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The Mental Health Needs of Different Age Groups Within an Urban Community as Perceived by Service Providers and Service Recipients Within That Community

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THE MENTAL HEALTH NEEDS OF DIFFERENT AGE GROUPS
WITHIN AN URBAN COMMUNITY AS PERCEIVED
BY SERVICE PROVIDERS AND SERVICE
RECIPIENTS WITHIN THAT COMMUNITY

BY
JOEL LASKIN

A THESIS SUBMITTED TO THE FACULTY OF THE GRADUATE SCHOOL
OF LOYOLA UNIVERSITY IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
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ABSTRACT

This investigation sought to determine whether the mental health need ratings of any given group or groups would be given priority over other age groups in the Rogers Park Community of Chicago. The study also sought to ascertain whether potential mental health service providers and potential mental health service recipients would differ in the priorities they assigned to various age groups.

The study was carried out by administering a questionnaire to 60 randomly selected potential service providers (20 teachers, 20 clergy, 20 social service agency representatives) working in Rogers Park, and to 20 potential service recipients (randomly selected residents of Rogers Park). The questionnaire consisted of a list of 34 potential services that could feasibly be provided by a Community Mental Health Center. Each potential service was rated by the Ss as to the apparent need of such a service on a 5 point scale. Selected services were pertinent to the following age groups: preschool, elementary school age, teenage, young adult, middle age, senior citizen. All ratings were done individually.

The ratings were analyzed using a factorial design. Neither the main effects nor the interactions reached an acceptable level of significance. The results were interpreted as suggesting that potential service providers and potential service recipients are essentially in agreement as to the mental health needs of the community. Further, while both recipients and providers recognize a strong need for mental health services of all kinds for the Rogers Park Community, no age group was seen as being in greater need of service than any other age group.

VITA

Joel Laskin was born on August 21, 1946, in Canton, Ohio. He received his undergraduate degree from Oberlin College in 1968. Before entering Loyola University he spent an interesting year as a taxi driver.

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THE MENTAL HEALTH NEEDS OF DIFFERENT AGE GROUPS
WITHIN AN URBAN COMMUNITY AS PERCEIVED
BY SERVICE PROVIDERS AND SERVICE
RECIPIENTS WITHIN THAT COMMUNITY

Joel Laskin

Loyola University of Chicago

Introduction and Review of the Literature:

Within the North Town-Rogers Park area, on Chicago's near north shore, a community mental health program is being developed. The State of Illinois and the city of Chicago have united in the initial planning of this program. Some of the groundwork has been laid by the North Town-Rogers Park Mental Health Council, composed of interested private citizens, of representatives from the city and state, and associations within the community. While outlining a program of mental health services, little information was found concerning the recipients' as well as the providers' perception of mental health priorities. It, however, seemed apparent at early meetings of the North Town-Rogers Park Mental Health Council that some differences of mental health priorities did exist. The council itself could not reach a consensus; therefore it was felt that a survey may be beneficial. This study, therefore, surveys the population of the North Town-Rogers Park community in order to contract the perceived needs of different age groups within the community as seen by the potential service providers and potential service recipients within the community.

To fully understand the relevance of this research, it may be helpful to document the trends that have brought the mental health field to its present position. The first trend is that of community

involvement in its own mental health planning and implementation. This trend began with the work of Dorothea Dix and Clifford Beers, both private citizens concerned with the welfare of the mentally ill. Miss Dix, through her crusades for the humane treatment of the mentally ill, helped establish the first state hospital (White, 1957). These hospitals, though inadequately staffed at the outset, have continued to function as the country's only answer to the mental health problem.

Beers, a former mental patient, dramatized the inhumane treatment in hospitals in his book, The Mind That Found Itself. This publication, coupled with hard work on the part of Beers, led to the initiation of the Community Mental Health movement in the United States. In 1908, Beers, with the help of many enlightened citizens, founded the Connecticut Society for Mental Hygiene, which one year later became the National Committee for Mental Hygiene, later to become the National Association for Mental Health. The function of all these associations was that of a watchdog. In spite of the efforts of Beers and others like him, the people involvement trend of mental health did not seem to crystallize until after World War II.

