondents in each group who checked the item as a priority; the "no" column are those who did not check the item.

TABLE 9

Independence as an Element
in Mental Health

Group	Level of Agreement					X^2
	VSA	SA	A	NS	D	
Professionals	23	12	5	0	0	9.28*
Non-professionals	9	7	10	1	1	

*$p < .05$

Group	Priority[a]		X^2
	Yes	No	
Professionals	24	16	4.55*
Non-professionals	9	20	

*$p < .05$

[a]The "yes" column represents the number of respondents in each group who checked the item as a priority; the "no" column are those who did not check the item.

TABLE 10

Warm Relationships as an Element in Mental Health

Group	Level of Agreement					X^2
	VSA	SA	A	NS	D	
Professionals	24	11	3	2	0	12.85*
Non-professionals	7	10	11	1	0	

*$p < .01$

Group	Priority[a]		X^2
	Yes	No	
Professionals	28	12	16.70*
Non-professionals	5	24	

*$p < .001$

[a]The "yes" column represents the number of respondents in each group who checked the item as a priority; the "no" column are those who did not check the item.

TABLE 11

Church Activity as an Element in Mental Health

Group	Level of Agreement					X^2
	VSA	SA	A	NS	D	
Professionals	1	2	6	10	21	19.00*
Non-professionals	7	4	9	6	3	

*$p < .001$

Group	Priority[a]		X^2
	Yes	No	
Professionals	1	39	4.27*
Non-professionals	6	23	

*$p < .05$

[a]The "yes" column represents the number of respondents in each group who checked the item as a priority; the "no" column are those who did not check the item.

regarding "Being honest and truthful," lay people were more prone to giving it priority, $\underline{X}^2$ (1) = 4.78, $\underline{p} < .05$, and were more likely than professionals to strongly agree with it, $\underline{X}^2$ (4) = 17.22, $\underline{p} < .01$ (see Table 12).

On 6 of the 26 mental health characteristics there were differences between professionals and lay people on the general level of agreement but not on the issue of priority. Professionals seemed more apt to disagree with the importance of "Being polite and well mannered," $\underline{X}^2$ (4) = 12.04, $\underline{p} < .05$, "Being ambitious, hardworking, and industrious," $\underline{X}^2$ (4) = 16.49, $\underline{p} < .01$, and "Being involved in activities (for example: sports, clubs, etc.)," $\underline{X}^2$ (4) = 23.74, $\underline{p} < .001$. On the other hand, the non-professionals were more apt to strongly agree with the importance of "Having goals and planning for the future," $\underline{X}^2$ (4) = 12.70, $\underline{p} < .01$, "Being even-tempered and agreeable rather than tense and nervous," $\underline{X}^2$ (4) = 13.63, $\underline{p} < .01$, and "Obeying the law," $\underline{X}^2$ (4) = 11.87, $\underline{p} < .05$. On one item, "Being able to take responsibility for his or her decisions and chores," lay people were significantly less likely to mark it a priority, $\underline{X}^2$ (1) = 7.15, $\underline{p} < .01$.

Problems. On 18 of the 27 problem items, there were no significant differences between the professional and non-professional groups. On three of these items there were differences both with regard to priority and level of agreement. Regarding the first problem on the list, "Children

TABLE 12

Honesty as an Element in Mental Health

Group	Level of Agreement					X^2
	VSA	SA	A	NS	D	
Professionals	9	6	22	3	0	17.22*
Non-professionals	15	9	3	1	1	

*$p < .01$

Group	Priority[a]		X^2
	Yes	No	
Professionals	6	34	4.78*
Non-professionals	12	17	

*$p < .05$

[a]The "yes" column represents the number of respondents in each group who checked the item as a priority; the "no" column are those who did not check the item.

need to be better able to behave, accept discipline, and respect adults," the non-professional group was more apt to mark a priority, $\underline{X}^2$ (1) = 8.22, $\underline{p} < .01$, as well as more apt to express strong agreement, $\underline{X}^2$ (4) = 14.87, $\underline{p} < .01$ (see Table 13). Professionals were more prone to disagree that "Children need to stop breaking the law and have more respect for authority" is an important need, $\underline{X}^2$ (4) = 12.26, $\underline{p} < .05$, and also less likely to award this priority, $\underline{X}^2$ (1) = 5.09, $\underline{p} < .05$ (see Table 14). The notion that "Drug abuse needs to be controlled" was seen less as a priority by professionals, $\underline{X}^2$ (1) = 6.09, $\underline{p} < .01$, and received less strong agreement from them, $\underline{X}^2$ (4) = 23.74, $\underline{p} < .001$ (see Table 15). Three items produced differences in general level of agreement but not on priority. Professionals were less likely to strongly support the importance of "Parents needing to better supervise children and spend more time with them," $\underline{X}^2$ (4) = 17.33, $\underline{p} < .01$, "Children needing better control over negative feelings (for example: aggression, anger, wanting to fight)," $\underline{X}^2$ (4) = 10.76, $\underline{p} < .05$, or "Sexual acting out and teenage pregnancies needing to be stopped," $\underline{X}^2$ (4) = 11.34, $\underline{p} < .05$. Another three items showed differences only on the awarding of priority. Professionals were significantly more likely to stress the problems of "Parents need to better understand how children develop," $\underline{X}^2$ (1) = 4.27, $\underline{p} < .05$.

