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The Role of Need Assessment in the Community Mental Health System

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THE ROLE OF NEED ASSESSMENT IN THE
COMMUNITY MENTAL HEALTH SYSTEM

by

William K. Redmon

A Thesis
Submitted to the
Faculty of The Graduate College
in partial fulfillment
of the
Degree of Master of Arts

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William K. Redmon
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INTRODUCTION

The general purpose of the present paper is to analyze community mental health services in Michigan with respect to the responsiveness of the system to the target community. In order to accomplish this goal, several variables must be considered.

First, historical precedents of the current mental health system will be examined to determine the responsibilities of the system to the citizenry. Both legislative mandates and informal recommendations will be reviewed. Second, the methodologies available for community need assessment and citizen-system communication will be summarized in terms of their utility for increasing citizen control of service planning. Third, an actual need assessment study will be presented in order to provide an example of the use of existing methods. In addition to the procedures used to collect data for the study, a number of environmental variables will be discussed. These variables include: the relationship between the scientist and the target community; the rapport of the agency sponsoring the study with the community; and historical events which may affect the cooperation between these entities in a determination of need. Need assessment data will be summarized and recommendations for services will be given on the basis of the data. The paper will conclude with: an
examination of the problems encountered during the course of the study; an analysis of barriers to the sensitivity of the mental health system to target community conditions; and suggestions for improvement of the current approach to service provision.

Community Mental Health: A Brief History

Although much was accomplished in mental health prior to World War II, this conflict and the years immediately following had a profound effect on the way this country now views and treats the mentally handicapped. Even though no battles were fought on American soil, the war brought about many domestic changes. Perhaps the most prominent of these effects involved advances in technology spurred by the demands of wartime. This certainly applies to the production of material goods, however, advances were not limited to this area. Human service systems began to undergo modification following the war that is evident in current program offerings.

The influence of the war is especially visible in the Community Mental Health movement, now operative across the nation. At least two factors can be directly related to later changes. First, the large-scale mobilization of men for fighting purposes, and the determination of their fitness, resulted in some rather alarming data. According to Menninger (1948), twelve percent of approximately
fifteen million men were rejected for neuropsychiatric reasons. In fact, these rejections accounted for forty percent of all men eliminated because of fitness problems. Thus, as Levenson (1972) has pointed out, "The war itself focused attention on the extent of mental illness in the United States" (p. 687).

Second, in addition to emphasizing the problem, the war provided an opportunity for experimentation with new treatment techniques. Through psychiatric work done on the front lines, mental health professionals began to discover that aid could be given at the point of origin of the disorder (Ginzberg, 1948; Coleman, 1972). This discovery helped pave the way for today's community mental health philosophy: the treatment of mental disorder as near the home environment as possible.

Although the war provided valuable statistical information and set an important treatment precedent, change could not take place immediately. Most of the nation's mentally ill were still cared for by private practitioners or long-term custodial care facilities (Deutsch, 1948). In the mid-1940's over 450,000 patients were still confined to large state institutions (U. S., 1966). However, due to knowledge resulting from the war effort, the government became concerned about the mental health needs and began to take steps toward effectively reducing this problem (Mechanic, 1969).

In 1946, Congress took the first official initiative toward
improving mental health services and formed the National Institute of Mental Health (NIMH) through passage of the Mental Health Act. This agency, under the jurisdiction of the U. S. Public Health Service, was established "for the aid of research on cause, diagnosis and treatment of psychiatric disorders; the training of professional personnel; and assistance to the states for the establishment of clinics and treatment centers and the provision of pilot and demonstration studies for prevention, diagnosis and treatment" (Brand, 1967, p. 29).

It was almost a decade later, in 1955, that Congress passed the Mental Health Study Act (Public Law 182) which directed NIMH to appoint the Joint Commission on Mental Illness and Mental Health "to analyze and evaluate the needs and resources of the mentally ill in the United States and make recommendations for a national mental health program" (Joint Commission, 1961, p. vii). Six years later the study was complete and the final report was made public under the title Action for Mental Health (1961).

This volume emphasized the need for more community involvement on the part of mental health practitioners and contained many specific recommendations. The following relate to community-based services, and as such are pertinent here:

"a national mental health program should set as an objective one fully staffed, full time mental health clinic available to each 50,000 of population" (p. xiv).
"no community general hospital should be regarded as rendering a complete service unless it accepts mental health patients for short-term hospitalization and therefore provides a psychiatric unit or psychiatric beds. Every community hospital of 100 or more beds should make this provision" (p. xv).

"Smaller State hospitals of 1000 beds or less . . . should be converted as rapidly as possible into intensive treatment centers for patients with major mental illness" (p. xv).

"No further State hospitals of 1000 beds should be built and not one patient should be added to any existing mental hospital housing 1000 or more patients" (p. xvi).

It is clear from the above recommendations and other information contained in the final report, that the Joint Commission felt it best to decentralize services to the mentally ill. The philosophy of the final report can perhaps best be summarized by the following quote:

"Community mental health clinics serving both children and adults, operated as outpatient departments of general mental hospitals, as part of state or regional systems for mental patient care, or as independent agencies, are a main line of defense in reducing the need of many persons with major mental illness for prolonged or repeated hospitalization" (p. xiv).

Although this quote and the remainder of the report express promising ideas, the Joint Commission was only an advisory board and had no power to implement its recommendations; legislation was required before action could be taken.
In response to Action for Mental Health, the President John F. Kennedy appointed a cabinet-level body to determine what steps should be taken. This committee forwarded its report to the President in the Winter of 1962-63 (Brown & Cain, 1964) and from that analysis the President planned his recommendations to the Congress. On February 5, 1963, President Kennedy addressed the people and Congress and delivered what is now an historic speech on mental illness and retardation. He called for "a bold new approach" to the treatment of the mentally handicapped. His plea was the result of years of study by literally thousands of professionals and initiated legislative action that was to eventually reorganize this country's approach in mental health.

**Federal mental health legislation**

In response to the factors discussed above, the Congress passed Senate Bill 1576, which became Public Law 88-164 on October 31, 1963. Title II of this act is known as "The Community Mental Health Centers Construction Act" and authorized funds for the initiation of a community based approach to treatment and prevention of mental illness. The Centers Act was amended in 1965 by legislation which authorized "assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers" (Public Law 89-105). Thus, a decade following the appointment of the Joint Commission and twenty years after the War's end,
community mental health was becoming a reality. However, no dependable precedent for action was available and many obstacles lay ahead.

The Centers Act provided $150,000,000 over a three year period for "construction of public and other nonprofit community mental health centers." This money was to be spent "on the basis of (1) the population, (2) the extent of need for community mental health centers, and (3) the financial need of the respective states."

The Secretary of Health, Education and Welfare was instructed by the Congress to issue regulations interpreting the conditions of the act in specific terms.

These regulations emphasized at least three major points:

1. **State plans**: Each State was required to furnish a mental health service plan in order to be eligible for funding. These plans were to serve as the blueprint for provision of service and were to be based on an inventory of existing facilities and a survey of need. In the event that such plans were inappropriate or not applied as written, the Secretary could cease funding.

2. **Comprehensiveness**: This principle relates directly to service provision and embodies, more than any other one concept,
the community mental health philosophy. Brown and Cain (1964) have provided an excellent review of this concept and their interpretation will be relied on for the present discussion. According to these authors,

"The regulations define 'comprehensive services' as the complete range of all elements of mental health services 'in sufficient quantity to meet the needs of persons residing within the community served by a community mental health facility, taking into consideration factors such as the age groups served, diagnostic categories treated and the availability of short, medium and long-term care.'"

The regulations emphasized that the complete range of services included at least the following five: inpatient, outpatient, partial hospitalization, emergency and consultation and education. Other services could be included, but these five were considered essential for funding eligibility. Comprehensive also means, say Brown and Cain, that "the essential elements must be linked together" for the purpose of providing "continuums of care, for there is nothing comprehensive about an abundance of services if each service is quite independent from all the others."

3. Need-based service provision: This concept was referred to throughout the Centers Act. According to the original legislation, projects were to be given priority on the basis of the "relative need" of the area for which a center is planned, state plans were to be based on a "survey of need," and funds were to be allotted on the
basis of "needs of states." All of these statements, when combined with the comprehensiveness requirement, make it obvious that the new approach to mental health was planned to be functionally related to the needs of the target area.

In summary, three things are clear from an examination of the Centers Act and its principle components. First, community mental health, as an approach to treatment, should be based on conditions present within the target area. Second, the mental health professional is required to determine what needs exist and is mandated to take the services to the people. Third, federal legislation enumerated broad guidelines, while leaving the details of implementation up to the individual states.

**State mental health legislation**

National community mental health legislation initiated activity at the state level. Each state was required to submit a plan for service provision in order to receive federal funds. A valid plan also required that legislation be passed in order to provide a legal basis for the proposed system of operation.

The current Michigan State Plan for Comprehensive Mental Health Services details: (1) the state administrative system; (2) public mental health service provision; (3) the community mental health organization; (4) methods for the inventory of resources and establishment of need; and (5) the areas to be served. In essence,
the plan initially provided operational procedures for the reorganization of mental health services in the state. Filed originally with the Secretary of Health, Education and Welfare in 1965, this document has been updated annually as stipulated in section 237(a) of the Community Mental Health Center Act. The latest version was released in July of 1977.

Public Act 54 of 1963 served as the supportive legislation for the plan. This act provided for the establishment of community mental health service programs and authorized funds for these services. It also prescribed powers of cities, counties and the State Department of Mental Health, however, community programs are of primary importance here. Specifically, PA 54 authorized the Department of Mental Health to "make matching grants to assist counties, a combination of counties, or cities of 500,000 or more population in the establishment and operation of local mental health programs" to provide the five essential services required by the federal Centers Act.

PA 54 also authorized governments of geographical areas of 500,000 or more population to appoint a twelve member community mental health board to oversee the spending of funds and the provision of services as the local level. Each board was empowered to

1Public Act refers to Michigan legislation while Public Law refers to Federal legislation.
hire staff as needed to carry out these responsibilities. Services could be provided directly or through contract with existing agencies. According to section 12 of PA 54, community mental health boards were given the following duties (among others).

1. "Review and evaluate community mental health service . . . and report thereon to the Department of Mental Health, the administrator of the program, and, when indicated, the public, together with recommendations for additional services and facilities."

2. "Recruit and promote local financial support for the program from private sources . . . and promote public support for municipal and county appropriations.

3. "Promote, arrange, execute and implement working agreements with other social service agencies . . . and with other educational and judicial agencies.

4. "Advise the administrator of the . . . program on the adoption and implementation of policies to stimulate effective community relations."

Public Act 54 was extended and updated in 1974 when Public Act 258 was signed into law. Chapter two of this legislation refers to the programming responsibilities of community mental health boards and section 226 of this chapter specifies the most recent legal requirements of this citizen supervisory organization. These requirements include:

1. The examination and evaluation of the mental health needs of the county or counties it (the board) represents and the public and private services necessary to meet these needs.
2. Submission of an annual plan and budget to the County Commission and State Department of Mental Health and provision for a public hearing on the plan and budget.

3. Action to secure other sources of funding to help support the county program.

4. Approval and authorization of service contracts and review and evaluation of the quality, effectiveness and efficiency of services provided.

Both Public Acts 54 and 258 illustrate the county community mental health boards were designed to provide a local supervisory base for services and to maximize citizen-department communication. Today, in Michigan, fifty-four boards serve seventy-nine counties while other boards are in the process of being formed to serve counties currently without organized mental health clinics (Michigan Department of Mental Health, 1976).

The Role of Need Assessment

The above information suggests that the success of community mental health, as planned, depends on the responsiveness of the system to citizen need. This requires that some type of communication between provider and recipient be established. If the community approach is to be any better than previous systems, high priority needs must be identified and used in the service planning process. Without this communication, it is doubtful that professionals can plan with citizen benefit in mind.
By way of review, two sources support this reasoning: the informal recommendations of professionals in the immediate post-WWII years and the formal legislative mandates passed down to the practitioner from state and federal legislative bodies. The recommendations of the Joint Commission (1961) emphasized a community approach and strongly suggested that services be established for limited geographical areas implying that such a system would be more responsive to citizen needs that previously available forms of treatment (i.e., the private practitioner or the public mental hospital). Additionally, the Community Mental Health Centers Act and subsequent state legislation and planning mandated the services be established for each 500,000 of the population (Tischler, Henisz, Myers & Garrison, 1972) and that services be offered to best meet the prominent needs of the areas.

A crucial variable that seems essential in maintaining such a system is a channel of communication from community to provider. If administered and used properly, needs assessment can supply this communication. If the community mental health approach is to be responsive to the needs of a defined population, an exchange of information must be built into the system. The following points are offered in support of needs assessment as a candidate for such a role.

First and foremost, approaches to assessment which sample consumer opinion can help to prevent the development of a closed
system and allow input from the citizenry and/or non-mental health professionals. Otherwise, programs may be allowed to continue irrespective of service priorities and population disorder patterns.

Second, needs assessment provides valuable data for the establishment of priorities within a program. Professionals who determine program content must have specific information about community conditions in order to properly allocate resources. Although legislation stipulates that a range of essential services be provided, the quantity of each was not specified. Service concentration or the degree to which one essential service takes precedence over another must be determined by the specific characteristics of the target population. Such information is also subject to change and should be. Need assessment data can help to establish priorities and maintain the relevance of service through continued data collection and programming adjustments.

Third, an initial determination of existing community conditions can provide a standard against which future effectiveness is compared. With the recent emphasis on evaluation in the mental health movement (Selig, 1976), many agencies are faced with assessing program effectiveness. Data collected to determine effectiveness become more meaningful if a baseline for comparative purposes is available. Assessment of community conditions prior to intervention, and measurement of the same conditions following intervention can
provide a powerful indication of effectiveness.

Fourth, the validity of program offerings can be established through need assessment. The fact that a program offers an effective service in terms of client benefit is secondary. Of primary importance, is the utility of the program in meeting existing needs. An effective, but low priority program is not effective in a functional sense. Effectiveness must be judged on the basis of at least two factors: the validity of the services in terms of maximum benefit to the target population and the effectiveness of that service, once it is determined that it meets a high priority need. The fact that a therapist can produce improvement in a client's condition means nothing if no person needs the therapy.