The other trend, that of professional involvement in fostering mental health in addition to treating those already mentally ill, rekindled the mental health flame with the development of the Child Guidance Clinics in the 1920's and 1930's. These clinics initially developed as adjuncts to the juvenile courts, rapidly broadened their perspectives by establishing relationships with schools and other social agencies. This change in orientation led to a broadening of approaches to mental problems from the more traditional approaches

(essentially inpatient care - often custodial in nature - of severely disturbed patients) of the 19th and 20th centuries. Thus, the professionals involved in this second trend were much more concerned with non-traditional mental health issues (e.g., primary prevention, treating cases other than psychotics and neurotics, outpatient psychotherapy, etc.). Two of the earliest clinics with a non-traditional approach were the Juvenile Psychopathic Institute in Chicago (1909) and Judge Baker's Guidance Center in Boston (1917). The major contributions of these guidance clinics were as follows: (1) they introduced preventive psychiatry by trying to work with parents and schools to detect and control abnormal behavior in its early stages; (2) they introduced the team approach, in which psychiatrists, psychologists, and social workers worked together with the patient; (3) they emphasized treatment without hospitals; (4) they also introduced innovative procedures such as environmental manipulation and family therapy (Bellak and Barton, 1969).

The experience of the two World Wars helped to solidify the role of professionals in the development of mental health agencies. Firstly, the armed services screened thousands of potential soldiers every day, making it necessary to develop precise screening techniques. Hunt (1969) feels that these techniques are the only way mental health agencies can successfully accommodate the great masses to which they will have to cater. Secondly, frontline intervention, a technique that was highly effective in dealing with psychiatric casualties, was instrumental in developing short term therapies and what is now called crisis intervention.

The World War I experience also influenced professionals in the military to push for the establishment of the Division of Mental Hygiene

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within the Public Health Service. The Division was established in 1930 but remained relatively inactive until 1946 when Congress passed the Mental Health Act which, for the first time, introduced the concept of a nationally co-ordinated mental health program (Bellak and Barton, 1969). This act contained two major points that have proven vital to the mental health movement: (1) federal funds were finally allotted to voluntary citizen organizations for construction costs and demonstration projects; (2) the act made the formation of the National Institute of Mental Health possible. Through the NIMH, federal support was given to programs in three new focus areas: (1) development of mental health research; (2) training and mental health manpower; (3) support of state and local programs to improve mental health services and resources (Duhl and Leopold, 1968).

The role of the professional in the mental health movement became much more explicit with the passage of the Community Mental Health Centers Act of 1963. The provisions of the act were divided into three major areas: (1) funding; (2) recipients; (3) services.

Funding: The Act authorized the appropriation of money to provide for financing of one-third to two-thirds of the cost of constructing local community mental health centers.

Recipients: The services were provided in terms of population rather than geographical area. To obtain these funds, centers had to agree to provide for an area in which the population is greater than 75,000 and less than 200,000 in number.

Services: To be eligible for funds, a community mental health center had to provide the five essential services: (1) inpatient care for people who need intensive care or treatment around the clock; (2) out-patient care for adults, children and families; (3) partial hospitalization,

at least day care, for patients who are able to work but are needing limited support or lacking suitable home arrangements; (4) emergency services on a 24-hour basis by one of three services previously mentioned; (5) consultation and education to community agencies and professional personnel.

Community mental health centers were also encouraged to develop the following supplemental services: (1) diagnostic services; (2) rehabilitation services; (3) pre-care services, including screening of patients prior to hospital admission, home visits, and halfway houses after hospitalization; (4) training for all types of mental health personnel; (5) research and evaluation concerning the effectiveness of programs and the problems of mental illness and its treatment (Bellak and Barton, 1969).

Professionals are also concerned with where the mental health resources should be focused. Hobbs (1968) feels that over half of the resources should go into the area of child psychology. He feels that children should be of primary concern and that much of the remaining resources should go into areas of family and education. Rosenblum (1968) feels that professional interest should move to the professional well-being of the community at large. He feels that the professional should move out of his office and act as an integrating mental health agent working with problems that arise as a function of stressful community situations. Hersch (1969) states that psychotherapy must change its orientation. He feels that the patient, as previously defined, now includes any member of the community who suffers from some degree of impairment. Thus, it is apparent that the professional interest is moving from what was classically called psychopathology to a more

broadly used term: impairment.