Solutions. There were no significant differences between the two groups on 21 of the 28 proposed solutions, and no single item produced differences both on level of agreement and

TABLE 13

Discipline as a Mental Health Problem

Group	Level of Agreement					X^2
	VSA	SA	A	NS	D	
Professionals	3	2	15	4	13	14.87*
Non-professionals	12	4	9	1	3	

*$p < .01$

Group	Priority[a]		X^2
	Yes	No	
Professionals	2	38	8.22*
Non-professionals	10	19	

*$p < .01$

[a]The "yes" column represents the number of respondents in each group who checked the item as a priority; the "no" column are those who did not check the item.

TABLE 14

Law Breaking as a Mental Health Problem

Group	Level of Agreement					
	VSA	SA	A	NS	D	X^2
Professionals	2	3	21	6	7	12.26*
Non-professionals	7	6	13	1	1	

*$p < .05$

Group	Priority[a]		
	Yes	No	X^2
Professionals	0	40	5.09*
Non-professionals	5	24	

*$p < .05$

[a]The "yes" column represents the number of respondents in each group who checked the item as a priority; the "no" column are those who did not check the item.

TABLE 15

Drug Abuse as a Mental Health Problem

Group	Level of Agreement					X^2
	VSA	SA	A	NS	D	
Professionals	9	9	17	0	5	23.74*
Non-professionals	23	4	2	0	0	

*$p < .001$

Group	Priority[a]		X^2
	Yes	No	
Professionals	6	34	6.08*
Non-professionals	13	16	

*$p < .01$

[a]The "yes" column represents the number of respondents in each group who checked the item as a priority; the "no" column are those who did not check the item.

on the issue of priority. Three solutions produced differences in general level of agreement, while four others resulted in priority differences. On the issue of "more drug abuse prevention centers," lay people tended to express stronger agreement, $\underline{X}^2$ (4) = 12.50, $\underline{p} < .01$; whereas professionals tended to disagree or be uncertain with regard to "More church activities for youth," $\underline{X}^2$ (4) = 16.01, $\underline{p} < .01$. Although the idea of "More low cost, conveniently located mental health services with transportation and convenient hours" produced significant differences between the two groups, these differences were not clearly in one direction. Non-professionals gave priority significantly more often than their counter parts to "More training for school personnel in how to see problems in children and handle them early," $\underline{X}^2$ (1) = 4.81, $\underline{p} < .05$, "More careful control of movies and books children see," $\underline{X}^2$ (1) = 8.26, $\underline{p} < .01$, and "Agencies following up families that do not return for service," $\underline{X}^2$ (1) = 5.09, $\underline{p} < .05$; while professionals placed more stress upon "more educational programs for children and adults in parenting, family life, relationships, and family planning," $\underline{X}^2$ (1) = 10.21, $\underline{p} < .001$.

Responses of CMHS Staff

Although the small number of staff members at CMHS made it impossible to compare their responses statistically to other groups, it was felt important to report them. Nine out of ten CMHS staff members returned the second questionnaire, and their responses to the three issues are summarized in Tables

16, 17, and 18. Overall, there is clearly a great deal of scatter in opinions; however, some trends emerge.

Mental Health Characteristics. On the issue of important characteristics for mental health the three most often given priority were:

1. Being able to form warm, trusting relationships with other people. (8)

2. Being independent, thinking for oneself, and working toward being able to care for oneself. (6)

3. Being able to understand oneself, like oneself, and feel confident in oneself. (6)

These same statements tended to elicit "Very Strongly Agree" responses.

Mental health characteristics most commonly disagreed with by CMHS staff were:

1. Being quiet, subdued, and cautious. (7)

2. Being christian and active in church. (7)

Problems. In terms of problems, the staff placed greatest priority on:

1. Parents need to be better able to solve their own problems and conflicts without involving their children. (7)

2. Parents need to better understand how children develop. (6)

Again, these also elicited the highest number of "Very Strongly Agree" responses.