All of the above, represent components that help to insure that the community mental health agency is aware of need and that an attempt is made to deal with significant problems in the most effective manner; this is the essence of the community approach. Without appropriate information about the target population, deviations from this method may arise. Priorities may be determined and dollars spent as a function of the whims of agency personnel or governmental figures. This is not to say that need assessment can totally prevent such practices (Fisher, Mehr & Truckenbrod, 1973). However, if reliable information is available, the probability that planning will be appropriate is at least increased.
Thus, in summary, need data can be more than simply a collection of fact and opinion. Such information can serve as a means of citizen-provider communication and as an important instrument in the mental health planning and evaluation process. Yet, it is a difficult task to collect useful information and thus, the method must be carefully chosen. We proceed now to a brief review of the major need assessment approaches.

Need assessment: definition and methodology

Need assessment is a process and must be defined in terms of the steps required to complete it. Several authors have attempted such a definition in recently published works (Blum, 1976; Warheit, Bell & Schwab, 1976; Siegel, Attkisson & Cohn, 1974). All of the definitions are similar.

Generally, most will agree, the assessment of need involves the measurement of conditions in a specified populated area and interpretation of the resulting data in terms of service priority. Warheit et al. specify three steps that they feel should be a part of this process: (1) the determination of target community conditions; (2) the evaluation of existing programs; and (3) the planning of additional services in the context of new information. These steps are rather general and many different methods are available for the completion of an assessment. The agency conducting the study must choose the approach best suited to its own specific conditions.
Factors such as the availability of personnel and funds and the size of the target area, among others, are important.

Three excellent reviews of need assessment methodologies are available. One is a manual by Warheit, Bell and Schwab, 1976; a second is a book authored by Siegel, Atkinsson and Kohn (1974); and a third source is a series of articles on methodology published in Evaluation (1975). The last source will be used primarily for a brief review of common approaches, with information included from other publications as needed.

Needs assessment methodologies can be divided into at least three general categories: (1) epidemiologic, (2) consumer response, and (3) social indicator analysis. The epidemiologic method is borrowed from the field of public health and originated with investigations of the study of causes and incidence of disease during epidemics (Barker, 1976). However, as Anderson (1976) points out, it has come to include "methods and strategies used to identify and study that which determines the level and distribution of health and disease in the community" (p. 19). The epidemiologic method has been advocated as a useful one for mental health needs assessment by Schwab, Warheit and Fennell (1975). These authors conclude that epidemiologic methods are necessary in community mental health "because they are designed for studying patterns of illness and delivery of services in an ecological setting."
Operationally, the epidemiologic study includes two major processes: field surveys designed to identify those experiencing problems or at risk of experiencing problems and an ecological analysis of community service utilization patterns and illness. The first step involves the administration of an interview or questionnaire to a sample of persons selected from the target population and the second is completed by an analysis of statistics that serve as indices of health, service delivery and illness patterns. The central goal of this method is to match the needs of the community with service delivery by agencies which serve the area.

A second method, consumer response, includes approaches based on information obtained from a sample of individuals or groups residing in the target area. The principle tools of measurement are the questionnaire (set by mail or administered by trained personnel) and the personal interview (either by telephone or face to face). The sample is sometimes stratified according to significant characteristics of those surveyed or interviewed (Weiss, 1975). Samples may include the general citizenry surveyed at random, certain significant individuals who serve as key informants, clergymen, business owners, human service workers and so on. Groups may also be used as sources of information; as when civic organizations are asked to contribute data or community meetings are held to assemble citizens in a public forum to identify and prioritize needs (Warheit et al.,
1976). In general, any method which depends primarily on citizen-produced need data would be included under this heading.

A third general category involves the use of social statistics as indicators of community need. This type of study requires that the individual or agency conducting the assessment hypothesize as to relationships between broad population statistics (usually census data) and community needs. For example, if one is able to assume that a large proportion of low income families in a defined population is indicative of increased emotional stress, then this statistic would provide useful information. Typically, a list of factors known or hypothesized to be related to problem development is constructed, and the degree to which the factors are present in the target area determine the level of risk. If the hypotheses are valid, then fluctuation in such statistics depicts the degree of need.

Several authors have advocated the use of census data to obtain information on significant community deficiencies (e.g., Beech, Fiester & Silverman, 1976). Some have shown that there is considerable evidence to support the relationship between unfavorable economic and social conditions and increased psychiatric disorder (Srole, 1962; Dunham, 1964; Buss, 1966). Examples of commonly used factors include: the status of target area residents in the work force, the number of minority families, income, and persons per household (Michigan Department of Mental Health, 1976). These
statistics are normally available through local governmental offices in the form of census data or other regularly collected information (e.g., crime statistics, school drop-out rate, etc.). Stewart and Poaster (1975) present three methods of using social statistics for need assessment and their work provides some excellent examples for the interested reader.

Admittedly, the above categories are rather broad, however, it is beyond the scope of this paper to present an extensive review of known methods. Rather, this information is designed to give the reader some understanding of the methods used in the present study.
PURPOSE

Even with the powerful mandate provided by legislation and in spite of the fact that tested approaches are available, formal need assessment procedures specific to service areas are only now in the process of being established. According to the 1977 Michigan State Plan,

"During the past year [1975], the Department of Mental Health has been developing a need assessment/planning process targeted for implementation in late 1976. . . Through working with a planning resource group, the Department has selected a state guided, local participatory approach to need assessment and planning" (p. 107).

However, little evidence exists to support the fact that this type of procedure has or will soon be implemented. Again, quoting from the plan,

"However, it is necessary to implement a survey of need before the summer of 1977 in order to prioritize catchment areas. Thus in the interim, a social indicators system utilizing the National Institute of Mental Health Demographic Profile System has been adopted" (p. 108).

Thus, the only need assessment approach in use in the State is one that depends on very broad social statistics used to rank catchment areas. Nearly fifteen years after the passage of community mental health legislation, need assessment has not become a viable part of the mental health system. This potentially crucial variable which
could serve as the core of citizen-provider communication has virtually been ignored in service planning. In this context, the purpose of the present study is twofold: (1) to present an example of need assessment in a defined geographic area and consider issues raised by such an application; and (2) to add support to the movement toward more community participation in mental health through further research on variables affecting this process.
METHOD

The present study consists of a need assessment carried out in census tract one of Kalamazoo County, Michigan (Figure 1). The boundaries of this tract form the community known as the Eastside. Before presenting the details of the assessment methodology, and the resulting data, an attempt will be made to convey to the reader something of the context of the study. Published accounts of scientific work seldom contain such information, yet it is extremely important in the total interpretation of so-called objective results. Some variables cannot be sufficiently quantified to be presented in a formal results or method section, however, this should not lead one to ignore them. Factors beyond scientific control such as community attitudes, historical relationships and so on are vital information in the interpretation of statistics and the establishment of service priorities. In order to prepare the reader for such an understanding three variables will be considered: (1) the community, (2) the agency, and (3) community entry by the researcher.

The Eastside Community

The Eastside is a community of approximately 3,500 residents.

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The data presented were obtained from records of the 1970 census sample.
Figure 1. Kalamazoo County Michigan census tracts with the Eastside neighborhood outlined (census tract 1).
Almost thirty percent of the people living there are nonwhite. The majority of working community members between the ages of 16 and 64 are laborers or service workers. Most of the members own their homes and live in single family dwellings. As of 1970, the median census tract income was $8,626 and eleven percent of the households were considered to be below the poverty level. The average education of community members is 10.7 years, yet approximately forty percent of the adults are high school graduates. Roughly one-half of the Eastside families have children in the home under eighteen years of age. Fifteen percent of the population is 60 or over, while fifty-one percent is nineteen or under. The median value of a housing unit is $10,300, and the median fee for rental units is $110.00 per month. Most of the dwellings (66.5%) were built in 1939 or earlier while only thirteen percent were built between 1960 and 1970.

The Eastside was once one of the more affluent areas of Kalamazoo, however, as the city grew outward from its center, this community and others became attached to the urban environment and correspondingly detached from suburban areas. Industry moved into surrounding areas and a large sewage treatment plant was located there. Families began to move out, causing a portion of the housing to be left unkept. With this move, citizens with less money began to occupy housing and, thus, the constituency of the community changed over a period of years. As the population changed, the
commercial and social environment was also affected. Businesses closed or became part of larger operations and small stores were consumed by the urban mall or shopping center located outside of the community. As it exists today, the Eastside community is without major shopping areas inside its boundaries; no health services are located within the community (i.e., medical doctor or dentist), no mental health services are located there; the Methodist church was moved to a new building outside the area; the community elementary school (in operation for fifty years) was recently closed and the property sold at public auction. School children, in excess of 250 per day, are bussed to other schools in adjacent communities; recreational facilities for any age group are very limited. Transportation to outside areas is available in the form of city busses, however, this is not available in the evening hours and only at certain times on weekends. Recently, reports of vandalism and crime have increased, in particular breaking and entering.

The Eastside is currently served commercially be several small businesses, including gas stations, fast food outlets, a drug store, a market, a small restaurant and a private child care agency. Medical care is received either at a large city hospital immediately outside the tract or from private practitioners at least a few miles away. Most human service agencies are located quite a distance away; none are within comfortable walking distance. This is of
particular importance for senior citizens. The main city shopping and service areas are three to four miles from the Eastside, but accessible through bus service for most daylight hours. Many after school activities are not accessible because of the distance to school facilities and a lack of evening transportation.

Recently, the Eastside has undergone the beginnings of revitalization. Much of the impetus for this effort came from the Eastside Block Association, a citizen group formed in 1975. In the past two years, this group has been the focal point of work toward community improvement. The Block Association has incorporated as a nonprofit organization and has been active in city government decision-making. Because of this organization, the community has already participated in a model block program, whereby federal dollars are loaned or granted to needy families for purposes of improving all of the housing on a block. Other blocks are slated for this treatment, however, a project of immediate importance is the acquisition of space for a community recreation and social services center. This project has been in the making for two years; the property has now been purchased with an adequate building and it appears that activities will begin full-scale in the first quarter of 1978.

The Block Association has been important in other areas as well. Through this organization, a semiformal network of communication has been established via the election of block captains who
gather and distribute information from and to the citizens on their respective blocks. A newsletter is published monthly and communication lines seem to be opening. This is enhanced by regular monthly community meetings held at the prospective neighborhood center site. Attendance has been consistently good as of late and these gatherings have become a setting for the voice of the community. Through the Eastside Association, much has been accomplished and it appears that this trend will continue.

Over the past few years, many issues have been raised in the community. In order to provide an indication of the existing social climate and illustrate recently utilized problem-solving skills, a few examples will be presented here.

The school issue

The closing of the neighborhood school has effected almost all activities within the community. The citizens of the Eastside have vented a great deal of anger on school officials and others connected with this event. The school closing forces children to be bussed outside the community; it means that evening recreation and social events must now be held elsewhere; and it means that Eastside citizens must now pay school taxes without the opportunity to see any direct usage of such funds within their living environment. All of these points and others have been raised in recent meetings with school officials.
Following the school closing, the community association attempted to acquire the property for use as the community center mentioned above. School officials refused and indicated that the property would be sold at auction. Furthermore, these officials made it clear that the only way the community could acquire and/or use the facilities was to purchase the property as the highest bidder. The citizens argued that they had already purchased the property with tax dollars and were entitled to it. This did not change the decision of the public school officials. In fact, conditions worsened when the school was sold. The property was purchased by a private religious group and subsequently used as a school. This provided more cause for anger because school officials had emphasized that the school building was unfit for use as an educational facility and, thus, had decided to sell it. Even more tension was added when it was discovered the community children would have to wait for busses in inclement weather on the outside or use a very small portion of the school building, less than suitable for this purpose. Relations between community and school officials remain tense even as this paper is being written.

The public transportation issue

This problem has also received attention in the past two years, however, more positive results have been gained. A significant portion of Eastside residents are senior citizens (15-20%) and, thus,
are unable to walk long distances, especially in inclement weather. Yet, the site for a mid-day meal for these community members is two miles away and most shopping areas are even further removed. The public transit busses originally passed through the Eastside only on the main thoroughfare which, depending on the individual, could be quite a distance from many homes. Thus, even though transportation was "available," a number of residents could not reach bus stops.

The Eastside Block Association invited transit officials to a meeting and discussed the problem. This community joined forces with others who had voiced the same problem and eventually proved instrumental in the transit decision to acquire and use mini-busses to provide front-door service to main transportation routes.

Community center issue

Recently, Eastside residents have become concerned about the lack of recreation facilities for teenagers, the distance of the meal site for senior citizens from the neighborhood and a shortage of available space for central community gatherings and activities. As a function of these needs and a concern over the inadequacy of after school activities for area children, citizens made it known to city community development officials that they were interested in purchasing and operating a center. Fortunately, money was available for eligible communities from the Department of Housing and Urban
Development for such purposes. A proposal was submitted in November of 1976 and the effort to meet this objective began.

A suitable building has been located. It is situated at approximately the geographical center of the area and contains sufficient space for rental to centralized human service agencies, who have indicated a willingness to place outreach workers in the neighborhood. After a great deal of work, numerous meetings and interactions with government officials and real estate agents, formal negotiation for the purchase has been initiated. Nearly one year after the submission of the proposal it appears that the property will be purchased and turned over to the Block Association. Thus, with the help of city workers assigned to the project, local volunteers and the perseverance of the community organization, a multi-purpose neighborhood center will soon be in operation.

Other problems have received attention, however, these examples are sufficient to illustrate recent efforts.

The Agency

The Kalamazoo Learning Village is an early-education preventive mental health agency which serves approximately fifty children between the ages of six weeks and six years. The target population is considered to be "at risk" of developing mental health problems in the future, if some type of intervention is not undertaken.
The program is aimed at preventing these problems by teaching adaptive skills early in life. The children are divided into two age groups: Infant/Toddler (six weeks-2-1/2 years) and Nursery/Pre-elementary (2-1/2-6 years). The staff consists of members of the community hired by Learning Village, University students who work for academic credit and volunteers.

The Learning Village has been in existence for ten years in various locations throughout the Kalamazoo area. It began in 1967 with five or six children in a renovated greenhouse attached to the private residence of its founder. The original purpose of the Learning Village was to determine: (1) if future mental health problems could be prevented through early intervention, and (2) if behavioral scientists could be effective in a non-academic laboratory setting. These goals have not changed, although a great deal has been learned about the feasibility of achieving them (Ulrich, Surrat & Wolfe, 1969; Wolfe, Ulrich & Ulrich, 1970; Ulrich & Metheany, 1975).

The original funding for the Learning Village came from the Michigan Department of Mental Health via the Governor's office. This was the result of a meeting between the Learning Village founder (Dr. Roger Ulrich, Psychology Department, Western Michigan University) and the Governor's staff regarding the 1967 Detroit riot situation. Dr. Ulrich's advice was solicited because of his extensive experience in laboratory research on aggression.
(Ulrich, 1962; Ulrich, 1966; Ulrich & Favell, 1970). He recom-
mended that prevention of such problems be attempted and asked
that a model program be established under his direction to determine
the potential of early intervention in mental health.