Professionals now feel that community mental health centers and their workers must be concerned with all areas of psychology as well as other sciences. Glidewell (1968) feels that community psychology must be a psycho-social thing, and community psychologists must be able to integrate urban values to other in socio-economic security. Thus it is evident that community mental health centers are no longer seen as just hospitals or extensions of the psychiatric co-op. Rief (1963) feels that it is imperative that mental health centers also realize that the poor people are not interested in self-actualization or inner peace, but they are much more concerned with self-determination. They do not see themselves as victims of their own selves, but rather as victims of circumstances.

Since community mental health centers are going to be much more concerned with stressful circumstances than intrapsychic problems (Hersch, 1969), each center must be sensitive to the circumstances that its population feels. This research hopes to bridge this sensitivity gap by not only finding what the perceived mental health needs are, but also by informing the community residents of what services are available, and by re-initiating the people-involvement trend of mental health which seemed to die out after people like Dorothea Dix and Clifford Beers.

When developing a community mental health center, it is felt that community appraisal and understanding are two of the most important ingredients necessary for community acceptance. Caplan (1969) sees knowledge of the mental health priorities of the community members as being essential in organizing community programs. Smith and Hobbs (1968) point out that to be effective the services of a community mental health center must

be carefully tailored to the priorities of the community. Klein (1965) suggests that group cohesion and organization are essential to the development of a sense of community as a pre-requisite for the initiation of mental health services. Rieman (1969) goes a step further in saying that local in-depth involvement in problem appraisal, development of priorities and implementation of services are other essential ingredients for effective community rapport.

It is also apparent that in order to effectively work within a given community, an accurate appraisal of the community's needs and resources is necessary. Klein (1968) feels that the community's distinctive way of viewing itself often correlates with the community's reaction toward the introduction of a mental health program. He feels that in order to establish the necessary hierarchy of community needs it is essential that the community has an accurate concept of itself and its needs. He suggests that the perception of the community's needs are also tied in with the community's social-psychological structure based on demographic variables such as nationality, religion, educational level, occupational pursuits, etc. These demographic variables seem to alter both the awareness of existing problems and the appropriate utilization of present community resources. Bahn (1965) found that bio-social and ecological attributes are also vital to an accurate appraisal of community needs.

The most efficacious way of thoroughly assessing any community seems to be by survey techniques. Klein (1968), in a ten-year mental health research program in Wellsley, Massachusetts, found survey techniques necessary in determining the distribution of mental health concerns within the given community. He feels that such surveys are an integral part of any successful mental health operation. Weisman (1969) echoes these sen-

timents. He feels that in order to meet the needs of the clients, as clients define them, the client populace must be surveyed. This is how he began developing mental health services on New York's Lower East Side, which has proven to be one of New York's most successful mental health developments. Kellam and Schiff (1968) also applaud survey techniques through their experiences in developing community mental health services in the Woodlawn area of Chicago. They felt that survey techniques made it possible (1) to assess the mental health needs of an urban neighborhood community; (2) to assess the resources available to meet these needs of this urban community; (3) to establish with the community a system that would indicate the sequence of problems to attack; (4) to develop with community support mental health programs directed at top priority problems.

Though these large scale evaluation programs seemed to be successful in developing mental health services and community cohesion, there still is the feeling that such studies have vaguely defined goals and lack of technical knowledge as to what data are most relevant for the development of community programs (Moore, Blum, Gaylin, 1967). Moore et. al. (1967) also feel that the skills needed for the understanding of the data for program development are certainly not utilized and possibly not available. Smith and Hansell (1967) echo these sentiments; they feel that large community evaluation programs do not set a positive example of well-executed studies, due in part to the absence of carefully controlled laboratory environment and difficulties in controlling and identifying important variables involved, and thus an inability to meet the criterion of scientific method.

Though there is a paucity of available research in the area of perceived needs, one researcher does consider the point. Whittington (1960) developed a program that attempted to meet the community's perceived needs as rapidly

as possible via all available agencies. Given the groundwork by surveys, community cooperation and understanding, Whittington discerned that mental health efforts can refocus misperceptions and expectations of the community into more realistic areas. For example, Whittington found that he and his staff were able to alleviate many of the mystical fears that are often associated with psychology and mental health.