Problems thought to be least important by this group included:

TABLE 16

CMHS Staff Responses to
Mental Health Characteristics

Responses						
X	VSA	SA	A	NS	D	Mental Health Characteristics
0	0	1	4	2	2	Being well disciplined, behaving, and respecting authority.
0	0	0	3	3	3	Being polite and well mannered.
2	3	0	6	0	0	Being bright, alert, clear headed, and having common sense.
2	2	6	1	0	0	Being generally curious, interested in trying new things in the world.
6	5	3	1	0	0	Being independent, thinking for oneself, and working toward being able to care for oneself.
5	6	3	0	0	0	Being able to take responsibility for his or her decisions and chores.
0	0	2	6	0	1	Having goals and planning for the future.
0	0	0	4	0	5	Being ambitious, hardworking, and industrious.
0	0	0	0	2	7	Being quiet, subdued, and cautious.
1	2	1	4	1	1	Being out going and friendly.
8	8	1	0	0	0	Being able to form warm, trusting relationships with other people.
5	7	1	1	0	0	Being sensitive toward other people and being able to show loving concern for others.
1	2	3	3	0	1	Being able to express feelings and ideas freely in words.
0	0	5	4	0	0	Being able to reasonably control emotions in dealing with frustration and conflict.
6	6	3	0	0	0	Being able to understand oneself, like oneself, and feel confident in oneself.
1	2	2	4	0	1	Being happy, carefree, fun-loving, and enjoying life.
0	0	2	5	0	2	Being even-tempered and agreeable rather than tense and nervous.
2	2	6	1	0	0	Being flexible and able to deal with new situations, even when there is stress.

Table 16 (continued)

0	0	1	2	1	5	Being relatively clean, neat, and well groomed.
0	0	0	0	2	7	Being christian and active in church.
3	3	3	2	0	1	Having close relationships with family members and being happy at home.
0	1	0	5	2	1	Being interested, motivated, and able to succeed in school.
0	0	1	4	0	4	Being involved in activities (for example: sports, clubs, etc.).
0	0	0	7	1	1	Being able to relate well with people of other races.
2	2	1	5	1	0	Being honest and truthful.
0	0	1	4	3	1	Obeying the law.

TABLE 17

CMHS Staff Responses to
Mental Health Problems

Responses						
X	VSA	SA	A	NS	D	Problems
0	0	0	3	1	5	Children need to be better able to behave, accept discipline, and respect adults.
6	6	1	2	0	0	Parents need to better understand how children develop.
5	3	4	2	0	0	Parents need to be more effective parents (for example: using more moderate, consistent discipline).
7	6	2	1	0	0	Parents need to be better able to solve their own problems and conflicts without involving their children.
2	3	1	5	0	0	Children need help in adjusting to divorces, broken homes, and new step parents.
3	3	3	1	1	1	Children need to believe more strongly that they are loved and that parents are concerned about them.
0	2	1	5	0	1	Parents need to better supervise children and spend more time with them.
2	3	1	5	0	0	Children need to be able to form better, more trusting relationships with other people.
0	0	3	4	0	1	Children need better control over negative feelings (for example: aggression, anger, wanting to fight).
0	1	3	5	0	0	Children who are hyperactive need help and understanding in dealing with the world.
0	0	0	3	2	3	Children need to stop breaking the law and have more respect for authority.

Table 17 (continued)

4	3	3	3	0	0	Children need to be able to communicate more freely, being able to listen and express feelings.
1	1	1	7	0	0	Children who are somehow different (handicapped, overweight, retarded, etc.) need understanding and the ability to be happy with themselves.
1	1	1	5	1	1	Children need more encouragement to be motivated and have reasonable goals and ambitions in life.
1	2	2	3	1	1	Children need to have better family relationships so there will be fewer runaways.
3	2	4	3	0	0	Children need to better understand themselves and feel good about themselves.
0	0	1	2	2	4	Sexual acting out and unwanted teenage pregnancies need to be stopped.
0	0	1	7	1	0	Children need to be more happy, easy going, enjoying life.
0	2	2	3	1	1	Children need help to succeed in school and achieve all that they can.
0	1	2	3	1	2	Children need to be more motivated to try in school, attend and finish school.
5	2	5	2	0	0	Children need help to become more independent and responsible.
1	0	5	4	0	0	Children need help in dealing with hard life situations.
0	0	1	6	0	2	Drug abuse needs to be controlled.
2	2	3	3	1	0	Physical and sexual abuse of children in families needs to be stopped.
0	0	0	5	1	3	Race relations among children need to be improved.
1	1	1	2	2	3	Families need more financial aid in order to care for their children.
0	0	0	2	2	5	Bedwetting in older children needs to be stopped.