Eventually, funds were obtained in response to a formal
proposal and the Learning Village became a preventive mental health
program. Originally, funds were received from 314-D allocations
reserved for innovative programs. This continued through 1971. In
1972, with support from key legislators, Dr. Ulrich and colleagues
secured continued funding on a contract basis with the Michigan
Department of Mental Health. This money was appropriated for the
local mental health board and all subsequent agreements were between
the Learning Village and the County Community Mental Health Board.
This citizen body (referred to previously) was established under Public
Act 54 of 1963 and continued under Public Act 258 of 1974, the current
Michigan Mental Health Code. At the time of this study, the Learning
Village was still a mental health agency and was receiving funds from
the local board, however, that relationship has since been dissolved,
in spite of the fact that follow-up data has demonstrated program
effectiveness (Cullari, 1976).

The Learning Village is currently located in census tract one
of Kalamazoo County (the Eastside community), where it has been
since the fall of 1969. This agency occupies the former Eastside
Methodist Church building; this facility is also the site of the proposed community center. The relationship between the Learning Village and the surrounding community is good, although this has been variable over the past few years.

The Learning Village has not always been sufficiently conscious of the power of the community. The current study is representative of a more recent attitude which reflects a greater concern with events in the surrounding neighborhood. As with many academic scientists, the move from university to community was difficult for the staff and management of the Village. The primary focus was on teaching methods, and because of the isolation of the campus environment, less attention was given to conditions in the host community. As a result, some problems were encountered in the area of social relationships; one of the most dramatic will be presented as an example.

In the late 1960's, a civil unrest was sweeping the country. A major part of this movement involved the fight for racial equality by Blacks. Local Black leaders in Kalamazoo became upset by the fact that the Learning Village, operated by an all-white board of directors, was in control of a program in which 60% of the children were Black.

Certain Black community leaders wanted total control over what their children were being taught. In some instances both Blacks and whites were distressed by the use of behavior modification techniques and felt that a subtle form of brain washing was taking place. Although
some of the concerns were felt to be legitimate, the Learning Village operators insisted that program control remain their prerogative. Several incidents occurred, including community meetings to organize against the Learning Village, the publication of letters to the editor of the local paper, and the distribution of anti-Learning Village materials. Whether good or bad, the Learning Village survived this period and important lessons were learned (Ulrich & Metheany, 1975). However, because of events exemplified by the above, consistent support from the Black community was, in certain instances, difficult to gain.

Now, several years later, after other similar lessons, much more emphasis is placed on the family and the social environment of the child. Over the past two years, the present author has been assigned as Learning Village-Community liaison and has been intimately involved with the effort to establish a neighborhood center in the current Learning Village building. The present paper provides an example of knowledge gained from this experience.
Community Entry

Recent emphasis on the application of behavioral science principles within existing complex social systems (Harshbarger & Maley, 1974) has led to a change in the skills that are required of the applied psychologist (Libo, 1965). Previously, while the majority of psychological research was being done in the laboratory or similarly restricted social settings (e.g., hospital ward, school classroom), little was required in terms of studying the operative molar system, and determining how best to become a part of that system in order to bring about change. Now, as the behavioral scientist becomes what Libo calls the "general practitioner(s) in the human welfare services," he or she must be able to implement scientific methodologies and be able to enter and function within the system that is the focus of study. The "practitioner" is faced with determining the existing climate for intervention and the implications of this climate for the success of the project; this process is called "entry" (Glidewell, 1959).

Entry is not a new topic in other professional disciplines and much can be learned from published accounts in industrial consultation (Beckhard, 1961) and sociological field research (Lippitt, Watson & Westley, 1958). Many published articles, concerning recent interventions in social systems, contain only sketchy information about the relationship between the scientist and the system being studied. In fact, in the majority of cases, the reader is given no information
about the events leading to the formal study. In this context, the entry of the present author into the Eastside community and the implications of that process for future results will be presented here. The following is a personal account of significant events that occurred prior to the study and will be related in the first person.

When the present study began, I was an employee of the Kalamazoo Learning Village. As pointed out earlier, this agency serves preschool children and is located in census tract one. The Learning Village, for quite some time, had been concerned with the problem of family involvement in the program. Many of the children in the program originated from homes that are considered "high risk," have less contact with parents, and these parents typically show less interest in the activities of their children at school. Yet, funding sources were encouraging more work with parents and, of course, the Learning Village was interested in facilitating program progress in the off hours at home. Thus, I was asked to attempt to gain more parent involvement. Specifically, the assignment involved the establishment of a program that would increase the probability of enlisting the aid of those who control the home and primary social environment of the child.

In conjunction with the Learning Village administration, I developed a plan. This approach consisted of: (1) opening the Learning Village facilities in the evenings and on weekends as a
semiformal community center; (2) establishing a central office for the community in the building; and (3) offering the services of a community liaison (myself) to help in the development and maintenance of program offerings in the center.

At this point, the scope of this project may seem to be broader than the goals call for. However, there is an inherent problem with families of "high risk" children. The primary problem is probably lack of interest on the part of parents; because of lack of money, inability to cope with frustration, alcoholism, unemployment, etc. Whatever the reason, this group is more difficult to deal with than a "typical" middle class population. We felt that any effort to involve parents would have to be one that contained sources of attraction other than the trite "I think your child has a learning problem." We felt that the establishment of a new and broader Learning Village identity would promote more community involvement in general, and indirectly allow extended contact with parents, family and friends of the children served. It was this attitude that led to the community center approach: a vehicle by which family and community contact could be made under circumstances more desirable than usual.

The context of entry

At the beginning of the project, I was not aware of the existence of the Eastside Block Association, or of any other organized association in the area. I was faced with a problem that probably
confronts many who must, in some way, become familiar with community people and functions, and eventually complete a successful program that requires the aid of those outside the advocate agency.

I began by attempting to determine what organizations, if any, happened to be operating on the Eastside. As a beginning, a member of the Learning Village staff mentioned that he had been invited to attend a meeting of a local community club (located in an area adjacent to the Learning Village community). I felt that since this invitation had been initiated by community residents, it would provide a stable point of beginning.

The first meeting that I attended was a gathering of the subcommittee for neighborhood improvement and a component of a nearby community club. Their purpose was to determine what could be done to improve the physical appearance of the area in order to encourage more investments on the part of local banks. These people felt that lending institutions were reluctant to loan money to area businessmen because of the conditions of homes and vacant property surrounding their establishments.

At this meeting, I met a local minister who had organized the subcommittee meeting and a representative of a school located in a nearby census tract. The three of us talked at length following the meeting about the humanistic concerns that should be considered when community improvement is the goal. I left feeling that the
committee which had just met was more interested in the physical property than they were in the people inside the houses that they wanted to improve. This was supported by the fact that nearly everyone present had something to gain "business-wise" by community improvement. One member had just been denied a loan and the majority of those present owned businesses in the area.

The minister recommended that I become familiar with the Eastside Block Association which, he told me, had just been formed. He further explained that this organization was to represent the Eastside community when any funds for improvement became available and to make known to city officials and others the needs of the Eastside in general. I felt that this was more nearly my point of direct entry with the target population and those most closely associated with clients of the Learning Village. So, I planned to attend the next meeting.

In the time between my learning of the Block Association and their next meeting, I was informed that a public hearing on the spending of Community Development funds was to be held at city hall. I attended the hearing where the Director of Community Development for the City and a number of City Commissioners were present. They passed the budget without objection or discussion and I was at a loss to know exactly what was happening. Since I had not been following the process up until that hearing, I knew very little about the role of
the Community Development Bureau (CDB). However, immediately following the meeting, I spoke with the CDB Director about the possibility of using the Learning Village building as a community center. She felt that the Eastside definitely needed a facility like that and told me that someone from her office would contact me.

A representative from the CDB called me the following day. He mentioned that he would like to see the Learning Village building and an appointment was arranged. I met with this representative and he looked over the building and came to the conclusion that the structure was at least adequate for purposes of a center, and certainly superior to other available sites. He felt that we should bring the idea up before the Community Block Association, because he could act only as an agent of the people.

Phase I—direct entry

Once I had learned of the Community Block Association, I began planning to attend the meetings. I attended the first public meeting. I was fortunate in that my entry into this setting corresponded with the first open meeting of the association. My intention was to examine the structure of the community as revealed by those in attendance and their position in the community hierarchy. This gathering was also important for one additional reason: I had to meet the key people of the area without having them perceive me as an outsider attending their meeting for the purpose of using them and
their organization in some way.

Over the two months of work previous to this meeting, I had met a number of area people, but most of these had been involved in an agency or in some profession that had allowed them to become accustomed to the entry of new people into their setting; this was not necessarily true of the community people themselves. In order to be as cautious as possible about my perceived affiliation with any particular group or agency, I arranged to be introduced in an informal manner by a local minister whom, I had observed previously, had already established good rapport with community residents. The introduction went well and I met a number of people who seemed pleased that the Learning Village board was interested in becoming involved in the work of the Block Association. It was at this meeting that a representative of the CDB informed the Association that the CDB would be holding a series of need assessment meetings in the Eastside community. He explained that this process would begin with the next public meeting and that federal monies were available to help the citizens meet what they felt were the most pressing needs of the area.

During the period between this meeting and the first need assessment meeting, I continued to talk with area residents about the possibility of using the Learning Village facility as a neighborhood center. All that I talked with responded favorable to the idea and said
that they would be glad to cooperate, but that the people as a group should decide the matter. This was the consensus of those at a meeting arranged at the Learning Village with representatives of the following agencies present: Community Development Bureau, Northwestern Community Schools, Michigan State Cooperative Extension Office, the Eastside Block Association and the Learning Village.

At this meeting, I did nothing to convince these community members that my ideas were superior to any others. I merely presented the possibilities from the viewpoint of the Learning Village. I did not want to convince them that the Learning Village plan was the best when to them it might not have been. Since any center that developed would be the responsibility of the people to operate, staff and plan, I did not want them to approach the possibility with the idea that help would always be there. In my estimation, unless the people planned and designed the program, there would always be the chance of inappropriate programming and, as a result, ineffective offerings.

Phase II--response of the community

This phase of the project began with the first CDB need assessment meeting and consisted of the three need assessment gatherings and the results of that process.

The first meeting of this series was held to gain the initial impression of community residents with regard to priorities of spending forthcoming federal funds. The CDB furnished an outline
to help structure this process. The purpose of this first hearing was not to list the needs in any order of importance, but to simply establish the deficiencies of the area in any order.

In general, everything went smoothly, however, one important idea seemed to pervade the meeting: the anger of the community residents over the closing of the public elementary school was overwhelming. It appeared that community members were perceiving CDB representatives as agents of those responsible for the school closing (i.e., the Public School Board).

A second incident took place near the end of this meeting. The last section of the CDB outline dealt with the question: What is good about your community? Someone answered, "The Learning Village." I took this opportunity to mention that the Learning Village facilities might be available to meet some of the recreation needs that they had referred to during the meeting. I received a very strange reaction: a marked negative response. This reaction was especially strong on the part of those people who were the operators of the store-front school in which the meeting was being held. The same was true of one association officer. I was at a loss to understand this reaction. This was proof that I had not done my homework thoroughly enough and that I had had relaxed too much, forgetting all the implications that even a simple remark can have, especially if one is not aware of all the operative variables.
To add significance to the remark, the CDB representative immediately spoke-up supporting my suggestion, and mentioned that he had looked over the facilities and felt that they were excellent for purposes of a community center. This comment may have indicated that we were planning for the people and arranging things without their input. At any rate, the reaction soon dissipated and the meeting closed.

I wished to find out more about this reaction because I felt that if I was to continue to progress toward the set goal, this attitude must be explored and satisfactorily explained. So, during the period between the first and second need assessment meeting, I arranged a gathering between myself, the CDB representative and the operators of the school in which the meeting was held. During this meeting, concern was expressed that the Learning Village was "moving into the territory" of the store-front school and, it was pointed out, that the Village had been in the community for quite some time without being extensively involved in community affairs: so why now? I explained that our move into the community was independent of the activities centered at the school and that our efforts had originated for different reasons (i.e., to involve the parents and community in the education of young children and not to take credit for anything that the school had accomplished). This explanation did not seem to be adequate and the school operators then verbally attacked the
CDB representative. They were antagonistic toward the both of us, because they felt that we (the CDB representative and I) had one thing in common: we were outsiders who were attempting to take advantage of the poor people in the area. After a long discussion, and further clarification of my motives, I explained that the Learning Village was not involved to "corner the market" on the community "helping" profession, but merely attempting to complement any existing efforts. The resistance was noticeably lessened. However, I was disturbed to discover that a Block Association officer, who was not present, felt much the same as the school operators.

It was fortunate in this regard that I was present at another meeting and was able to talk to this association officer in a different context. Because of this conversation and evidence that I was involved in areas of community improvement other than the Eastside effort, our relations improved. Thus, I felt that this issue had been resolved. A short time later, the Association officer and I worked on the organization of a community clean-up campaign and our relationship continued to improve.

The second need assessment meeting was characterized by the school issue; more and more anger was vented on the CDB representative and a member of the city planning department, who was attending his first meeting in this series. After an exceptionally long meeting, the needs articulated in the first meeting were clarified
and again listed. During this gathering, I said little in the hope that the incident of the first meeting would lose potency over time.

During the third and final need assessment meeting, the CDB returned the final list of needs, as determined by the community in previous forums. The purpose of this final interaction was to prioritize the needs. Again, the issue of the school closing came up; this time the people were more emotional than they had been previously. This occurred immediately following my suggestion that a number of identified needs could be met by a community center. Again, I felt that the citizens had overreacted, or at least it seemed that way, given my comment. However, I soon observed that they were looking for a reason to argue the school issue. The citizens had chosen the opportunity provided by my comment to express disappointment with school officials who refused to allow the former school building to be used as a neighborhood center. This discussion was further stimulated by the presence, for the first time, of the CDB Director. The CDB promised to look into the school-use matter and report back to the Association. This provided some reassurance on the part of the citizens and their anger again subsided. At the final meeting, the identified needs were finally prioritized and a community facility for recreation and human services was at the top of the list.

My formal entry into the community social structure was now complete. I knew several key community members personally and
was able to relate to them without an intermediary. I had gained credibility and could speak as an interested member of the Eastside. The entry process required roughly six months and spanned from March to August of 1976.