Thus it would seem that even though the survey technique can be criticized as a scientific instrument, it has proven to be useful in evaluating a given community and its needs. This usefulness is extremely important in combatting the immediate problem in developing community mental health facilities.

METHOD

SUBJECTS:

Twenty citizens, defined as the service recipient group, were randomly subselected from a larger sample of 300 randomly selected Ss within the North Town-Rogers Park community. Rogers Park is located in the most extreme northeast corner of Chicago. Dydyk (1970) found the typical Rogers Park resident to be American born, middle class, and having some college education. The service provider group was composed of twenty teachers, twenty clergy, and twenty social service agency representatives within the North Town-Rogers Park community who were also randomly selected.

INSTRUMENTS:

The needs questionnaire utilized in this study was based on the six developmental periods of infancy, childhood, adolescence, early and middle adulthood and old age (based on Lidz, 1968). Specific needs unique to each area were listed, to be ranked on a five-point Lichert scale from strongly agree (1) to strongly disagree (5) by each respondent on the basis of how he perceived each need. Specialists in the areas of developmental psychology and community psychology cross-checked the applicability of the need questionnaire to the Rogers Park community. The completed need survey questionnaire can be found in the Appendix.

PROCEDURE: The surveyors utilized in this study were undergraduate students from a large university and college located in the Rogers Park area; they ranged in age from 19 to 21 years of age. They were enrolled in courses in either abnormal psychology or psychology of personality and chose to take part in this survey as a term project.

The surveyors underwent a two-stage training program. Their training began with an orientation meeting wherein the project was explained to the student volunteers by community professionals, and some background of the

Rogers Park community was provided. In a second meeting the survey method was explained, problems anticipated and confronted in role playing, and specific assignments were given after teams of two people had been formed. This latter was done first on preference, secondly in order to provide male-female teams, and third, as related to ease of transportation and mobility. Interview techniques were reviewed and roles played.

Students involved in surveying community members were provided with suggestions regarding door-to-door interviewing and advised to proceed as follows: to request to see the head of the household, to identify oneself by name, university affiliation and by presenting one's identification card and to state one's purpose as follows:

We are conducting a research project to try to determine how people of the Rogers Park and North Town areas feel about mental illness, and to determine what they think the community could use in the way of programs, facilities, and so forth to help people live a happy, well-adjusted life, and to help those people who have developed mental problems deal with these problems. This survey is a very important step in helping to make this area a happier and more enjoyable place to live. Therefore, we would like you to help us with this survey by answering certain questions about mental illness and the community in general. We will not ask you any personal questions. Further, we will not report your name with your answers. Your answers will be kept secret to all but the members of the research team, so that there is no way that your answers can be traced back to you as an individual. Your cooperation is very important in making this survey a success, and

we would appreciate it greatly if you would agree to cooperate.

Would you be so kind as to help us out?

Students were advised to allow the community participants to look over the questionnaire in order to decide whether they wished to participate. Given that people claimed to have no time, questionnaires could be left and retrieved at a later date by the surveyor.

Surveyors were also requested not to provide the community member with a questionnaire and not to begin reading the initial instructions to him until assured that he was capable of handling the questionnaire by himself. Surveyors could leave the questionnaire with the respondent for approximately the length of time required to complete it. Given that the respondent could not individually complete the form, surveyors were advised to remain and assist in the mechanics.

Throughout the two meetings the students were encouraged to verbalize what they perceived to be critical issues regarding the surveying process, as well as their related feelings. Opportunities were provided throughout the two month survey period to obtain assistance with problems encountered, as well as to give feedback regarding their reactions and general opinions about the community as well.

The sampling technique was a simple stratified block sampling technique. The Rogens Park area was divided into 18 subzone areas and by means of such natural boundaries and elevated train tracks, highways, etc., and by approximately equal numbers of precincts. Each subzone area contained between 13 and 48 blocks, each individually numbered. Within each sampling unit ten percent of the number of blocks were randomly sampled using a table of random numbers. (Garret, 1958). Thus, in subzone area B, for example, blocks B-6, B-11, and B-21 might be randomly selected from a choice of 30 blocks in subzone B.