TABLE 18

CMHS Staff Responses to Possible Solutions

Responses						
X	VSA	SA	A	NS	D	Solutions
4	2	4	1	1	1	More residential (live-in) treatment centers for children, which both diagnose and treat problems.
3	1	4	3	1	0	More living placements (both permanent and temporary) for hard to place children (retarded, delinquent, less intelligent, etc.).
5	4	3	1	0	1	More low cost, conveniently located mental health services with transportation and convenient hours.
2	1	2	5	0	1	More immediate services for crises.
1	2	2	3	1	1	Less waiting time for all services.
2	0	4	4	0	0	More treatment available for learning disabled and hyperactive children.
4	5	1	2	0	0	More community understanding and support for mental health services.
1	1	2	4	1	1	More public information on what service is available and a central agency to make referrals.
2	1	6	2	0	0	Inexpensive day care in local areas for both normal children and problem children.
1	1	1	5	0	2	More financial and social aid for needy families.
3	2	5	2	0	0	More training for school personnel in how to see problems in children and handle them early.
1	1	4	4	0	0	More mental health teams in schools to work with unmotivated, problem children and help curb truancy and drop outs.
0	0	5	2	1	1	More free recreation in local areas which is supervised by interested adults.

Table 18 (continued)

2	2	1	5	1	0	More vocational training and jobs for youth.
0	0	0	4	3	2	More drug abuse prevention centers.
0	0	0	6	1	2	More bilingual services with staff members from several races and cultures.
2	1	2	4	1	1	More educational programs for children and adults in parenting, family life, relationships, and family planning.
0	0	0	2	3	4	Better law enforcement, control of problem youth.
2	1	3	5	0	0	Discussion groups providing support for parents (both single and couples).
2	2	4	2	1	0	More family centered approaches used by agencies and emphasis on family activities.
1	1	2	2	3	1	The law putting children's needs first rather than seeing children as parents' property.
0	0	0	1	1	7	More careful control of what movies and books children see.
0	0	0	6	2	1	Home and school visits by mental health teams.
1	1	3	3	1	1	Use of television and radio to teach important things about mental health.
0	0	2	1	1	5	More church activities for youth.
0	0	1	5	1	2	Agencies following up families that do not return for service.
2	1	2	3	1	2	More volunteer men and women to work with individual children.
3	2	1	4	1	1	School classes on values, emotions, and self-knowledge.

1. Children need to be better able to behave, accept discipline, and respect adults. (5 disagree)

2. Bedwetting in older children needs to be stopped. (5 disagree).

Solutions. Concerning solutions needed, CMHS staff gave highest priority and greatest agreement to:

1. More low cost, conveniently located mental health services with transportation and convenient hours. (5)

2. More community understanding and support for mental health services. (4)

3. More residential (live-in) treatment centers for children, which both diagnose and treat problems. (4)

Strongest disagreement was voiced concerning "More careful control of what movies and books children see." (7 disagree)

CHAPTER V

DISCUSSION

Given the design and goal of the present study, questions most important for consideration would be: (a) what conclusions can be drawn with regard to mental health characteristics, problems, and possible solutions relevant to Harris County? (b) what resources are potentially available within the catchment area? (c) what are the attitudes of CMHS staff and how do these fit in with those of other groups? (d) what are the implications of the present findings for CMHS? and (e) of what realistic benefit are the methods used in the present study?

Greatest correlation of priorities between lay people and the professional community occurred around the issue of most important characteristics of a mentally healthy child. Majority opinion in both groups gave strongest emphasis to self understanding and a positive self image. Based upon the opinions gathered, a mentally healthy child would be a child who is self aware, who feels self confident and positive about himself, and who is actively striving for independence and an acceptance of responsibility for himself and his activities. Such a child would be capable of being open and establishing trust in interpersonal relationships. Respondents placed emphasis upon qualities of assertiveness and being in command of oneself, while elements of docility and external appearance

were clearly de-emphasized. It is interesting to note that discipline and respect for authority ranked below nine other characteristics, with six persons disagreeing and nine other unsure of their importance. The establishment of warm, secure relationships (both in the home and in the community) was given greater priority for mental health than was discipline.

Lay people did seem to conceptualize mental health somewhat differently from the professional community. Non-professionals put significantly more stress upon discipline, honesty, and obedience to law and authority. They were also more concerned about children entering into more socially productive activities, working hard, and planning for the future. Professionals, on the other hand, placed less emphasis upon externally prescribed activities and rather stressed the development of independence and personal responsibility. The professional community also gave greater weight to the qualities of warmth and trust in social relationships than to politeness or respect for authority. Overall, it appeared that parents in the community were more concerned with issues of social conformity, while mental health professionals were stressing development of individuality as the key to mental health.