Following formal entry, I continued to attend meetings and activities. As with many interventions, the original goals of the Learning Village plan changed. I felt, along with the Learning Village administration, that we should not only involve parents in our program but many others as well. We began to discuss how services might be offered to meet other community needs (i.e., in addition to those of the preschool population). Initially, we explored ways in which the Learning Village building could be used for a variety of programs, supervised jointly by the Village and the Eastside Association. A proposal for funding was submitted to the Department of Mental Health, however, we were informed that money was not available for such purposes. Our original plan was modified and other alternatives were sought. We considered leasing a portion of the building to the city for use by the community. Yet, in the final analysis, given the constraints on spending and the use of personnel by the Village, we decided on an arrangement whereby CDB funds would be used to purchase the entire building for the use of the Eastside. As it currently exists, the Learning Village will sell the property to the city and then lease space for the continuation of its program. Other
parts of the facility will simultaneously be used for community purposes. This approach has emerged as the preferred one and planning is now in progress. Other agencies have already agreed to rent space and the resulting revenues will be used as an initial budget for operation and maintenance of the center.
PROCEDURE

Through Learning Village-Community interaction, the original goals were modified. Interest was no longer limited to community members who were Learning Village parents, but was expanded to encompass the Eastside as a unit. The community needed an advocate and the Learning Village began to serve that purpose. As a function of the shifted focus of the project, the present study was designed to determine the general mental health needs of the Eastside, with more specific planning postponed until a later date.

In order to form a community need profile, a number of specific procedures were selected. The general approach represents a combination of need assessment methods discussed earlier (i.e., consumer response, epidemiologic, and social indicator analysis). Each component is discussed below.

The Questionnaire

The instrument

The questionnaire (see Appendix A) was designed to sample three general types of information from the community population. These categories are: personal/household (items 1-26); self-report on health and attitudes (27-53); and community report (54-77). The first category includes statistics on the respondent and the household
and attempts to obtain information on factors such as occupation, age, family size, etc. The second category consists of items designed to sample the personal health (mental and physical) of the respondent. The third section was constructed to sample service usage by the respondent and to determine how the respondent views community conditions in general.

Questionnaire items were selected from the Florida Family Health and Life Survey (Warheit et al., 1976), The Midtown Manhattan Survey (Srole, Langner, Micheal, Opler & Rennie, 1962) or written by the present author. Many valuable suggestions were also obtained from the work of Oppenheim (1966).

Items 27-48 comprise a "mental health" scale developed by New York City researchers in the early sixties (Srole et al., 1962). This scale was originally devised from items of the Minnesota Multiphasic Personality Inventory (MMPI) and the Neuropsychiatric Screening Adjunct (NSA). A respondent's score is indicative of the presence or absence of symptoms which are common to clients with psychological impairment. The range of scores is 0 to 22, with the larger score indicating an increased probability of the presence of psychopathology. Each question was designed by the original authors to determine if one particular symptom was present. If a symptom is present (indicated by the response to an item), a score of "one" is assigned; if not, a score of "zero" is recorded. This is done
for each item and the assigned numbers are added to obtain a total score which is designed to reflect the degree of pathology present.

Originally, a score of 4 or above was considered indicative of impairment, however, in the present study a score of seven or more was used as the "cut-off" point. A score of four or less was considered to indicate "no impairment" in the present study.

In the New York City study 2.6 symptoms were found to be average for non-clients, and 4.8 for out patient clients. These researchers indicated that if a cut-off point of "seven or more" is used, one is able to choose those who would be considered impaired by a psychiatrist with a great deal of accuracy (Srole et al., 1962).

Even though the Midtown Manhattan Scale has a basis in extensive research, one cannot say with certainty that it will allow identification of all those experiencing impairment in a sample. However, this scale does allow the researcher to make an "educated guess" regarding the number of citizens who might be experiencing substantial problems. This estimate is strengthened by the use of a rather stringent criterion (7 or above) for impairment.

The sample

A list of all household addresses in census tract one was obtained from city government offices. Five hundred addresses were selected from this list such that some addresses from every city block within the tract were included in the sample. There is a total
of 840 households in the tract. Thus, a questionnaire was mailed to approximately 59% of the available residences.

Each envelope contained a letter of introduction, a questionnaire with instructions and a self-addressed stamped envelope. The mailing envelope and letter of introduction contained the name and address of the Learning Village and the letter was signed by the present author.

Social Indicators Data

Census factors

The primary source of this information was the 1970 census. Information was obtained from the public library. In order to provide a useful summary of relevant statistics, twelve census factors were combined to obtain five indices of population mental health need. These calculations are based on a method of need estimate recommended by the National Institute of Mental Health (NIMH) and used by the Michigan Department of Mental Health to prioritize catchment areas in terms of service need (See Michigan Mental Health Plan, 1977). The indices and the formulae for calculations are presented below.

- Employment Status (E.S.)

\[
E.S. = \left( \text{Low occupational status} + \text{unemployment} \times 2 \right) / 2
\]

Where low occupational status is defined as percent of employed males 16 and over who are operatives, services
workers and laborers, including farm workers, and

Where unemployment is defined by the percent of the civilian labor force 16 and over that is unemployed.

b. Economic Status (E.S.)

\[ E.S. = \text{population in poverty} \]

Where population in poverty is defined as the percent of the population below the poverty level (as given in the census).

c. Family Status (F.S.)

\[ F.S. = (\text{nonhusband/wife households} + \text{children under 18 not with both parents} + \text{youth dependency ratio} + \text{aged ratio} + \text{one-person households}) \]

Where nonhusband/wife families equals the percent of all households with nonintact husband/wife families.

Children under 18 is the number of persons under 18 per 100 persons 18-64 in the household population not with both parents.

Youth dependency ratio is the number of persons 18 and under per 100 persons 18-64 in the population.

Aged ratio is persons 65 and over per 100 persons 18-64 in the household population, and

Where one person households equals the percent of households with only one person in residence.

d. Neighborhood Structure (N.S.)

\[ N.S. = (\text{overcrowding} + \text{recent movers}) \]

Where overcrowding is defined by percent of persons in households in housing units with 1.01 or more persons per room, and

Where recent movers equals the percent of the population who moved into residence within the past year (or in this case, the year before the census).
e. Ethnicity (E)

\[ E = (\text{non-white} \times 2 + \text{foreign stock}) \]

Where nonwhite equals the percent of the household population that is not white, and

Where foreign stock is the percent of the population who are foreign born or native born, or of foreign or mixed parentage.

The larger index values are indicative of greater need for mental health services. These five indices were calculated separately for the City of Kalamazoo, Census tract 1 and five adjacent tracts (2, 3, 4, 9 and 10).

Profiles of Change Information

In the case of the City of Kalamazoo, additional population statistics were available in the form of data collected by an independent firm (R. L. Polk and Company). These data were summarized as a computer processed by-product of a door-to-door canvass of the city for information to be used in a commercially available city directory. Data were available from 1973 and 1974, thus, one year comparisons could be made for each data set.

Public Forum Data

As mentioned previously, three public need assessment hearings were sponsored by the Kalamazoo Community Development Office in the Eastside Community in the Spring of 1976. The summary
of results was obtained and incorporated into the assessment results presented here. The first meeting was a general session; the second was held to clarify ideas presented in the first; and the third meeting was held to prioritize needs identified in the first two. Since federal monies were involved, only a limited number of projects were eligible for consideration. Thus, this data is more specific than other types of information.
RESULTS

Questionnaire Response

Sample response

Five hundred questionnaires were mailed to household addresses in the Eastside community. Fifty-five, or eleven percent, were returned. Three of the returned forms were refusals; no items were answered. Thus, the sample consists of 6.1% of the available 800 households. This return rate compares favorably with other studies utilizing the mailed questionnaire (e.g., Weiss, 1975). As Cochran (1963) has pointed out, nonresponse provides a substantial problem for the mailed questionnaire method. However, evidence indicates that those who return the questionnaire are most likely to be the ones who most influence the directions of the community and, thus, express opinions that can be given considerably more credence than citizens who did not return the form (Devine, 1970).

Sample characteristics

Of those who responded, 59% were household heads; 52% had lived at their present address for five years or longer; and 17% had changed addresses within the past year. The majority of respondents were female (8%) and 44% were between the ages of 21 and 35. Seventy-nine percent were white and 12% were black. Fifty-five percent of
those who responded were married and 19% indicated that they were either divorced or separated. Forty-one percent of the households were one-parent families. An overwhelming 40% of the respondents indicated that they were unemployed and 34% of the households were receiving some type of outside financial assistance. The median income of the sample was in the $7,000-$8,000 category. Sixty-nine percent of the respondents checked "high school graduate" for the highest degree completed, while only 11% held college degrees.

Reliability estimate

A rough estimate of the representativeness of the response can be obtained via a comparison of the major sample characteristics with 1970 census data from the same area. Table 1 presents these comparisons in summarized form. This process indicates that significant deviations occur in sex: 19% of the sample respondents were male, while 53% of the tract population over 20 in 1970 was male. The black population appears to be under-represented in the current sample as compared to the 1970 census count (11.5% - 1977 vs 28% - 1970). Marital status proved to be reasonably reliable, although the number of divorced or separated seems to be over-represented in the present sample. Income, education and transiency comparisons appear to support the accuracy of the present sample. When making such comparisons, one must keep in mind that the census data were collected seven years ago and that some differences are probably due
### TABLE 1

A Comparison between 1977 Sample Characteristics and Statistics from the 1970 Census (Tract #1)

<table>
<thead>
<tr>
<th>Factor</th>
<th>1977 Sample*</th>
<th>1970 Census</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age</td>
<td>44% (21-35)</td>
<td>40% (over 20)</td>
</tr>
<tr>
<td>2. Sex</td>
<td>19% male, 81% female</td>
<td>53% male (over 20), 47% female (over 20)</td>
</tr>
<tr>
<td>3. Race</td>
<td>77% white, 12% black</td>
<td>71% white, 28% black</td>
</tr>
<tr>
<td>4. Income</td>
<td>Median Category $7,000 - $8,000</td>
<td>Median Income $8,626</td>
</tr>
<tr>
<td>5. Marital Status</td>
<td>55% Married, 11.5% Single, 19% Separated or Divorced</td>
<td>57% Married, 26% Single, 10% Separated or Divorced</td>
</tr>
<tr>
<td>6. Education</td>
<td>Average = 11.05 yrs.</td>
<td>Average = 10.7 yrs.</td>
</tr>
<tr>
<td>7. Transiency</td>
<td>52% at address for 5 or more years</td>
<td>41% at address for 5 or more years</td>
</tr>
</tbody>
</table>

*All respondents in the 1977 sample were 21 years of age or over.

to trends that have emerged within that time period. However, sex and race characteristics certainly deviate from the proportion expected in a representative sample.

**Mental health scale**

The results of the "mental health" scale indicated that 15% of the respondents could be considered psychologically "impaired"
(scores of 7 or above), while 74% showed little or no "impairment" (scores of 4 or below). The range of scores was 0-10; the mean number of symptoms per respondents was 3.13. This compares remarkably well with a study using the same scale done in Kalamazoo in 1959 which found a mean of 3.7 symptoms per respondent (Manis, Brawer, Hunt & Kercher, 1959). This comparison lends some credence to the present results.

When the percentage of "impaired" in the sample is extended to the total population, in excess of 500 community residents could be included in the "impaired" category (15% of 3,496). This result is rather dramatic, given that the psychiatrists who developed the scale considered a score of 7 or above as a very reliable indicator of "impairment" (Srole et al., 1962).

**Personal-community attitudes**

This category was designed to determine how community residents view the quality of their personal life and the adequacy of the community environment. In general the answers portray a "good" attitude with a tendency toward the negative.

When asked "how does the future look to you," 48% answered "good" and 30% answered "fair," while only 8% responded "poor" or "bad." "Money" was the most frequently cited as the greatest personal problem (48%) and "health" was the second most frequently chosen (23%). Most respondents thought that fellow community
residents saw the future as fair (51%) or good (30%). Interestingly, 30% thought that their neighborhood had "deteriorated" over the past five years, rather than "improved" (25%) or "remained the same" (25%).

**Respondent-community service usage and need**

These items were designed to ascertain: (1) the extent of usage of existing general health services by the respondent or an acquaintance, and (2) the opinion of the respondent concerning the need for services with the community.

The average number of visits to a medical doctor in the year prior to the study was 3.37; the range was 0 to 14 visits. Ten percent of the respondents had been hospitalized within the past year; the reasons were variable and no clear illness patterns were discernable within the sample. Fifteen percent of the sample had used the services of a psychologist, psychiatrist and/or social worker in the year before the study.

A rather large number (33%) felt that social services in the area were inadequate, in particular for senior citizens and teenagers (43%). This was supported by further questioning. When asked "what age group is most in need of services," "12-18 years" was the most frequent answer, with "over 60" the second most cited age group.

In response to the question, "How many people do you know that could be helped by mental health services?" 12% answered six
or more, 30.7% responded 1 to 3, and 52% did not know any. Thirty-eight percent of the respondents knew someone with what they considered a mental health problem, while only 20% indicated that the person had sought help for the problem. Roughly one-third of the sample knew someone who had been admitted to a mental hospital. On one item (#68), all of the local community mental health services were listed and the respondent was asked to circle all those that had been used by someone he/she knew. Thirty-three percent did not know anyone who had used any of these services; twenty percent knew someone who had used one service; and 29% of the sample knew of usage of two to four of the services.

General issues

The respondent's opinion on a number of unrelated issues was sampled by items placed throughout the questionnaire. These are discussed below.

In regard to education, 39% of the sample felt that the public schools were "adequate." Thirty percent stated that they knew of someone who had "dropped out" of school; forty-eight percent did not. Only 28% felt that their children would be "well-prepared" for the future; thirty-six percent answered "no" to this question. Over three-fourths of the sample (80%) felt that children should be exposed to education earlier than kindergarten. The results in this category (in particular the adequacy of public schools) are rather surprising
given the recent dissatisfaction of community residents with other aspects of the school system (i.e., school closing).

On other issues, 35% felt that there was a drug problem in the community while 16% said "no" and 47% were unsure. Fifty-three percent answered affirmatively to the question, "Do you know anyone who has what you consider to be a drinking problem?" Similarly, 53% thought that there was a crime problem in the Eastside area.

**Learning Village response**

In order to determine the general attitude toward the Learning Village, three items were included near the end of the questionnaire (items 72, 73 and 74). Fifty-five percent were familiar with the Learning Village; thirty-six percent rated the services as "excellent," 44% rated them "good," and only 4% felt that services were "poor." Surprisingly 93% of the respondents had never used the services of the Learning Village.

**Questionnaire Analysis by Variable**

In order to determine if any of the results of the questionnaire could be attributed to one group of community residents more than another, the sample was divided according to age, location of household and mental health scores. Age was chosen to determine if one particular age group was more in need than others; the same is true
for location. Psychopathology was chosen as a variable to determine if those evidencing "impairment" were of one particular area or age group, or if scores on this scale were related to patterns of response.