At the second meeting, each survey team received a number of randomly selected blocks for which they would be responsible in determining the number of unit dwellings per block. A block was defined as that inside area bounded by four streets. A unit dwelling was defined as the number of families within a building, as determined by the number of door-bells or mail-slots. Also included were transient hotels, old-age homes, school residences, etc. For each block the number of unit dwellings found by the surveyors was totaled and ten percent of these unit dwellings were randomly selected for the sample. Thus, if block B-6 had two hundred unit dwellings, 20 were randomly selected to be surveyed. A cross sampling of each block provided extra addresses in the event that residents of the initially chosen family dwellings were either uncooperative or unable to complete the questionnaire. Surveyors were then provided with a list of designated unit dwellings and with the survey material packets to begin the interviewing process. Each interview was estimated to require approximately 40 to 60 minutes and each survey team was given about 18 addresses or unit dwellings to sample. The survey teams were given approximately one month within which to complete the total sampling.

STATISTICS:

The data were analyzed using a 4×7 factorial design with repeated measures. The four levels of the first variable being the subject groups (resident, teachers, clergy, and social service agency representatives) and the seven levels of the second variable being the need scores for the six developmental periods and the total need score for all periods.

TABLE 1

Means And Standard Deviations For Age-Group Priorities As Rated By
 Service Providers (Teachers, Clergy, Social Service Agency Staff)
 And Service Recipients (Residents)

	<u>M</u>	<u>SD</u>		<u>M</u>	<u>SD</u>
r1*	1.57	0.02	t1	1.72	0.01
r2	1.59	0.02	t2	1.74	0.02
r3	1.51	0.01	t3	1.70	0.02
r4	1.57	0.01	t4	1.78	0.03
r5	1.56	0.00	t5	1.78	0.03
r6	1.50	0.04	t6	1.73	0.01
r7	1.54	0.04	t7	1.79	0.04
a1	1.61	0.04	c1	1.91	0.03
a2	1.69	0.02	c2	1.89	0.02
a3	1.64	0.02	c3	1.87	0.01
a4	1.66	0.02	c4	1.87	0.02
a5	1.68	0.01	c5	1.89	0.01
a6	1.68	0.03	c6	1.89	0.01
a7	1.65	0.04	c7	1.88	0.04

r=recipients; a=agency; t=teacher; c=clergy

1=infancy; 2=childhood; 3=adolescence; 4=early adulthood; 5=middle adulthood; 6=old age; 7=total

*r=...etc.

TABLE 2

ANOVA Summary Table For Age Group Priorities

As Rated By Service Providers

(Teachers, Clergy, Social Service Agency Staff)

And Service Recipients (Residents)

Source	df	MS	F	Significance
Mean	1	1399.95		
A	3	2.40	2.20	No
B	5	.19	1.00	No
Within Group	76	1.10		
AB	15	.16	.84	No
Bx Within (error)	380	.19		

Variable A= the four selected groups

Variable B= the six age groupings

RESULTS:

Table 1 gives the means and standard deviations of the 28 possible groupings. Table 2 gives the Analysis of Variance of these means and standard deviations. It is apparent that neither the main or interactional effects are significant, which means that the hypothesis was not supported by the data. The non-significance of the A Main Effect indicates that there were no significant differences when comparing the recipients and providers as to the relative priorities that they gave the various age-group needs. (e.g. comparing the data of teachers' concern with infancy needs with recipients' concern with childhood needs).

The lack of significance for the B Main Effect indicated that there was no significant difference observed between the various age-need groupings. The non-significant AxB interaction indicated that no significant difference for any of the age-need ratings emerged when these ratings were considered in relation to the group (providers vs. recipients).