The most global needs stressed by respondents were the need to improve children's self awareness and sense of self worth and the need to improve their interpersonal relationships, both with families and with people in the larger community. A very specific target of concern was physical

and sexual abuse of children within families. Several specific problems mentioned in the original interviews (e.g. bedwetting, sexual acting out, racial friction) were not emphasized as primary areas of need. This may reflect a lack of generalized concern about these issues or the idea that these are secondary to the more basic problems of low self esteem and inability to form satisfactory social relationships.

Once again, parents and professionals showed some differences in their perspectives on needs. Lay people placed more stress upon prevention of drug abuse and better law enforcement. They evidenced a greater concern about their children's school behavior and performance. Mental health professionals tended to emphasize the need for improved parental understanding of children and how they develop. On the whole, parents demonstrated a greater concern about increased discipline, supervision, and control, while the professional community advocated a re-opening of parental awareness and understanding of children's behavior.

With regard to possible solutions to existing problems, strong support was given to making mental health services more generally accessible, rather than developing new and different services. The importance of utilizing more effectively resources within the school system was heavily stressed. Considerable disagreement was voiced regarding increased censorship and control; however, this disagreement received much

of its strength from the professionals rather than from parents. Although professionals emphasized the need for more family education, this did not seem to be a major concern among parents.

Upon examining the entire list of resources mentioned by respondents, it was clear that a wide variety of services are potentially available to residents of Harris County. However, during the interviewing process it was evident that individuals were generally unaware of the services offered. Interviewees (professionals as well as non-professionals) frequently stressed a need for services which the interviewer already knew to be in existence. In addition, interviewees were often uninformed as to the specific nature of services offered by the various agencies. This would certainly add support to the notion of making present services more generally accessible, before attempting to develop new ones.

The attitudes and opinions expressed by CMHS staff members do not appear to differ markedly from those of the broader community. Priorities given to important mental health characteristics, as well as to needed solutions, concurred substantially with general opinions. However, in the area of need, CMHS staff members placed greatest emphasis on need for change in parental understanding and attitudes. This appeared to reflect an agency emphasis on work with families, stressing heavily the importance of interpersonal relationships.

For the staff members this focus seemed to extend beyond the family and include a concern about community understanding.

Data gathered in the present study suggest several areas of need, generally agreed upon, which could be considered for emphasis at CMHS. However, data also indicate several areas of disagreement between mental health professionals and parents in the community. If the credibility of CMHS and other mental health agencies is to be strengthened, and if they are to work with parents in meeting the mental health needs of children, it would be important for disagreement to be fully understood and minimized. A first step would be to communicate conflicting attitudes to the CMHS staff for consideration. Beyond this, the following possibilities might be considered for program development:

1. More specific programs could be developed to work on imporvind self esteem and enhancing relationship skills. Since the need seems very broad in scope, it would be advantageous if such programs could be developed for use not only by CMHS, but also by others in the community (e.g. school counselors).

2. Programs could be developed to deal specifically with abused children and abusive parents.

3. More stress might be placed on developing the area of preventive mental health services.

4. Since much emphasis was placed upon the school system, it might be important to develop stronger ties with school

personnel. This could take the form of consultation, increasing school visits, offering occasional in-service training, or simply the sharing of programs developed to deal with specific problem areas.

5. Since the issues of discipline and control seemed to generate the most disagreement, programs designed to promote communication between parents and professionals around these issues might prove helpful.

6. There appears to be a clear need for more contact among professional agencies serving children and an increase in mutual dissemination of information.

7. Continued emphasis on working with parents could not only serve therapeutic purposes but also aid in bridging the communication gap between parents and mental health professionals.

The methodology employed in the present needs assessment offered several advantages over previous methods. It was able to gather ideas from all three segments of the population (the servers, the served, and the community at large) and establish priorities common to all three groups. Both differences and similarities between views of mental health professionals and parents were clearly accented. In addition to its usefulness to program planners, an awareness of such basic differences could be potentially helpful to clinicians in understanding families with whom they work. It seemed that differences in thinking about mental health became

particularly obvious using a method which invited respondents to express original ideas rather then dictating ideas from which to choose. This approach was quite valuable in working with individuals from a variety of sub-populations and subcultures. At the same time the personal interview gave an opportunity to examine the ideas of these various individuals in some depth, so that needs rather than solutions could be the focus. The final instrument which was developed provided a foundation for an on-going process of needs assessment which incorporates the original ideas from the community about current problems.