The respondents were subdivided in terms of location according to criteria used to rank within-tract areas by the city planning commission. Three distinct areas were identified within the community (see Figure 2). Area one according to the planning commission is stable and should receive attention only if deterioration from the present condition is observed. Area two is considered "less stable" by planners and is targeted for "spot upgrading." Area three is zoned for industrial and commercial use and, according to the commission is not desirable for residential use. Thus, in terms of desirability of living conditions area one would be most conducive to adaptive living and area three would be least conducive. Age and psychopathology variables were divided into groups on the basis of age given on questionnaire and total score respectively.

**Intercorrelation of independent variables**

The Spearman Rank Order Correlation Test (Siegel, 1956, p. 202) was used to determine the extent of the relationships between age, location and psychopathology score. The relationship between age and psychopathology was not statistically significant (p > .05,
Figure 2. Census tract 1 of Kalamazoo County Michigan (enlarged) with three areas of need identified by the Kalamazoo City Planning Commission outlined.
\( r = -.03 \); the same was true for the relation between location and psychopathology scores \( (r = .15, p > .05) \). The correlation between age and location was reliable \( (r = .35, p < .05) \) indicating that these two measures vary together. Examination of the raw data indicated that younger respondents live primarily in area one, while older respondents live for the most part in area three.

**Analysis by age, mental health score, and location**

Respondents were divided into groups on the basis of age. Four categories were formed: 20-30, 30-45, 45-60, and over 60. Subsequently, questionnaire items 25 and 49-76 (excluding 51b, 55b, 67, 68, and 75) were analyzed by categorizing frequency of response to each item per age group and performing chi-square tests of significance (Siegel, 1956, p. 104). Only one test resulted in a chi-square value with an associated probability of .05 or less. All others were not statistically significant. This item (66) addressed the adequacy of community social services. Here, the two youngest age groups answered negatively, while the "older" groups were divided with many responding "don't know."

For analysis in terms of "mental health" scores, respondents were divided into three groups on the basis of scores presented previously. Those scoring 0-4 formed one category, those scoring 5 and 6 formed a second category and respondents evidencing 7 or more symptoms were placed in a third group. Chi-square analyses were
performed using the same items as were used with the age variable. Again, only one chi-square value reached statistical significance at the .05 level (item 56). This question deals with how the respondent thought other community members saw the future. An examination of the grouped data revealed that those with fewer symptoms, as measured by the questionnaire, saw the future as predominantly "good" or "fair," while those with 5 or more symptoms answered predominantly "fair," "poor," and "bad."

In a manner similar to that of age and "mental health" analysis, respondents were divided into groups on the basis of the three areas of the Eastside identified by the Kalamazoo City Planning Commission. Chi-square analysis was carried out for the location variable using the same questionnaire items as were used with age and "mental health" analysis. Only two chi-square values were statistically significant (items 52 and 61). For item 52, a large proportion of residents from area one answered "excellent" or "good" when asked, "how does the future look to you?" Conversely, more residents from areas two and three answered less optimistically in reaction to this question (e.g., poor, bad, fair). In fact, not one resident from area three answered "excellent." For item 61, which asked which age group most need services, most respondents answered age 12-18. Furthermore, most respondents from area one indicated that the 12-18 group was more in need of service than other age groups, while
residents of areas two and three emphasized the needs of both younger and older populations (i.e., 0-6, 6-12, and over 60).

In summary, few differences in questionnaire responses were observed due to the variables of age of respondents, mental health score or location within the community. Of sixty chi-square tests used to analyze the data, only four values were statistically significant at the .05 level of confidence. Those differences that were observed were consistent with hypothesized trends.

Social Indicator Analysis

NIMH need indices

Twelve census factors were combined to form five indices of need which depict conditions in the following areas of community life: employment status, economic status, family status, neighborhood structure and ethnicity (see pp. 53-55 for formulae for calculation). Each index value was calculated separately for the City of Kalamazoo, the Eastside community and a group of five nearby census tracts (tracts 2, 3, 4, 9 and 10, see Figure 1). A grand mean (average of the five indices) was computed for each area, as well as standard deviations for each index and the grand means. Table 2 presents a summary of these values and the calculations are contained in Appendix B.

Since mental health funds are allotted for defined geographical
TABLE 2

A Summary of NIMH Need Indices* as Calculated for the City of Kalamazoo, the Eastside (Census tract 1) and Five Nearby Census Tracts

<table>
<thead>
<tr>
<th>Index</th>
<th>City</th>
<th>Eastside</th>
<th>Five Tract Average</th>
<th>Standard Deviations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment Status</td>
<td>23.75</td>
<td>32.30</td>
<td>38.87</td>
<td>8.85</td>
</tr>
<tr>
<td>Economic Status</td>
<td>7.9</td>
<td>11.40</td>
<td>17.28</td>
<td>8.17</td>
</tr>
<tr>
<td>Family Status</td>
<td>22.6</td>
<td>32.60</td>
<td>34.04</td>
<td>5.80</td>
</tr>
<tr>
<td>Neighborhood Structure</td>
<td>23.3</td>
<td>25.60</td>
<td>24.08</td>
<td>2.89</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>16.75</td>
<td>33.05</td>
<td>41.65</td>
<td>26.66</td>
</tr>
<tr>
<td>Grand Mean</td>
<td>18.86</td>
<td>26.99</td>
<td>31.18</td>
<td>9.19</td>
</tr>
</tbody>
</table>

*Formulae for calculation are presented on pages 53-55.

areas and because planning must be specific for each area, the most meaningful approach is to establish areas of risk, within a service area, through comparative analysis. Thus, in the present case, need indices calculated for the entire city were used as the "norm" against which indices for more specific areas were compared. This approach allows one to depict community conditions on a continuum relative to the average conditions, and then determine the significance of observed deviations.

In order to transform index values to standard units, the following formula was used:  

$$ Z = \frac{X - \mu}{\sigma} $$
where \( x \) is the value being transformed (index value), \( \mu \) is the population mean (in this case the city index value), and \( \sigma \) is the standard deviation of values computed for all areas on a given index. When scores are transformed to "Z" they are expressed in terms of a distribution having a mean of "0" and a standard deviation of "1." Deviations of 1.64 units or more are considered statistically significant at the .10 level of confidence (see Glass & Stanley, 1970, p. 86).

Table 3 presents the transformed index scores and the deviation of each from the city value for that index (columns 2 and 3). Also shown are the deviations of Eastside index values from those calculated for a group of five nearby tracts (column 4). The signs indicate the direction of the differences with "+" indicating a higher ranking for the area listed relative to other areas and "-" indicating a lower ranking. Here it must be recalled that a larger index value depicts increased need.

In general, the Eastside falls between the city and the "five tract average" in terms of need. This is true with one exception: on the neighborhood structure index, the Eastside was ranked above the "five tract average" (+.52 units). Thus, the Eastside was ranked above the city average on all indices (Mean difference = +.90 units) and below the "five tract average" on four of five indices (Mean difference = -.33 units). Therefore, we can conclude that the Eastside has more conditions conducive to the need for mental health


<table>
<thead>
<tr>
<th>Index</th>
<th>City</th>
<th>Eastside</th>
<th>Five Tract Average</th>
<th>Eastside vs. Tract Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment Status</td>
<td>0 (23.75)</td>
<td>+.96</td>
<td>+1.70</td>
<td>-.74</td>
</tr>
<tr>
<td>Economic Status</td>
<td>0 (7.9 )</td>
<td>+.42</td>
<td>+1.15</td>
<td>-.73</td>
</tr>
<tr>
<td>Family Status</td>
<td>0 (22.6)</td>
<td>+1.72</td>
<td>+1.97</td>
<td>-.25</td>
</tr>
<tr>
<td>Neighborhood Structure</td>
<td>0 (23.3 )</td>
<td>+.79</td>
<td>+.27</td>
<td>+.52</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>0 (16.75)</td>
<td>+.61</td>
<td>+.93</td>
<td>-.32</td>
</tr>
<tr>
<td>Grand Mean</td>
<td>0 (18.86)</td>
<td>+.88</td>
<td>+1.34</td>
<td>-.46</td>
</tr>
<tr>
<td>Mean Difference</td>
<td></td>
<td>+.90</td>
<td>+1.23</td>
<td>-.33</td>
</tr>
</tbody>
</table>

*See text for explanation*

services than the city overall and less need than other area neighborhoods.

In order to make these data meaningful in terms of programming, more specific information is needed. First, the Eastside is ranked above both the city and the "five tract average" in terms of neighborhood structure. This index addresses problems with "over-crowding" and "recent movers." Thus, a large proportion of Eastside residences have too many people per room and a large proportion of the population moves frequently; that is, of course relative to the two
other areas included in the comparison. Other indices can be
interpreted in similar fashion. Relative to the city, the Eastside has
more problems with family status. This indicates that: a significant
proportion of Eastside households contain only one parent, a large
proportion of area citizens are under 18 or over 65, and that an
excessive number of one-person households are present in the
community.

Other problem conditions exist, relative to the city, with
employment status, ethnicity and economic status. The first is
indicative of high unemployment and a low percentage of skilled
laborers. Differences on the ethnicity index are representative of
the larger number of minority group residents in the Eastside area.
The last index (economic status) was the only measure on which the
Eastside was within as little as .5 units of the city. This is made up
of the percentage of households below the poverty level in terms of
income. This small difference is rather surprising given the
problems with employment status in the community.

Profiles of Change

Population statistics, in addition to the 1970 census, were
available through a commercial firm (R. L. Polk, 1975). These data
were used to further explore the needs of the Eastside. Table 4
presents Eastside, city and "five tract average" comparisons for
seven key factors of this data set. These comparisons involve factors
normally related to family and social stability and as such are reveal­
ing in the area of mental health. In general, the Eastside is ranked
above the city in the categories listed as far as the presence of
problematic conditions. And the Eastside scores are similar to
values derived from the five tract average. The exception in both
cases is with "percent renters"; the city and five tract average were
higher in this category.

The Profiles of Change data also contain a rank-order of all

---

### TABLE 4

Profiles of Change Summary Data for Seven Need Indices for the City of Kalamazoo, the Eastside and an Average of Five Surrounding Tracts

<table>
<thead>
<tr>
<th>Index</th>
<th>City</th>
<th>Eastside</th>
<th>Five Tract Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average persons per household</td>
<td>2.6</td>
<td>2.76</td>
<td>2.74</td>
</tr>
<tr>
<td>% Husband/wife households</td>
<td>56.16</td>
<td>52.29</td>
<td>47.77</td>
</tr>
<tr>
<td>% Households with children</td>
<td>34.5</td>
<td>41.43</td>
<td>40.52</td>
</tr>
<tr>
<td>% Female headed households with children</td>
<td>6.9</td>
<td>13.65</td>
<td>15.66</td>
</tr>
<tr>
<td>% Retired household heads</td>
<td>21.3</td>
<td>25.3</td>
<td>21.35</td>
</tr>
<tr>
<td>% Jobless household heads</td>
<td>14.2</td>
<td>19.02</td>
<td>24.24</td>
</tr>
<tr>
<td>% Renters</td>
<td>41.01</td>
<td>37.03</td>
<td>54.27</td>
</tr>
</tbody>
</table>
area census tracts in terms of conditions on eight key indicators. These indicators involve the measurement of conditions in the following areas: tract income, residential vacancies, commercial vacancies, unemployment, number of persons per household, female headed households and a household income index (prepared by Polk and Company). The status of these conditions is measured for each area and the tracts are then ranked, with a rank of "1" indicative of the presence of the least desirable conditions in these areas. On this scale, the Eastside was ranked number 6; the combined rank of the five nearby tracts was 4.6; the ranks ranged from 1-20 for tracts within the city. Thus, although the Eastside was slightly below the composite rank of other area communities, it was still ranked with the top ten potentially problematic areas.

Profiles of Change data was also used to determine the direction of change for the Eastside community on a number of crucial indices. The period between samples was one year (September 1973-September 1974). These data are presented in Table 5. Although one year is hardly enough time to identify reliable trends, these statistics certainly provide interesting ideas. These "directions of change" are supported by the fact that all five nearby tracts as a group followed exactly the same pattern. In fact, four of the five nearby areas were ranked within the top ten tracts in the city in terms of absolute change and the trend was toward deteriora-
tion rather than improvements.

**TABLE 5**

Direction of Change from 1973 to 1974 on 10 Need Indices for the Eastside Community (Census Tract 1)

<table>
<thead>
<tr>
<th>Index</th>
<th>Direction of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of households</td>
<td>✓</td>
</tr>
<tr>
<td>One-person households</td>
<td>✓</td>
</tr>
<tr>
<td>Husband/wife households</td>
<td>✓</td>
</tr>
<tr>
<td>Households with children</td>
<td>✓</td>
</tr>
<tr>
<td>Female households with children</td>
<td>✓</td>
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<tr>
<td>Retired households</td>
<td>✓</td>
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<tr>
<td>Jobless households</td>
<td>✓</td>
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<tr>
<td>Renters</td>
<td>✓</td>
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<tr>
<td>Owners</td>
<td>✓</td>
</tr>
<tr>
<td>Business and Professional Establishments</td>
<td>✓</td>
</tr>
</tbody>
</table>

In summary, it should be mentioned that the Profiles of Change data source does not indicate which conditions are problematic and which are not. Only the statistics are presented. However, in mental health and social stability terms these statistics depict worsening conditions. Although one cannot state with certainty that these conditions "cause" mental health problems, increases in joblessness,
the number of female-headed households and one-person households do not indicate improvement. The same is true for decreases in the number of home owners, the available business and professional establishments and husband/wife households. All of these are signals of alarming interpersonal and community conditions.

Public Forum Data

Three public need assessment meetings were held in the Eastside community for purposes of identifying and prioritizing needs. The results of this process are summarized in Table 6 and discussed below.

