MENTAL HEALTH AND PUBLIC HEALTH PERSONNEL AND PROGRAMS:

THEIR RELATIONS IN THE FIFTY STATES

A Report of a Survey of Key Public Health
and Mental Health Officials

VOLUME I

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INTRODUCTION

This report is based upon a study of the degree and form of collaboration between mental health, public health, and related professionals. The basic data are derived from interviews with key State and local officials in mental health and public health programs in the fifty States and the District of Columbia. The respondents were asked particularly about the current utilization of mental health personnel outside of direct mental health programs, the organizational arrangements for the provision of mental health services and their preferences about such utilization and organizational arrangements. The respondents were also asked about the barriers to the more effective use of mental health personnel and about the responsibility of various levels of government in meeting mental health needs.

The study was commissioned by the Ad Hoc Committee on Mental Health Activities, formed at the request of the Surgeon General of the United States. The mission of the Committee was "to study and make recommendations to the Surgeon General as to the role which the Public Health Service should play in (1) strengthening community mental health programs, (2) integrating mental health concepts and practices, and the social and behavioral sciences into other health and disease programs, and (3) estimating the resources, including trained personnel for which provision should be made in order that these needs can be met."

The Underlying Issues

If we are to understand an aspect of the world in which we live, we cannot wait until it has attained a stable equilibrium. This observation is particularly pertinent for the present study. The fields of mental health and public health are undergoing profound changes and this makes analysis

difficult; but if the problems arising during these changes are to be minimized and the opportunities for more effective service are to be maximized, reflection and study must be undertaken in the midst of the stream of change.

There are several major changes in public health and mental health programs which are relevant to the increasing cooperation between personnel in these and related fields. First, there is the great increase in mental health activities. The public has increased its readiness to utilize and its demand for the services of mental health personnel. At the same time, more persons in a wider range of professions are providing such services. Second, there is a change in the activities of mental health personnel. In the past, mental health activities have been rooted in psychiatry and as a consequence they have dealt with the treatment of individuals, to a large extent, in institutions. At present, there is growing concern with preventive and social psychiatry, the development of integrated programs of care, treatment and rehabilitation, bridging the gap between hospital and community, consultation and in-service training with other agencies which deal with people in trouble, and at least some groping for methods of primary prevention. Third, there is a change in the activities of public health personnel. Historically, the public health movement has been concerned with prevention of illness and the promotion of health as exemplified by public sanitation and control of communicable diseases. The related activities such as quarantine, case finding, licensing, and inspection are directed toward the total community. In recent years, public health persons have moved toward treatment and care and a concern with prevention and rehabilitation which is patient-centered. Thus, the fields of mental health and public health have converged in many areas.

In addition to the increase of mental health activities and the convergence between mental health and public health activities, any study of the relations between mental health personnel and public health and other personnel

must take into account the extreme variation and complexity of organizational forms among the States and localities of the nation. For example, mental health activities may be divided at the State level into institutional programs (responsible for mental hospitals) and community programs (responsible for mental health centers and clinics); one or both may be in a department of welfare, a department of institutions, a department of public health, or in their own mental health department. There is considerable change in such arrangements as new organizational forms are tried.

In such a rapidly changing and complex situation, and given the wide range of topics investigated, it is important to know what key officials' judgments are about many of these issues. In addition, an analysis of their preferences and of the factual information they provide, even if the interpretations must sometimes be tentative, will be of use to all persons concerned with the provision of health services to the public.

The Source of Data

The data upon which this report is based are largely derived from personal interviews with 740 key State and local officials. A detailed description of the procedures used in selecting and interviewing the respondents is presented in Appendix A. In brief, the list of respondents was prepared by Dr. Richard H. Williams, Staff Coordinator of the Committee, with the assistance of the Community Services Branch and of the Regional Offices of the Public Health Service. A detailed summary of the positions occupied by the respondents is presented in Appendix B, Table B-1. Two-thirds of the interviews were conducted by long-distance telephone; all respondents were sent copies of the questionnaire in advance of the interview. Eighty-seven per cent of the respondents used this opportunity to look through the interview schedule and thirty-nine per cent discussed the questions with their colleagues.

This certainly indicates that the answers are likely to be the result of considerable reflection. The interviews lasted from about one hour to three hours and averaged about an hour and fifteen minutes to two hours. The National Opinion Research Center staff began work on the study in January, 1961; interviewing began in April and was completed in June. Preliminary findings were reported to the Ad Hoc Committee in September, 1961.