A final advantage to this particular method lay in the process itself. It provided an opportunity for the agency to make direct contact with other agencies and professionals in the community, as well as with a group of parents. Such contacts on a periodic basis could lay the foundation for an improved communication system. Even in the present study, the second questionnaire allowed each respondent exposure to the ideas of the broader comunity. Responses from other professionals requesting copies of the report in final form indicated that interest had been generated.

An essential part of any needs assessment is obtaining adequate responses from the population. Although in this case, the sample was relatively small, it was found in the interviews that major ideas quickly began to be repeated, and, before the sample was exhausted, almost no new ideas

were forthcoming. The second round questionnaire produced a 69% return, considerably higher than the usual return of questionnaires distributed by mail. A key element in achieving this return appeared to be personal contact. The initial interview provided an opportunity for personal interaction and gave the investigator an opportunity to encourage further participation. The follow-up telephone call provided additional contact and resulted in an additional return of 15%. Although significantly fewer Blacks, non-clients, and persons of lower socio-economic status returned the second questionnaire, the method still offered the potential for inclusion of their ideas in this instrument.

Despite advantages, it became clear that the present methodology has several important drawbacks in terms of needs assessment. It is clearly a cumbersome technique to apply to broad populations. Given the costs (particularly in terms of staff time) involved, it is not feasible to contact a very large sample and, therefore, difficult to adequately represent a variety of sub-groups. Additionally, in large urban areas, it is less likely that single individuals will be aware of the needs of the larger community. The method would, therefore, be best utilized in small areas, and results would not be expected to generalize on a broad scale.

It is also clear that results are based totally upon the subjective opinions of respondents, which they are able

to articulate. It can be questioned whether all important mental health needs can be clearly articulated by such a population. Other methods have offered slightly more objective observations (e.g. diagnostic interviews), and it is unclear whether such procedures would not produce an array of needs not mentioned by respondents. The present procedures seem to assume that individuals are consciously aware of their primary needs and able to articulate them.

Although the method provides a broad base of information, there are three particular content areas it fails to illuminate. First, it gives little information on high risk groups, which would be particularly valuable in planning preventive programs. Second, needs are not analyzed in terms of geographic location, which would be helpful in broad program planning. Finally, little was offered in terms of forecasting potential needs of the near future, and procedures would need to be repeated several times in order to establish trends. It would seem then ideally desirable to employ a combination of methods to examine needs from all pertinent focuses.

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APPENDIX A

Sample Interview Schedule

Group _____

1. I would like you to describe a child you know who is mentally healthy/well adjusted/gets along well in life/ is as you feel a child should be.

   Why did you choose this particular child?

   What do you think makes him/her this way?

2. Describe a second child (as above).

3. What are the major mental health problems you and your family are experiencing/have experienced? When I talk about a "problem" I mean the difference between the way things are now and the way that you would like them to be -- a gap in other words.

4. What types of problems (gaps) do you think are important in the community around you?

   Groups: Ages birth to 5, grade school children, junior high children, high school children, boys, girls

5. What do you feel is most needed in the community to combat these problems? Possible solutions?

6. What agencies/services have you personally used?

APPENDIX B

Personal Data Sheets

Personal Data Sheet

(For Professionals)

Please do not write any identifying information on this form. The information given here is to be anonymous.

Age _____ Sex: M F Ethnic group _____

Occupation _____

Agency (if any) _____

Number of years in present occupation _____

Education (last level completed) _____

Thank you very much!

Personal Data Sheet

(For Non-professionals)

Age _____ Sex: M F Ethnic group _____

Your occupation _____

Occupation of head of household (if different) _____

Education (last level completed) _____

Education of head of household (if different) _____

Do not write any identifying information on this form. However, please give the interviewer an address and telephone number where you may be reached for the rest of the summer, if different from your present address and telephone number. This will allow us to give you the second questionnaire.

Thank you very much for your cooperation!

APPENDIX C

Needs Assessment Questionnaire

Instructions:

You will see that the questionnaire has three pages and each page begins with a statement. On Page 1 you are asked to decide what characteristics are most important to develop in a child if he or she is to be healthy, well adjusted and generally able to get along well in life. Please begin by reading all 26 statements. In front of each statement there are a group of letters which stand for answers:

VSA = Very Strongly Agree
SA = Strongly Agree
A = Agree
NS = Not Sure
D = Disagree

Once you have read all the statements go back to each and circle the letters which give your opinion about the idea. You may think that many, if not all, of the statements are good ideas. However, we want to know which of them you feel are most important, or the ones you think should have priority. For example, if you do not agree that a particular characteristic is very important for a child to be mentally healthy you would circle "D" and go on to the next item. Once you have circled one answer for each item on the page, please go back once more and put an "X" beside the five items you think are of greatest importance to mental health.