Priority one: Neighborhood services

Within this broad category, four areas of need were identified and arranged in order of importance. They are: (1) a multi-purpose community center; (2) adequacy of shopping areas; (3) health and social services; and (4) parks and recreation. The first need, a center, is in the process of being met through the purchase of the Learning Village building. In the second area, citizens felt that they either needed a suitable grocery store within the community or adequate transportation to services outside the tract. The addition of mini-bus service has helped with this problem. With regard to health and social service needs, citizens identified three specific problems: (1) the lack of medical services, (2) the need for a local hot-meal
<table>
<thead>
<tr>
<th>Priority</th>
<th>General Area</th>
<th>Specific Needs</th>
</tr>
</thead>
</table>
| 1        | Neighborhood Services | 1. Multi-purpose center  
          |                     | 2. Neighborhood grocery  
          |                     | 3. Health and social services outreach workers  
          |                     | 4. Hot meal program for senior citizens  
          |                     | 5. Recreational programming for area parks and nearby schools (emphasis on seniors and teens)  
          |                     | 6. Counter-loneliness for those who live alone  |
| 2        | Neighborhood Environment | 1. More police patrols and an organized neighborhood watch to discourage crime (in particular those involving senior citizens)  
          |                     | 2. Sidewalk and street repair  
          |                     | 3. Repair and paving of streets  
          |                     | 4. Cleaning and upkeep of vacant and abandoned property  
          |                     | 5. Garbage pick-up for abandoned cars and junk  
          |                     | 6. More monitoring of traffic by police in the neighborhood  
          |                     | 7. Better bus scheduling for school children and senior citizens  |
| 3        | Housing             | 1. Code enforcement and better upkeep of housing (especially rental units)  
          |                     | 2. Some means of settling landlord/tenant disputes  
          |                     | 3. Lowered taxes for those who improve their property  
          |                     | 4. Help for senior citizens and disabled who wish to improve their housing  |
program for senior citizens, and (3) deficiencies in community-based access to centralized social service agencies. In general the majority wanted outreach workers placed in the area to connect the community with available, but inaccessible, services. Other expressed needs related to recreation programming. Citizens suggested that recreation programming was needed for community parks and nearby schools. A need for tot-lots (small playgrounds) for preschool children was also included in the list. Senior citizens were mentioned as a primary target population in most areas, however, the need for a counter-loneliness program was specifically addressed.

Priority two: Neighborhood environment

Needs in this category include those related to: (1) crime, (2) street and sidewalk maintenance, (3) street lighting, (4) unkept property, (5) garbage pick-up, and (6) transportation (in that order). Although the above may not directly relate to mental health service provision, few will argue against their consideration as factors that play a role in the emotional well-being of community residents.

Crime problems centered around breaking and entering, drug usage and vandalism in parks. Crimes against senior citizens were also cited as a problem. The needs related to increased police patrols and an organized crime watch to protect the park and citizens who are unable to protect themselves.

A portion of the needs in this category relate to physical
improvement of the community. Unpaved streets, flooding and broken or missing sidewalks were cited as problems. Street lighting was considered inadequate and certain sections of the neighborhood were reported "extremely dark" after businesses close. Most citizens felt that there was a need to improve the condition of vacant lots and to remove or repair abandoned houses.

The final portion of priority number two addressed garbage and transportation services. The garbage issue focused on abandoned cars and junk. The discussion of transportation pertained to "speeding" on community street, the positioning of traffic control signs, front-yard parking and additional mass transit services. Most citizens felt that busses should be better scheduled in order to serve students who are forced to walk to school if their home is within one mile of the school.

Priority three: Housing

Four areas of concern were raised: (1) maintenance of housing, (2) tenant-landlord problems, (3) taxes, and (4) the special needs of the elderly and handicapped. Most felt that there was a need for stricter housing code enforcement (in particular for rental units).

Tenant-landlord disputes were termed "a significant problem." Citizens also felt that many did not improve or maintain their homes because of the possibility of an increase in value and subsequent tax increase. The general feeling was that a tax break should be given
to those willing to improve their property and the community.

Finally, emphasis was given to the fact that senior citizens and the handicapped need help in repairing and maintaining their property.

Although several measures of need were used here, other sources of information are available. A complete list of these factors is presented in Appendix B.

Eastside Need Profile

Several sources of data have been used to provide facts about the Eastside community. However, in order to be useful in planning functions, this information must be combined in a way that allows the planner to determine the most pressing needs and recommend services to meet them. The data were examined for the most obvious and consistent indicators of need and seven major categories were formed: family problems, employment problems, residential stability, target populations, services recommended by citizens, education, and specific mental health needs. In order to indicate the source of data used, each statistic will be followed by an abbreviation representing its source. These abbreviations are as follows: questionnaire (Q), census data (C), profiles of change (P), and public forum (F).

Family problems

In the Eastside community, 20% of the residents over 21 were estimated to be divorced (C); 41% of the households were estimated to
be one-parent (Q). A sizeable proportion of the Eastside population was found to be under 18 and over 60 years of age (C). Households with children and female-headed households with children were also numerous as compared to the city as a whole (P). Thus, relative to the city, the Eastside is experiencing a substantial number of problems in family stability.

**Employment problems**

In this category, conditions appear to be less than desirable, relative to the city. The median income of the Eastside was found to be $7,000-$8,000 (Q). A large number of household heads were estimated to be jobless or retired (P). The number of unskilled laborers was large and unemployment high (C), while 34% of the households were estimated to be receiving "outside" financial assistance (Q). Consistent with the above, the greatest reported general problem centered around money (Q).

**Residential stability**

The stability of the neighborhood appears good in terms of transiency. Approximately 50% of the residents have been at their present address for five years or longer (Q), while the percentage of renters is relatively low (P). Some problems appear to exist with overcrowding in residential units (C) and vacancies in professional and business establishments (P).
Target populations

Two specific age groups seem to be most in need of services. This is supported by several facts. First, teenagers (under 18) and senior citizens (over 60) comprise a relatively large proportion of the Eastside population (C). Additionally, the 12-18 and over 60 age groups were pinpointed by citizens as the groups most in need of services (Q). Juvenile crime was reported to be a problem (F) and this was supported by data available from local law enforcement agencies. Citizens also emphasized the need for a hot meal program for senior citizens and expressed concern about elderly community citizens who live alone (F). One-parent families and families in crisis were also indicated as need populations (see family problems).

Services recommended by citizens

Citizens felt that existing community social services were inadequate (Q) and that health and human service programs should be the number one priority (F). Community residents emphasized the need for outreach workers from centralized agencies and community recreational programs (F). Other, less urgent, needs were also identified including increased police patrols, physical improvement of streets and sidewalks, and housing property improvement (F).

Education

The average number of years of education for Eastside
residents was 10.7 years (C). In a more recent sample, 69% indicated that they had received a high-school degree (Q). An estimated 40% felt that the public schools were adequate (Q) while only an estimated 28% felt that their children would be "well-prepared" for the future. Eighty percent of the questionnaire sample felt that children should be exposed to education earlier than kindergarten (Q). In the context of these data, educational services do not seem to present any pressing problems.

Specific mental health needs

An estimated 15% of Eastside residents were identified as experiencing significant emotional problems (Q). Forty-eight percent of questionnaire respondents knew someone that they felt could be helped by mental health services (Q). Thirty-eight percent knew someone with what they considered to be a mental health problem (Q). Forty-nine percent knew someone who had used an existing community mental health service (Q). Although a rather large number of residents appear to be experiencing problems and citizens think that several community members are in need of mental health services, existing services appear to be used by Eastside citizens to some extent (Q).

Also of importance here are community resident attitudes toward the environment. Most community citizens saw the neighborhood as fair or good (Q). However, an estimated one-third felt that
the community had deteriorated over the five years prior to the study (Q). From the questionnaire sample, one-third felt that there was a drug problem, one-half knew someone with a "drinking problem" and over one-half felt that the community has a "crime problem." Residents of community areas two and three were less optimistic about the future, as were residents with larger scores (toward "impairment" criterion) on the mental health scale.

Existing services

No human service agencies or workers are officially located within the Eastside community, with the exception of the Learning Village. Access to agencies is not readily available and no referral network is in existence.

Service Recommendations

On the basis of the need areas just presented, several services can be recommended. These are presented below.

1. Since no human services are currently offered within the community and because expressed needs could be addressed through referral services or other formalized contact with centralized agencies, it is recommended that outreach workers from mental health and social services entities be placed in the Eastside community. This action would address the following needs:

   a. family crisis counseling
b. counter-loneliness programs for senior citizens

c. employment counseling and aid to the unemployed

d. child-care for single parents with children.

2. Since the community school was recently closed and made inaccessible, and due to the fact that no centralized site for community activities and services is available, it is recommended either:

a. that funds be sought for a suitable space to offer activities and services with the community or,

b. that regular and dependable transportation be made available to other sites where such programs are offered. Either of these services would respond to the following deficiencies:

(1) lack of organized programming for teenagers

(2) lack of accessible activities for senior citizens

(3) shortage of afterschool activities for students.

3. Because a substantial number of one-parent households appear to be present within the community, it is recommended that meetings be publicized and held to determine citizen interest in the establishment of regular programming to inform these community members of services that are available. Furthermore, if interest is sufficient, these meetings should also include the dissemination of information that is requested and deemed of value by residents
experiencing such problems.

4. Although the public does not seem to be overly dissatisfied with existing educational services, there is data to indicate the need for organized adult education programs. Based on census data and questionnaire responses, a program leading to the General Equivalency Degree (G.E.D.) appears to be needed.

5. Since a rather large proportion of area residents appear to be experiencing emotional problems (mental health scale) and since community members indicated that they are aware of residents who need aid, it is recommended that the community mental health board provide counseling on a regular basis for those needing help on demand. This would involve the establishment of a small office staffed with one or two qualified personnel.

6. Because the attitudes of citizens toward their environment is "fair" with a trend toward the negative and because residents see their environment as "deteriorating," it is recommended that the city government or other municipal authority place within the Eastside community a liaison worker on at least a part-time basis. This would allow citizens more direct access to available community development funds now available through the Department of Housing and Urban Development. This is particularly important for areas two and three.

7. In general, any services that might be available for teens and/or senior citizens appear to be needed in the Eastside area.
Area three is targeted for senior citizen aid, while areas one and two would need more services for younger citizens (see questionnaire analysis by variable). Additionally, areas two and three seem to be the most likely parts of the Eastside for counseling intervention.

Since the residents of the Eastside have been shown to form a stable population and because conditions in the area appear to be worsening, the opportunity for prevention of future difficulties appears to be at hand. If the above recommendations, or a portion of them, are addressed, perhaps the currently existing trend toward the negative can be reversed. Other nearby areas are experiencing even more serious problems, however, on the basis of the present data, it seems that remediation is needed more than prevention for these citizens. The Eastside is in the unique position of being able to help itself, if and only if aid is given now.
DISCUSSION

The present paper represents an attempt to identify the mental health needs of a small urban community. Several types of information were combined to reach this goal: questionnaire data, public forum information, census data and other population statistics. All of the data were interpreted by the present author in the context of knowledge gained via personal involvement within the community social structure. The final result was a translation of fact, opinion and informal information into a need profile and service recommendations.

As a function of this process, several problems were identified. These difficulties form categories which include: recency of data, reliability of sample and validity of questionnaire responses, representativeness of information gained from public meeting and interpretation of data.

First, census data and other population statistics are usually out-of-date by the time one is able to use them. In the present case, census statistics were at least seven years old and other data (e.g., profiles of change, crime statistics, etc.) were three to four years old. In mental health planning, the process of translating data into service priorities also requires a considerable amount of time. Thus, the age of the data when added to the time required for planning, leads to programming that may be five to ten years behind the times.
Second, although questionnaire responses provide a more recent data base, this information is subject to qualification on a number of levels. For instance, when questions which relate to mental health are asked, the information is many times of a personal nature. This leads to a large number of refusals and an unknown number of misrepresentative answers. In the present study, three questionnaires were returned with letters or notes objecting to the personal material sampled by the questionnaire. Furthermore, unless the instrument is administered via personal interview, one cannot be sure who fills out the form or under what circumstances. Questionnaire items could be "checked" at random or completed by household children or by anyone else not necessarily knowledgeable about the household or community. Additionally, with the mailed questionnaire, a random sample cannot be assured. Even if questionnaires are mailed to households randomly selected, the return rate from various locations will probably bias the final sample (Cochran, 1963).

Some of the problems of the mailed questionnaire can be alleviated by use of the personal interview method. However, even with the increased cost and time required by this method, only the most cooperative community residents may submit to the interview. Furthermore, interviewers must be trained and a great deal of time is required for the actual collection of the data. If need assessment
is to be ongoing and information updated regularly, this method may not be cost-effective.

Nonresponse to both mailed and personal-interview questionnaires may be increased because of the association of the study with a particular agency or individual. For example, given the historical account of Learning Village conflict with the black community, one might expect cooperation from blacks to be less than that of white residents. Although this is speculation, it cannot be ruled out as an explanation for the lower-than-expected response to the questionnaire by blacks. Other factors, some unknown, could also be operating. Those most closely associated with the effort to secure a community center would probably be more apt to respond than those who are not aware of this project. Citizens who have been working toward this goal are more familiar with the Learning Village program and perhaps more likely to complete and return the questionnaire.

Other events, unrelated to the agency conducting the assessment, may also affect the type and extent of community response to a request for information. For instance, since community development workers have been in the community, a large number of questionnaires and requests for citizen input have been made. This has brought no tangible results as of yet and community members are disillusioned with such efforts. Thus, the present questionnaire may have provided reason for contempt rather than cooperation. One
or more of the above factors is likely to have influenced the observed response and the corresponding community picture obtained from the data. With these factors in mind, the questionnaire results can at best be considered tentative.

Specifically, in the present study, most questionnaire respondents were female and a large proportion were unemployed. This indicates that: (1) perhaps these citizens were home more and had time for completing the forms, and (2) that unemployment figures from the questionnaire were probably distorted by the large number of housewife respondents. Other examples can be expressed in similar fashion.

The third major data source is the public forum meetings where needs were identified and prioritized by a group of citizens. Although the meetings were publicized and open to all, the same group of citizens (with little variation) was present at all meetings. This was verified by a comparison of attendance records. Although a few different people attended, a stable core of citizens consistently provided the input for need establishment over the series of gatherings. Furthermore, only a few need areas were eligible for consideration because of the spending of federal monies earmarked for predesignated categories. Thus, the content and outcome of these meetings was restricted from the beginning.

In summary, practically all of the data presented here are
restricted, as far as generalization to the population as a whole is concerned. The age of population statistics and the tentative nature of more recent samples, severely limits utility.