DISCUSSION:

The basic hypothesis that there would be a difference in mental health priorities between the potential mental health service recipients and providers within the North Town-Rogers Park community was not supported by the results. It is also apparent from the results that the recipients and providers both endorsed needs for all age groups in a consistently favorable direction; the means range from 1.50 to 1.91 on a scale that runs from 1 for strongly agree to 5 for strongly disagree, with 2 being agree. This non-varying lowness of score on the Lichert scale is taken to mean that there is much more concern about mental health in the North Town-Rogers Park community than was expected by the researchers. By looking at the means and standard deviations in Table 1, it is also apparent that there is very

little variance in any of the categories, which lends further support to the proposition of the unanimity of overall mental health concern within the North Town-Rogers Park community.

It is quite possible that these findings reflect that the community consumer views the mental health age priority needs in the same way as the service providers within the North Town-Rogers Park community. Both groups seem to have a very positive orientation to mental health in general, and because of this orientation see all needs as having a similar degree of importance which precludes the possibility of obtaining the expected mental health age need hierarchy differences.

In some degree, this lack of discrimination may be a function of the type of scaling that was used. The Lichert scale may not have been appropriately sensitive to the needs of this survey since a Lichert scale is structured in such a manner that all the answers are mutually exclusive (on the Lichert scale the way that one need was rated had no affect on the way any other need was rated). This exclusiveness made the possibility of blanket positive responses much more prevalent. Thus, the subjects could have uncritically endorsed all the needs without having to establish a hierarchy of needs in terms of age groups. It is also felt that even though anonymity was insured to all subjects, systematic biases in responding are still distinct possibilities since demographic information was asked and tests were individually administered. Therefore, it is felt that either paired comparison or rank ordered scaling may have proven more useful in this study, since with either of these scaling procedures the subjects would have to determine their own mental health age need hierarchies (with paired comparison scaling the S would have to compare two needs choosing one over the other; with rank ordered scaling the S would

have to rank the needs in order from most agreeable to least agreeable).

Though the Lichert scale may not have been the most sensitive scaling procedure available, it did give the people surveyed an idea of the global mental health services that could be made available to them as part of a comprehensive mental health center. The Lichert scale also gave the researchers an idea of how strong the general attitude toward mental health was and this finding would have been obscured if either paired comparison or rank ordered scaling was used. It is also felt that the survey proved to be an excellent educational device within the North Town-Rogers Park community, as well as within the universities that the surveyors attended. In many cases there were opportunities for impromptu mental health education (e.g. residents were interested and surprised to hear that mental health services were to be provided.) In addition, informal feedback from the surveyors indicated that they may have become much more concerned with available and existing programs so that they could take advantage of these opportunities or at least be aware of facilities.

Two interesting though not significant findings should be mentioned at this time. Firstly, it should be noted that teachers sampled in this study did not feel that more mental health attention should be focused solely into the area of child needs. This leads to the possible conclusion that the child's problems exist in isolation; but the problems are possibly a function of the entire community mental health picture over which the child has very little control. Secondly, the myths that professionals show systematic bias due to their training and that mental health service consumers are less knowledgeable about what their needs are due to their lack of training were not supported by this study.

It is felt that there are many implications for further research that should also be explored at this time. First, as mentioned earlier, a different scaling technique should be used. It is felt that either a paired comparison or rank ordered type of scaling would prove more sensitive in determining need hierarchies since the subject would have to determine his own mental health need hierarchy and could not be uncritical in determining these priorities. It is also felt that any scaling structure that is used could be categorized according to service type (e.g. primary prevention, secondary prevention, tertiary prevention) rather than age differences. Such a method of categorization would make separation of needs much more decisive since with this categorical structure it would not be necessary to worry whether certain services overlapped a certain age grouping. It is, however, felt that possibly the most productive way of focusing on the most urgent needs within a given community would be first to survey the community with an open-ended type survey. From this survey researchers could determine what are considered the most pressing problems within the given community. From these results they could then devise a rank ordered or paired comparison type of scale to further focus on these specific problem areas. In essence, the reason for using the open ended type of survey is to get the range of mental health needs to a manageable size so that the paired comparison or rank ordered scaling could be more precise. Though this procedure may omit many of the peripheral mental health needs within a given community, it is felt that such focusing would prove to be much more useful to the establishment of a mental health center since such a center in its infancy does not lend itself to meeting all perceived community needs, but only a selected few.