Page 2 asks what problems you think are the most important in the community. Again, please read all statements first; then go back and answer as on Page 1. We are really interested in your honest opinion about how you see children's problems.

Page 3 asks what things you think are needed in the community. Please answer each item as you did on the first two pages.

It is very important that all of the items be answered. If you have any questions, please feel free to call Mary Alice Conroy at 524-9111. When you have completed the questionnaire, please return it as soon as you can in the enclosed envelope.

Again, thank you for your cooperation.

The most important characteristics of a mentally heathy, generally well adjusted child are:

VSA	SA	A	NS	D	1.	Being well disciplined, behaving, and respecting authority.
VSA	SA	A	NS	D	2.	Being polite and well mannered.
VSA	SA	A	NS	D	3.	Being bright, alert, clear headed and having common sense.
VSA	SA	A	NS	D	4.	Being generally curious, interested in trying new things in the world.
VSA	SA	A	NS	D	5.	Being independent, thinking for oneself, and working toward being able to care for oneself.
VSA	SA	A	NS	D	6.	Being able to take responsibility for his or her decisions and chores.
VSA	SA	A	NS	D	7.	Having goals and planning for the future.
VSA	SA	A	NS	D	8.	Being ambitious, hardworking, and industrious.
VSA	SA	A	NS	D	9.	Being quiet, subdued, and cautious.
VSA	SA	A	NS	D	10.	Being outgoing and friendly.
VSA	SA	A	NS	D	11.	Being able to form warm trusting relationships with other people.
VSA	SA	A	NS	D	12.	Being sensitive toward other people and being able to show loving concern for them.
VSA	SA	A	NS	D	13.	Being able to express feelings and ideas freely in words.
VSA	SA	A	NS	D	14.	Being able to reasonably control emotions in dealing with frustration and conflict.
VSA	SA	A	NS	D	15.	Being able to understand oneself, like oneself, and feel confident in oneself.
VSA	SA	A	NS	D	16.	Being happy, carefree, fun-loving, and enjoying life.
VSA	SA	A	NS	D	17.	Being even-tempered and agreeable rather than tense and nervous.
VSA	SA	A	NS	D	18.	Being flexible and able to deal with new situations, even when there is stress.
VSA	SA	A	NS	D	19.	Being relatively clean, neat, and well groomed.
VSA	SA	A	NS	D	20.	Being christian and active in church.
VSA	SA	A	NS	D	21.	Having close relationships with family members and being happy at home.
VSA	SA	A	NS	D	22.	Being interested, motivated, and able to succeed in school.
VSA	SA	A	NS	D	23.	Being involved in activities (for example: sports, clubs, etc.).
VSA	SA	A	NS	D	24.	Being able to relate well with people of other races.
VSA	SA	A	NS	D	25.	Being honest and truthful.
VSA	SA	A	NS	D	26.	Obeying the law.

*IMPORTANT! Now that you have answered each of the questions be sure to go back and put an X beside the FIVE characteristics which you think are the most important.

The most important problems of children in Houston which need to be worked on are:

VSA	SA	A	NS	D	1.	Children need to be better able to behave, accept discipline, and respect adults.
VSA	SA	A	NS	D	2.	Parent need to better understand how children develop.
VSA	SA	A	NS	D	3.	Parents need to be more effective parents (for example: using more moderate, consistent discipline).
VSA	SA	A	NS	D	4.	Parents need to be better able to solve their own problems and conflicts without involving their children.
VSA	SA	A	NS	D	5.	Children need help in adjusting to broken homes, divorces, and new step parents.
VSA	SA	A	NS	D	6.	Children need to believe more strongly that they are loved and that parents are concerned about them.
VSA	SA	A	NS	D	7.	Parents need to better supervise children and spend more time with them.
VSA	SA	A	NS	D	8.	Children need to be able to form better, more trusting relationships with other people.
VSA	SA	A	NS	D	9.	Children need better control over negative feelings (for example: aggression, anger, wanting to fight).
VSA	SA	A	NS	D	10.	Children who are hyperactive need help and understanding in dealing with the world.
VSA	SA	A	NS	D	11.	Children need to be able to communicate more freely, being able to listen and express feelings.
VSA	SA	A	NS	D	12.	Children who are somehow different (handicapped, overweight, retarded, etc.) need understanding and the ability to be happy with themselves.
VSA	SA	A	NS	D	13.	Children need to stop breaking the law and have more respect for authority.
VSA	SA	A	NS	D	14.	Children need more encouragement to be motivated and have reasonable goals and ambitions in life.
VSA	SA	A	NS	D	15.	Children need to have better family relationships so there will be fewer runaways.
VSA	SA	A	NS	D	16.	Children need to better understand themselves and feel good about themselves.
VSA	SA	A	NS	D	17.	Sexual acting out and unwanted teenage pregnancies need to be stopped.
VSA	SA	A	NS	D	18.	Children need to be more happy, easy going, and enjoying life.