Aside from shortcomings specific to the data, interpretation of the results probably serves as the second major problem in need assessment. Although the planner is no longer basing services on a hunch per se, wide variation is possible where interpretation and data-based service planning are concerned. In mental health need assessment, indicators of deficiencies are usually very broad (e.g., number of families below poverty level, citizen opinion as to needs, etc.) and lend themselves to multiple interpretation. This allows the planner a great deal of latitude in determining the meaning of the data. For example, in the present study, a large percentage of those responding to the questionnaire were "white." Due to the personal involvement of the author, this was treated as a characteristic of a biased sample and interpreted as such. However, if the need assessment had been done by an agency or individual that chose to ignore the bias, or had no personal knowledge of the community, minority programming could have been reduced. Since mental health providers are not encouraged to interpret need data in any standardized manner or attest to the validity of information, statistics and/or opinion could be used to support any program that is desired. In short, guesswork is still the rule.
Still other interpretation problems arise. Although many publications have furnished data to demonstrate the relationship between need indicators and need (Wechsler & Pugh, 1967; Deutsch, Jensen & Katz, 1968) our knowledge in this area is insufficient. We do not know what type of service is suggested by a large minority population indicator. A high unemployment rate does not automatically tell the planner what service should be offered. Objective data is simply not sufficient for proper planning. In spite of this shortcoming, however, there are ways to increase the efficiency of need-based programming. First, as in the present study, service priorities should be based on deficiencies that surface in all or the majority of need measures. For example, services for teenagers and senior citizens were the focus of citizen concern in public forum, and in the questionnaire response. Population statistics provided support for need by these groups via an indication that both age ranges were present in relatively large numbers in the community. Thus, this need was identified by several different instruments of assessment. This constitutes a basic form of reliability and services for these target groups would, in all probability, be valid. The same was true for one-parent households.

The same process can be used to determine which services should constitute high priorities. The fact that we can state, with some degree of surety, that senior citizens and teenagers are most
in need, does not mean that we automatically know which services would be best. We must return to the data to search for reliable indicators. Here, personal knowledge of community conditions is essential. We do not know why seniors and teens are priority target groups.

We know from crime statistics and public forum that juvenile crime is a community problem. Questionnaire respondents indicated that there is a need for services for teenagers and that the school dropout rate is a problem. Yet, what service should be offered? The same is true for senior citizens. Elderly residents are numerous; they need transportation; and counter-loneliness programs were suggested. However, service priorities are not supported by any reliable trend. Here, the data are insufficient and more information must be obtained in order to ascertain the specific program offerings that would best alleviate deficiencies.

One of two courses of action would probably suffice. Either more specific information must be gleaned from the citizenry or the provider must have intimate contact with the target community. The first approach requires additional expense and time necessary for another sample and the construction of additional instruments; and still, the information that is acquired is nonspecific and subject to multiple interpretation. The second approach is certainly more efficient and perhaps more feasible when service appropriateness is
the major concern.

If the community mental health system is to truly be responsive to citizen needs and concerns, as was the original plan, providers and/or planners must have more contact with target areas in personal, and not statistical terms. The remainder of this paper addresses a proposed method of community contact that would facilitate the collection and use of data to provide adequate and appropriate mental health and human services. Since the present author's knowledge of the Community Mental Health system is related most directly to the Michigan approach, this organization will serve as the example with information pertinent to other systems added as needed.

First, let us examine the present system. Figure 3 summarizes, in simple terms, the supervisory and feedback channels presently in operation. The Michigan Department of Mental Health serves as the State Mental Health authority and is responsible to the Governor, the State Legislature and federal funding sources. This department provides policies and procedures along with the majority of funds for all services in the State. This supervision is channeled through regional offices to institutions and community mental health programs. Programming at the community level is under indirect control in that County Community Mental Health Boards determine priorities and request funds. The Community Boards have the option of providing service directly through board staff or contracting with existing
Figure 3. A diagram of the current Michigan Mental Health System in terms of channels of communication between significant departmental units. The solid lines represent formal channels of communication and the dotted lines indicate informal channels.
agencies (1974 PA 258). Funds are passed through the regional offices from the State to the local boards.

The channel of communication from federal, state and regional offices to the community are well-specified both in legislation (PA 258) and in policies and procedures. The channels from the community providers back to these sources are also detailed. The same is true for contact between contract agencies and the Community Board, as this process is governed by a formal contract procedure. Communication between target area citizens and the Community Board, however, is not specified. As mentioned earlier (see State legislation), these boards have responsibilities to the citizenry, however, rules governing this type of communication are few or nonexistent. Need assessment, the most obvious candidate for formal community contact, is not a standard procedure in the State. As was pointed out earlier, the only formalized assessment approach in operation in the State is the use of five census-based need indices to rank catchment areas (Michigan State Plan, 1977). Otherwise, feedback channels are informal, or at best left to the discretion of community boards. The most common type of ongoing contact with the community-at-large is client service demand (represented by the dotted line in Figure 3). This hardly allows planning for future needs and does not consider those who are without problems, in manifest terms.

From this analysis, it appears that one essential link is
missing: that of formalized and well-specified communication between the general service population and the service provider. In the context of the original legislation and subsequent mandates, this link would seem to be crucial to a responsive mental health system. Thus, we are faced with the question, how is such communication established? From the study just presented, we know that broad statistics cannot suffice, nor can more specific data unless consistent trends emerge. Specific planning cannot be done from general information. Furthermore, the target community in the present study was very small compared to the areas for which state or county mental health entities must plan. And still, needed services were not clearly indicated by the data alone. Contact with the community or a personal level appears to be the only effective alternative.

Figure 4 presents a revised system which includes liaison staff hired to provide the interface between mental health planners and the people. In this model, staff are hired, trained and placed within a defined geographic community. The staff member, who should have an office of some type and a well-publicized telephone number, could then provide both direct and referral services to clients on demand. But, perhaps more importantly, this worker would be charged with data collection and the maintenance of a general awareness of community conditions. He or she would be available to attend meetings, listen to citizen concerns, identify potential problems and
Figure 4. A diagram of the proposed Michigan Mental Health system including mental health liaison workers. Solid lines represent formal channels of communication and the dotted lines indicate informal channels.
interpret broad statistics in personal terms. Such information could then be communicated to the centralized local or state mental health authority for purposes of needs feedback. Once this staff member is placed, procedures for reporting could be established and an ongoing feedback process maintained.

Although some training in direct service skills would be needed, this staff member would primarily be responsible for crisis intervention and referral. Additionally, much time would be spent attending community functions and/or communicating with leaders and the general citizenry. It appears, given the ultimate intention of Community Mental Health, that funds would be better spent toward this end than for additional planners who would be affiliated with and located within centralized service sources.

At least two criticisms of the above approach are readily apparent. First, existing community boards consist of citizens from the overall service area who are responsible for the maintenance of a responsive service network. Many argue that these boards are the community tenacles of the larger mental health system. However, it is questionable that a twelve-member board can adequately represent the entire population (at least 200,000) of the service area.

Holton, New and Sessler (1973) have criticized the Community Mental Health System arguing that "their programs are most appropriate for, and acceptable to, the middle class." These authors continue,
"citizen participation in CMHC's (Community Mental Health Centers) has its roots in middle class boards of housewives, businessmen, and professionals raising money to develop mental health services." These boards cannot possibly maintain contact with service areas in such a way that data is collected and planning formulated in a continuous and effective manner. This could not be done with twelve citizens even with a board representative of the target areas, let alone one made up of residents who are from a specific stratum of the population.

A second criticism and possibly a more valid one, involves the placement of responsibility for community feedback. Many of the data and resulting recommendations presented in this paper would not be limited to the mental health system. Other human service providers are implicated as parties responsible for needs already pointed out. This presents a recurring dilemma. In Michigan, as in many other states, the Department of Mental Health, the Department of Social Services, public health and other related disciplines are separated in terms of administrative structure and, in most cases, service offerings. It is not clear where the responsibility of one agency ends and where another begins.

Although lack of education or financial resources may precipitate problems considered to be mental health in nature, another agency may be responsible for alleviating these conditions. In this context,
the worker placed in the community would be dealing with problems and information not specifically related to the mandate of the mental health system. However, this does not appear to be justification for ignoring the need for more citizen contact. Although some coordination of funding among responsible entities would be ideal, this is not a likely occurrence. More probably, the placement of such outreach personnel could be justified, in mental health terms, as prevention. The rationale is as follows. If one responsibility of the mental health providers is to reduce the likelihood of the use of treatment services in the future, then the placement of a worker to intervene early on with clients in difficulty would seem to be appropriate. This would be the case, even if referrals must be made to other types of government sponsored or private agencies. This is true for primary prevention as well as secondary and tertiary prevention. In the former, clients are prevented from entering the treatment system and in the latter two cases, the client is prevented from reentering the system, once treatment has been received for a specific problem. The utility of this rationale for service justification, of course, depends on the willingness of the system in question to consider prevention as a major and essential function of a broad service mosaic.

If such a staff member cannot be placed in the community to translate conditions into need and service, then we must begin to question the purported involvement of citizens in the mental health
system as a seriously intended portion of the Community Mental Health approach. Is citizen involvement possible? And, if so, to what extent? More importantly, are citizens being led to believe that they have a voice in service planning, when this is not the case? An attempt will be made to answer these questions in terms of the available literature.

A number of studies which address the issue of citizen participation indicate that citizen control is inadequate (Holton, New & Hessler, 1973; Krauss & Phillips, 1974; and Kane, 1975). Holton et al., after studying citizen participation in six Community Mental Health Centers in four states, concluded that citizen involvement was observed primarily in two forms: elitist and advisory. In the first form, these authors state, "community leaders and resident volunteers serve on boards largely for purposes of moneyraising, public relations, and imagebuilding." They continue, "Most professional decisions are left up to the staff, and the board is little concerned with representing the interest of clients or potential clients." In the second form (advisory), citizens serve to advise the community board on issues and decisions, but in general, formal "power" is not involved. In their study, these authors found little direct citizen participation. Kane (1975) indicates that, "Mental health service providers still retain a degree of isolation which makes citizen participation more lip service than reality."
Both Holton et al., and Kane recommend approaches that involve more consumer control. Kane suggests a model of "limited citizen participation" and places the responsibility for selection of affective citizen participants with the Community Mental Health Board. Holton et al., on the other hand call for more consumer control. These authors support citizen participation either in an advisory capacity or in terms of a board composed of two-thirds consumer representatives.

Both of the above approaches emphasize change within the existing system. They do not, however, consider that one board, whether consumer-oriented or not, cannot determine the needs and maintain functional feedback channels with all communities in a given service area. Other authors have suggested similar approaches (Krauss & Phillips, 1974; Bertelsen & Harris, 1973). However, none of these consider the responsibility of the mental health system beyond its association with citizens in an advisory capacity. None recommend that the system itself reach out with staff to take the responsibility to tap citizen communication systems in an ongoing fashion. If the primary purpose of Community Mental Health is to maintain service for an area and be responsive to the conditions of that area in terms of service planning, then more emphasis should be placed on the contact between provider and client, as well as prospective
client.

Planners in other public service fields provide suggestions that may be beneficial here. In citizen participation as relates to urban planning, Burke (1968) has suggested that several alternatives are available and that the strategy chosen depends on the organization which is involved. Burke identified five separate strategies. These are discussed below.

**Education-therapy strategy**

The primary purpose of this method is to train citizens in the participatory process. The goal of the method is to improve the individual participant. According to Burke, "Accomplishing a specific task is irrelevant: rather, the participants become clients who are the objects of treatment."

**Behavioral change strategy**

Designed to change the behavior of an individual through group membership pressure, this approach is based on the assumption that a group working together can plan effectively and influence others to contribute to the plan. Since a viable plan must have community support, this method emphasizes the cooperation of all toward a common goal. The behavior of dissenting community members is changed through group influence to form a cohesive attack.
Staff supplement strategy

Based on the use of volunteers, this approach emphasizes the use of citizens with a particular expertise to supplement staff energy. Many times the skills of a citizen are matched with the need. According to Burke, "The objective of this strategy is to exploit the abilities, free time, and/or the expertise of individuals to achieve a desired goal."

Cooptation

This approach is designed to enlist the aid of citizens in order to prevent obstruction to agency plans or methods. The support of citizens or citizen organizations is enlisted to reduce threats to the "stability and existence" of the organization involved.

Community power strategies

Burke identified two forms of operation for this approach. With the first, the cooperation of influential citizens is gained and this power is then used to achieve the goals of the organization. Second, the power of a large number of committed citizens is used to confront existing power centers to bring about change. Demonstration and boycotts provide illustrative examples.

Burke suggests that the behavioral change strategy and the staff supplement approach appear to be best suited for community
planning. He identifies the ability of staff to work with citizens as a crucial factor. Burke states, "The appropriateness of any strategy of citizen participation will depend in large measure upon the ability and knowledge of the staff to implement it."

Other models of citizen participation have been published. One additional viewpoint will be considered here. Zurchen and Key (1968) presented what he termed the "overlap model." He describes a study carried out in Topeka, Kansas in 1966 which involved citizen participation. The purpose was to provide a working relationship between the "poor" and the "not poor" in order to bring about social action and change. Target neighborhoods were identified; committees from each area were formed and the officers of these committees served on an area board. The committees met monthly, while the area board met quarterly. The committees were formed to provide a voice for the poor, and to furnish relevant data to planners on the target areas. As Zurchen has pointed out,

"The overlap model . . . expects self-esteem and confidence to grow among the poor as they expand the number and variety of their social roles through active participation. . . . It expects a 'we feeling' to grow among target neighborhood people as they shape their action committees and a sense of power and control to develop as they evolve expertise in using the 'establishment' to meet their needs and goals" (p. 90-91).

As can be seen, this model also depends heavily on the
cooperation and expertise of staff members to organize target area groups and to gain planning information from such groups. The system must be structured in a way that allows participation by community citizens. More importantly, however, citizen participation must be guided and actually used as a planning tool once it is elicited.

Both Burke and Zurchen present strategies which require initiative on the part of organization staff. In comparison to the suggestions found in the "mental health" literature, these methods in general call for more direct and active citizen involvement. The system is constructed to include the citizen and assimilate citizen-produced ideas into the planning process.

In the Community Mental Health system, one can safely say that citizen participation to this point has been very limited (i.e., small citizen boards) and many times unrepresentative. A more active citizen role is called for if the original goals of the system are to be met. Yet, such an approach requires money and personnel in an ongoing fashion. Ultimately, it appears that any serious attempt to move toward a true citizen-need-based system will have to be initiated by mental health professionals. Furthermore, money will have to be allotted for such purposes much the same as for
specific agency programs. In order to provide and maintain a responsive mental health service network, more direct community contact must be established and the communication channels must be specified and used for future planning.
REFERENCES


Bertlesen, K., & Harris, M. R. Citizen participation in the development of a community mental health center. Hospital and Community Psychiatry, 1973, 24 (8), 553-555.


Kane, T. J. Citizen participation in decision making: Myth or Strategy. Administration in Mental Health, 1975, Spring, 29-34.
Kennedy, J. F. Message from the President of the United States relative to mental illness and mental retardation, Washington, D. C., February 5, 1963 (88th Congress, First session, document No. 58).