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APPENDIX I

Community Mental Health

Age-Need

Priority Survey

Every individual in a community has problems of some sort, and everyone in a community is entitled to and needs help in dealing with these problems. The following statements concern services which could be made available within a community to assist people with their problems. We are interested in what you consider important for better living within your community, that is, what you might benefit from or what you feel your immediate neighborhood might benefit from.

DIRECTIONS: Indicate your opinions about each of the following statements and estimate its need within your community by circling the appropriate number under each statement. Be sure to circle each statement.

	Strongly Agree	Agree	Indifferent	Disagree	Strongly Disagree
1. Pre-natal classes for pregnant mothers and interested fathers.	1	2	3	4	5
2. Dinner delivery service for the sick and the elderly who are home- or bed-ridden.	1	2	3	4	5
3. A community youth program for teens.	1	2	3	4	5
4. An emergency alert service for quick help with such as suicide threats, accidents or any unexpected problems.	1	2	3	4	5
5. A job information and placement service.	1	2	3	4	5
6. Services for the emotionally disturbed in a local general hospital.	1	2	3	4	5
7. Day hospitals for the mentally ill who remain in the home.	1	2	3	4	5
8. Visiting nurses made available, especially for new mothers and for the aged.	1	2	3	4	5
9. A community boys club for boys between seven and thirteen years.	1	2	3	4	5
10. Help for the alcoholic and his family.	1	2	3	4	5
11. Help for parents of young runaways.	1	2	3	4	5
12. Well-baby clinics to which mothers might bring children for inoculations yearly check-ups, various sicknesses and medical emergencies.	1	2	3	4	5

13. A tutoring center for children with poor grades or with special difficulties in school, or for children with special types of learning disabilities.	1	2	3	4	5
14. Programs and activities for senior citizens.	1	2	3	4	5
15. Pre-marital counselling services.	1	2	3	4	5
16. Half-way houses for people just out of the hospital but not yet ready to return to the community.	1	2	3	4	5
17. Talks for teachers and parents about the different emotional problems of children, what they are, how you recognize them and what you do when they are evident.	1	2	3	4	5
18. An "off street club" for adolescent gangs.	1	2	3	4	5
19. Some type of companionship program for the elderly.	1	2	3	4	5
20. After-care for those with emotional problems who have returned to live with their families.	1	2	3	4	5
21. A telephone information service where one might learn where to go and whom to see when problems arise.	1	2	3	4	5
22. Nursery schools for preschool children.	1	2	3	4	5
23. A counselling service for adolescents with problems.	1	2	3	4	5
24. A number one might call when things get rough.	1	2	3	4	5
25. Day-care centers for the children or working mothers.	1	2	3	4	5
26. Professional information resources for parents and teachers about alcohol and drugs and their use by adolescents.	1	2	3	4	5

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| 27. Walk-in, side-walk or trouble-shooting clinics in your neighborhood, to which you might bring difficulties which could vary from getting help with budgeting to patching up quarrels, to receiving psychological help. | 1 | 2 | 3 | 4 | 5 |
| 28. Counselling for families with serious difficulties. | 1 | 2 | 3 | 4 | 5 |
| 29. Some type of guidance and information exchange for the parents of kindergarten and primary school children. | 1 | 2 | 3 | 4 | 5 |
| 30. Neighborhood rehabilitation services where one can receive help in getting back into the swing. | 1 | 2 | 3 | 4 | 5 |
| 31. A place where teenage drug users can go for help. | 1 | 2 | 3 | 4 | 5 |
| 32. Marital adjustment clinics where one might get counselling for stormy marriages. | 1 | 2 | 3 | 4 | 5 |
| 33. A clinic for children with emotional problems. | 1 | 2 | 3 | 4 | 5 |
| 34. A community center where many of the above might be localized. | 1 | 2 | 3 | 4 | 5 |

List any other services you or your neighborhood might benefit from which are not included in the above.

35. _____

36. _____

APPROVAL SHEET

The Thesis submitted by Joel Laskin has been read and approved by members of the Department of Psychology.

The final copies have been examined by the director of the Thesis and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the Thesis is now given final approval with reference to content and form.

The Thesis is therefore accepted in partial fulfillment of the requirements for the degree of Master of Arts.

June 7, 1971
Date

James E. Johnson
Signature of Advisor