VSA	SA	A	NS	D	19.	Children need help to succeed in school and achieve all that they can.
VSA	SA	A	NS	D	20.	Children need to be more motivated to try in school, attend and finish school.
VSA	SA	A	NS	D	21.	Children need help to become more independent and responsible.
VSA	SA	A	NS	D	22.	Children need help in dealing with hard life situations.
VSA	SA	A	NS	D	23.	Drug abuse needs to be controlled.
VSA	SA	A	NS	D	24.	Physical and sexual abuse of children in families needs to be stopped.
VSA	SA	A	NS	D	25.	Race relations among children need to be improved.
VSA	SA	A	NS	D	26.	Families need more financial aid in order to care for their children.
VSA	SA	A	NS	D	27.	Bedwetting in older children needs to be stopped.

*IMPORTANT! Now that you have answered each of the questions be sure to go back and put an X beside the FIVE problems which you think are the most important.

The most important things needed in the community to solve the problems children have are:

VSA	SA	A	NS	D	1.	More residential (live-in) treatment centers for children, which both diagnose and treat problems.
VSA	SA	A	NS	D	2.	More living placements (both permanent and temporary) for hard to place children (retarded, delinquent, less intelligent, etc.).
VSA	SA	A	NS	D	3.	More low cost, conveniently located mental health services with transportation and convenient hours.
VSA	SA	A	NS	D	4.	More immediate services for crises.
VSA	SA	A	NS	D	5.	Less waiting time for all services.
VSA	SA	A	NS	D	6.	More treatment available for learning disabled and hyperactive children.
VSA	SA	A	NS	D	7.	More community understanding and support for mental health services.
VSA	SA	A	NS	D	8.	More public information on what service is available and a central agency to make referrals.
VSA	SA	A	NS	D	9.	Inexpensive day care in local areas for both normal children and problem children.
VSA	SA	A	NS	D	10.	More financial and social aid for needy families.
VSA	SA	A	NS	D	11.	More training for school personnel in how to see problems in children and handle them early.
VSA	SA	A	NS	D	12.	More mental health teams in school to work with unmotivated, problem children and help curb truancy and drop outs.
VSA	SA	A	NS	D	13.	More free recreation in local areas which is supervised by interested adults.
VSA	SA	A	NS	D	14.	More vocational training and jobs for youth.
VSA	SA	A	NS	D	15.	More drug abuse prevention centers.
VSA	SA	A	NS	D	16.	More bilingual services with staff members from several races and cultures.
VSA	SA	A	NS	D	17.	More educational programs for children and adults in parenting, family life, relationships, and family planning.
VSA	SA	A	NS	D	18.	Better law enforcement, control of problem youth.
VSA	SA	A	NS	D	19.	Discussion groups providing support for parents (both single and couples).
VSA	SA	A	NS	D	20.	More family centered approaches used by agencies and emphasis on family activities.
VSA	SA	A	NS	D	21.	The law putting children's needs first rather than seeing children as parents' property.

VSA SA A NS D 22. More careful control of what movies and books children see.
VSA SA A NS D 23. Home and school visits by mental health teams.
VSA SA A NS D 24. Use of television and radio to teach important things about mental health.
VSA SA A NS D 25. More church activities for youth.
VSA SA A NS D 26. Agencies following up families that do not return for service.
VSA SA A NS D 27. More volunteer men and women to work with individual children.
VSA SA A NS D 28. School classes on values, emotions, and self knowledge.

*IMPORTANT! Now that you have answered each of the questions be sure to go back and put an X beside the FIVE solutions which you think are most important.

APPENDIX D

Cover Letter Accompanying Second Questionnaire

Dear _____:

You will remember that I visited you earlier this summer to collect some of your ideas about mental health problems and needs. By now I have collected a list of the major ideas everyone presented and put them together in three lists. The questionnaire I am sending you is basically the lists of everyone's ideas, and it asks for your opinion on each.

In total, I was able to speak with only about 100 people in Houston, so your response is very important to us at the agency. We very much appreciated your time and cooperation thus far and hope that you will take the time now to complete this final questionnaire. The sooner we get all of the questionnaires back, the sooner we will be able to complete the project and go ahead with further program planning.

I have one final request and that is that you read carefully the instructions before answering. The instructions should help to make items clear; however, if you have any questions please call me personally and I will be happy to try to answer them.

Thank you very much.

Sincerely,

Mary Alice Conroy
Research Manager