Appendix A

Letter of Introduction and Questionnaire
Dear Eastside Resident,

The Learning Village is attempting to determine what the citizens of the Eastside feel to be the needs of this area. In order to do this, we are asking several hundred Eastside citizens to fill out the enclosed questionnaire.

This information will be used to determine what services might be offered to this community in the future and we would like your input. None of your answers will be used for any other purpose and all returned questionnaires will remain confidential.

Please fill out the form and place it in the self-addressed stamped envelop which is enclosed and drop it in the mail.

Thank you for your cooperation.

Sincerely,

Bill Redmon
Associate Director
We are interested in gathering some information about the Eastside Community and the people who live here so that we may inform our government and social service agencies of the most pressing needs that exist. Since it is not possible to get information from everyone, some families have been chosen at random. From these families we can estimate the needs that exist across the community. Your cooperation in answering the questions below will be appreciated. Thank you.

1. What is your current address?__________________________

2. What is your relationship to the head of the household?______

3. What kind of house do you live in? (circle one below)
   1. Single family dwelling __
   2. Duplex __
   3. Rooming house __
   4. Apartment __
   5. Hotel __
   6. Mobile home __
   7. Other _______________

4. How long have you lived at your current address? ____________ months or years

5. How many times have you changed addresses in the past year? _____

6. Where did you live while growing up? (main place under 16 years)
   City_____________________ State_____________________

7. Where have you lived most of the time since then?
   City_____________________ State_____________________

8. How many years of school have you completed? (circle one below)
   1. Less than 4 years
   2. Five to eight years
   3. Nine to eleven years
   4. High school graduate
   5. Some college
   6. College graduate
   7. Post-graduate
9. What was the highest degree or certificate awarded? ________

10. Which word below best describes your race? (circle one below)
   1. White
   2. Black
   3. American Indian
   4. Spanish-speaking
   5. Other ______________________

11. What is your sex?
   1. Male __
   2. Female __

12. What was your age on your last birthday? ________ Years

13. What is your main job or occupation? ________ Job

14. Are you presently employed? Yes ___ No ___

15. If employed, where do you work? ______________ Name of employer

16. If employed, how many hours do you work per week? ________ # of hours

17. If you are working less than full time, what is the reason?
   1. Retired
   2. Physical illness
   3. Mental illness or disability
   4. Fired or laid off (circle one answer)
   5. Going to school
   6. Children at home
   7. Pregnancy
   8. Unable to find work
   9. Not looking for work
   10. Other ______________________

18. If employed, how many times have you changed jobs in the past five years? ________ # of times

19. If unemployed, are you currently receiving unemployment benefits? Yes ___ No ___

20. How many children live in your household? ________ # of children
21. What are the ages of children living in your household? (list those under 18 years)

____  ____  ____  ____  ____  ____

22. What is your present marital status? (circle one below)

1. Single  
2. Married  
3. Divorced  
4. Widowed  
5. Separated  
6. Other ______________________

23. How long has this been your marital status?   
   # of years or mos.

24. Does your family receive any outside financial assistance?  
   (Example: Social Security, Food Stamps, ADC, etc.)

1. Yes ______
2. No ______
   If yes, what type? ______________________

25. Which of the following comes closest to the family income in the last year?

1. less than 2,000  
2. 2,000 - 3,999  
3. 4,000 - 4,999  
4. 5,000 - 5,999  
5. 6,000 - 6,999  
6. 7,000 - 7,999  
7. 8,000 - 8,999  
8. 9,000 - 9,999  
9. 10,000 - 11,999  
10. 12,000 - 14,999  
11. 15,000 or over

26. How many parents are currently living in your household?  
One _____  Two _____

   If one, which is it?  Father _____  Mother _____

THE NEXT SET OF QUESTIONS DEAL WITH HOW YOU FEEL. PLEASE ANSWER EACH QUESTION BY CHECKING THE APPROPRIATE BLANK.

27. I feel weak all over much of the time  
1. Yes ______
2. No ______
3. Don't Know ______

28. I have periods of days, weeks or months when I couldn't take care of things because I couldn't "get going".

1. Yes _____
2. No _____
29. In general, would you say that most of the time you are in high spirits, low spirits, or very low spirits?
   1. High ___
   2. Good ___
   3. Low ___
   4. Very Low ___
   5. Don't Know ___

30. Every so often I suddenly feel hot all over.
   1. Yes ___
   2. No ___
   3. Don't Know ___

31. Have you ever been bothered by heart beating hard? Would you say often, sometimes, or never?
   1. Often ___
   2. Sometimes ___
   3. Never ___
   4. Don't Know ___

32. Would you say that your appetite is poor, fair, or too good?
   1. Poor ___
   2. Fair ___
   3. Good ___
   4. Too Good ___
   5. Don't Know ___

33. I have periods of such great restlessness that I cannot sit still long in a chair.
   1. Yes ___
   2. No ___
   3. Don't Know ___

34. Are you the worrying type?
   1. Yes ___
   2. No ___
   3. Don't Know ___

35. Have you ever been bothered by shortness of breath when you were not exercising or working hard? Would you say: often, sometimes or never?
   1. Often ___
   2. Sometimes ___
   3. Never ___
   4. Don't Know ___
36. Have you ever been bothered by nervousness (irritable, tense)? Would you say: often, sometimes or never?
   1. Often ___  
   2. Sometimes ___  
   3. Never ___  
   4. Don't Know ___

37. Have you ever had any fainting spells (lost consciousness)? Would you say: Never, a few times, or more than a few times?
   1. Never ___  
   2. A few ___  
   3. More than a few ___  
   4. Don't Know ___

38. Do you ever have trouble getting to sleep or staying asleep? Would you say: often, sometimes or never?
   1. Often ___  
   2. Sometimes ___  
   3. Never ___  
   4. Don't Know ___

39. I am bothered by acid (sour) stomach several times a week.
   1. Yes ___  
   2. No ___  
   3. Don't Know ___

40. My memory seems to be all right (good).
   1. Yes ___  
   2. No ___  
   3. Don't Know ___

41. Have you ever been bothered by cold sweats? Would you say: Often, sometimes, never?
   1. Often ___  
   2. Sometimes ___  
   3. Never ___  
   4. Don't Know ___

42. Do your hands ever tremble enough to bother you? Would you say: Often, sometimes, never?
   1. Often ___  
   2. Sometimes ___  
   3. Never ___  
   4. Don't Know ___
43. There seems to be a fullness or clogging in my head or nose much of the time.
   1. Yes  
   2. No  
   3. Don't Know  

44. I have personal worries that get me down physically (make me physically ill).
   1. Yes  
   2. No  
   3. Don't Know  

45. Do you feel somewhat apart even among friends (apart, alone, isolated)?
   1. Yes  
   2. No  
   3. Don't Know  

46. Nothing ever turns out for me the way I want it (turns out, happens, comes about, i.e., my wishes fulfilled).
   1. Yes  
   2. No  
   3. Don't Know  

47. Are you ever troubled with headaches, or pains in the head?
   Would you say: Often, sometimes, never?
   1. Often  
   2. Sometimes  
   3. Never  
   4. Don't Know  

48. You sometimes can't help wondering if anything is worthwhile anymore.
   1. Yes  
   2. No  
   3. Don't Know  

49. About how many times have you seen a doctor in the past year?
   # of times  

50. Have you been a patient in the hospital in the past year?
   Yes  
   No  
   If yes, what was the reason  

51. Have you used the services of any of the following in the past year? (circle all that apply)

1. Medical doctor 5. Psychologist
2. Dentist 6. Social Worker
3. Chiropractor 7. Public Health nurse
4. Psychiatrist

52. If you were in trouble of any kind, where would you go first?

53. How does the future look to you? (circle one below)

1. Excellent
2. Good
3. Fair
4. Poor
5. Bad

54. What would you say is your greatest personal problem? (circle one below)

1. Family
2. Money
3. Health
4. Job
5. School
6. Friends

55. Do you know anyone in your community who has what you would consider to be a mental health problem?

1. Yes
2. No
3. Don't Know

56. In general, how do you think the members of your community see the future? (circle one below)

1. Excellent
2. Good
3. Fair
4. Poor
5. Bad

57. Do you know anyone in your community that has been admitted to a mental hospital?

1. Yes
2. No
3. Don't Know
58. Over the past five years, do you feel that your community has:

1. Improved
2. Remained the same
3. Deteriorated
4. Don't Know

59. Do you feel that services to teenagers are adequate in your community?

1. Yes
2. No
3. Don't Know

60. Do you feel that enough services are offered in your community for senior citizens (those over 60 years of age)?

1. Yes
2. No
3. Don't Know

61. Of the age groups listed below, which do you feel most need services in your community? (circle all that apply)

1. 0-6
2. 6-12
3. 12-18
4. 18-25
5. 25-35
6. 35-45
7. 45-60
8. over 60

62. Do you feel that the public schools are adequate for the children in your community?

1. Yes
2. No
3. Don't Know

63. Do you know a child in your community who has dropped out of school?

1. Yes
2. No
3. Don't Know

64. In general, do you feel that children in your community are going to be well-prepared for the future?

1. Yes
2. No
3. Don't Know
65. Do you feel that children should be exposed to education earlier than kindergarten?

1. Yes  
2. No   
3. Don't Know  

66. Do you feel that social services in your community are sufficient to meet the needs of citizens?

1. Yes  
2. No   
3. Don't Know  

67. If you could choose additional services to be offered in your community, what would they be?

Please write in

68. Do you know anyone who has used any of the services listed below (circle the ones that apply)?

1. St. Joseph Lodge  
2. DeLano Clinic  
3. Douglass Community Association  
4. Edison Center  
5. Senior Services  
6. Family and Children Services  
7. Family and Divorce Counseling  
8. Kalamazoo Child Guidance  
9. Kalamazoo Learning Village  
10. Kalamazoo State Hospital  
11. Hull-Paulson Center  
12. Kalamazoo Consultation Center  
13. McKercher Rehabilitation Center  

69. Do you feel that there is a drug problem in your community?

1. Yes  
2. No   
3. Don't Know  

70. Do you know anyone who has what you would consider a "drinking" problem?

1. Yes  
2. No   
3. Don't Know  
71. How many people do you know that could be helped by mental health services (family, friends, relatives)?

1. One ___  
2. Two ___  
3. Three ___  
4. Four ___  
5. Five ___  
6. Six or more ___  
7. Don't know any ___

72. Are you familiar with the Kalamazoo Learning Village (located in the old East Main Methodist Church)?

1. Yes ___  
2. No ___  
3. Don't Know ___

73. Based on what you have heard or on personal experience, how would you rate the services of the Learning Village?

1. Excellent ___  
2. Good ___  
3. Fair ___  
4. Poor ___  
5. Bad ___

74. Have you ever used the services of the Learning Village?

1. Yes ___  
2. No ___  
3. Don't Know ___

75. What services do you feel that the Learning Village could offer that it does not now make available?

Please write in

76. Do you feel that your community has a crime problem?

1. Yes ___  
2. No ___  
3. Don't Know ___

77. Are there any issues that you would like to address that were not covered in the questions above?

Please write in
Appendix B

Suggested Factors for Social Indicators Analysis
**POSSIBLE ITEMS FOR SOCIAL INDICATORS ANALYSIS**

<table>
<thead>
<tr>
<th>Items</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Characteristics of the population</td>
<td></td>
</tr>
<tr>
<td>a. Count of total population</td>
<td>a. U.S. Census</td>
</tr>
<tr>
<td>b. Count of population by race</td>
<td>b. U.S. Census</td>
</tr>
<tr>
<td>c. Count of population by age</td>
<td>c. U.S. Census</td>
</tr>
<tr>
<td>d. Count of population by race, sex and marital status</td>
<td>d. U.S. Census</td>
</tr>
<tr>
<td>2. Environmental characteristics</td>
<td></td>
</tr>
<tr>
<td>a. Population density</td>
<td>a. Census maps</td>
</tr>
<tr>
<td>b. Amount of open space</td>
<td>b. Aerial photos</td>
</tr>
<tr>
<td>c. Count of housing by type of structure</td>
<td>c. U.S. Census</td>
</tr>
<tr>
<td>d. Count of housing by owned vs. rented</td>
<td>d. U.S. Census</td>
</tr>
<tr>
<td>e. Median value of owner occupied housing</td>
<td>e. U.S. Census</td>
</tr>
<tr>
<td>f. Median value of monthly contract rent</td>
<td>f. U.S. Census</td>
</tr>
<tr>
<td>g. Count of persons in overcrowded units</td>
<td>g. U.S. Census</td>
</tr>
<tr>
<td>h. Count of persons in units with incomplete plumbing</td>
<td>h. U.S. Census</td>
</tr>
<tr>
<td>i. Housing turnover</td>
<td>i. County tax records</td>
</tr>
<tr>
<td>j. Quality of housing</td>
<td>j. U.S. Census</td>
</tr>
<tr>
<td>3. Economic characteristics of the population</td>
<td></td>
</tr>
<tr>
<td>a. Median income of individuals</td>
<td>a. U.S. Census</td>
</tr>
<tr>
<td>b. Percentage of families below the poverty level</td>
<td>b. U.S. Census</td>
</tr>
<tr>
<td>c. Percentage of families with income above $15,000</td>
<td>c. U.S. Census</td>
</tr>
<tr>
<td>d. Number of families on welfare, unemployment, AFDC, etc.</td>
<td>d. Social Service Agencies</td>
</tr>
<tr>
<td>4. Social integration vs. disintegration</td>
<td></td>
</tr>
<tr>
<td>a. Percentage of voter registration</td>
<td>a. Supervisor of Elections</td>
</tr>
<tr>
<td>b. Divorce rates</td>
<td>b. County Court</td>
</tr>
<tr>
<td>c. Rate of illegitimate births</td>
<td>c. Vital statistics</td>
</tr>
<tr>
<td>d. Public drunkenness and arrests for DWI</td>
<td>d. Law enforcement agencies</td>
</tr>
<tr>
<td>e. Arrests for narcotics possession, use and sale</td>
<td>e. Law enforcement agencies</td>
</tr>
</tbody>
</table>
f. Arrests for prostitution

g. Arrests for crimes against property

h. Arrests for crimes against persons - assault, murder, rape

5. Health and use of human service agencies

a. Infant mortality

b. Rates of tuberculosis

c. Rates of veneral disease

d. Use of hospital emergency room

e. General hospital admissions

f. Admissions to state mental hospital

g. Suicide rates

h. Community mental health utilization data

i. Use of vocational rehabilitation and other related agencies

6. Educational level

a. Rates of illiteracy

b. High school achievement and placement tests

* The above information was adopted from Warheit, Bell and Schwab (1976)