Interviews were sought with the incumbents of certain key positions in all the States and in all the communities selected for study. Interviews were completed with over ninety-five per cent of the selected persons. Public Health respondents at the State level include heads of the overall public health programs, of public health nursing, of hospitals, and of community services. State mental health respondents are from community-based and hospital-based programs; they include heads of the overall programs, of psychiatric nursing, of psychological services, of psychiatric social work, and of psychiatric services. In States in which there are alcoholism programs, the heads of these programs were interviewed. At the community level, heads of the public health programs were interviewed and, among the heads of mental health programs, directors of mental health centers or clinics, heads of mental health bureaus or departments, and university-associated persons who direct community mental health programs were interviewed.

All the respondents have major program responsibilities, but they also vary in personal and professional background characteristics. Some of these characteristics will be used in the analysis of the respondents' preferences and judgments. At this point, it is necessary only to note the extent to which the respondents as a whole and respondents with different program responsibilities do or do not share certain personal and background characteristics.

The numbers of persons under the direction of the respondents vary a great deal (see Table B-3); fourteen per cent of the respondents direct 500 or more persons, but the majority (fifty-six per cent) direct fewer than thirty persons. Nearly all local mental health respondents direct fewer than thirty persons while half of the heads of State mental health programs have 500 or more persons under their direction; about one-half of the heads of the State public health programs have between 100 and 500 persons under their direction. Many of the respondents have been in their present position only a short time: nineteen per cent for less than two years and twenty-seven per cent for two - four years. Most respondents have been in their position for five or more years: forty-one per cent for five - fourteen years and thirteen per cent for fifteen or more years. Public health respondents generally have been in their present positions a longer period of time than the respondents with mental health program responsibilities (see Table B-41).

Although there is a close relationship between the respondents' program responsibilities and their profession (see Table B-39), the overall distribution of professions interviewed for this study is of significance. The respondents were asked what they considered to be their major professional field: twenty-seven per cent said public health; twenty-three per cent, psychiatry; seventeen per cent, administration; eleven per cent, psychiatric social work; ten per cent, clinical psychology; eight per cent, public health nursing; six per cent, psychiatric or mental health nursing; and seven per cent mentioned other professions--some respondents mentioning more than one profession. Approximately sixty per cent of the respondents have been employed in their major professional field for fifteen or more years; public health respondents generally have been in their professional field for more years than have the mental health respondents (see Table B-40). Fifty

per cent of the respondents have M.D. degrees and eleven per cent have Ph.D.'s (see Table B-37).

The respondents were also asked whether or not they ever had been, or currently were, employed in a variety of settings. Forty-eight per cent of the respondents report that they are or have been in private practice; forty-four per cent have been employed in a Federal government organization. There is some variation in the kind of settings in which different types of respondents have been employed: local mental health respondents and heads of State mental health programs are particularly likely to have been in private practice and to have worked in a Federal governmental organization at one time or another; State and local heads of public health are also likely to have been in private practice; heads of State alcoholism programs are least likely to have been in private practice (see Table B-42).

Nine per cent of the respondents are thirty-four years of age or younger; thirty-one per cent are thirty-five to forty-four years old; thirty-three per cent are forty-five to fifty-four years old; twenty-seven per cent are fifty-five or older. Respondents with responsibility for mental health programs are generally younger than are those with public health responsibilities (see Table B-36).

The distribution of the characteristics discussed above for all the respondents is summarized below:

Number of persons under respondents' direction:

30 or fewer persons	56%
30 - 99 persons	16%
100 - 499 persons	14%
500 or more persons	14%

Years in present position:

less than 2 years	19%
2 - 4 years	27%
5 - 9 years	25%
10 - 14 years	16%
15 or more years	13%

Major professional field:

public health	27%
public health nursing	8%
psychiatry	23%
clinical psychology	10%
psychiatric social work	11%
psychiatric or mental health nursing	6%

Years in professional field:

less than 4 years	7%
5 - 9 years	16%
10 - 14 years	19%
15 - 24 years	31%
25 years or more	28%

Respondents' degrees:

M.D.	50%
Ph.D.	11%

Setting in which respondents have been employed:

private practice	48%
Federal government organization	44%

Respondents' age:

under 35 years	9%
35 - 44 years	31%
45 - 49 years	13%
50 - 54 years	20%
55 - 59 years	13%
60 years or older	14%

The Officials' Views of Their Problems

Before beginning the presentation of the findings concerning their professional relations, it is important to consider how the respondents themselves view their problems. This will provide a better understanding of the relative salience of the issues with which we are concerned. After asking the respondents what are the services for which they have responsibility, they were asked, "What are the three most important problems that confront you in providing these services?" The responses to this question were grouped into a large number of categories; the distribution of responses among different types of respondents is presented in Table B-2. The most striking result is the similarity of responses among the respondents with

different program responsibilities. Every group of respondents mentions staffing problems most frequently, closely followed by lack of financial support. Among all the other problems mentioned, two others are frequently cited: these are "organizational problems" and lack of public support. Let us examine these problem areas in more detail.

In mentioning staffing problems, many respondents simply stated that they lack an adequate staff and do not give any specific explanation of the reasons for this difficulty. Most respondents give one or more explanations for the difficulty in recruiting staff; not surprisingly, the most frequently mentioned specific reason is the shortage of trained personnel to be recruited. This is mentioned particularly by State heads of public health, State heads of mental health, and other State mental health officials in hospital-based programs; indeed, these three groups of respondents are most likely to mention various staffing problems as one of the three greatest problems they have. The other specific explanation of the lack of adequate staff is related to finances, but it is not merely lack of funds to hire personnel--even more frequently mentioned are the limitations on the salaries which they can pay. Finally, there are references to particular handicaps in recruiting needed staff: lack of nearby training facilities, unfavorable attitudes toward State service, working in an isolated community, and other poor working conditions.

Simple lack of funds is, of course, very frequently mentioned. As one respondent said, the "legislature has not appropriated enough money, still getting same amount as in 1957 even though there has been great increase in population." Interestingly, the public health respondents generally mention this problem somewhat more than do mental health respondents, except that State heads of mental health cite this about as frequently as any other group.

The lack of understanding and support from the public and non-governmental groups, surprisingly, is not particularly mentioned by mental health

respondents. The State heads of alcoholism programs do frequently mention this; as one of them said, "...acceptance of alcoholism as an ever expanding program and acceptance of alcoholics as legitimately ill, needing help, by the public and the State executives and legislature from whom our funds must come."

The organizational problems which the respondents mention are divided into many categories. Lack of cooperation and mutual understanding among professionals, inadequate coordination among agencies, and the lack of cooperation from other agencies are particularly cited among the organizational problems. Organizational problems are mentioned relatively frequently by State mental health officials in community-based programs, State heads of mental health, and by State public health officials who are not heads. More detailed results of the question concerning problems faced by the respondents can be found in Table B-2.

The respondents had been asked about their problems in providing the services for which they are responsible. Given this focus, the emphasis upon the interrelated problems of financial support and staffing shortages is not surprising. Nevertheless, problems such as lack of cooperation and mutual understanding among professionals, inadequate coordination among agencies, and the lack of cooperation from other agencies are mentioned by many respondents. This indicates that the changing character of mental health and public health programs may be the source of difficulties, as well as opportunities, in meeting the traditional objectives of these programs.

Overview of the Report

The report is divided into five major parts. Part I consists of an analysis of the organizational forms within which public health and mental health activities are performed and particularly the preferences for various

forms expressed by the respondents. The major portion of the analysis is in Part II, in which we consider the extent and nature of the cooperation among mental health, public health, and related professions; the actual situation is described as well as the respondents' preferences. In Part III of the report the barriers to such cooperation are analyzed. In Part IV there is a discussion of new developments in the use of mental health personnel outside of direct mental health programs. In Part V, there is a consideration of the respondents' preferences for the role of various levels of government in providing mental health services. The findings are summarized in Part VI.

In Appendix A a detailed presentation of the methods used in gathering the basic data for the study is set forth. Appendix B consists of respondents' answers to the major questions in the interview schedule. The interview schedule used in the study constitutes Appendix C.

PART I.

ORGANIZATIONAL ARRANGEMENTS

CHAPTER I

PRESENT ORGANIZATIONAL ARRANGEMENTS

The central topics of this study are the relationships between mental health personnel and other health and health-related personnel in public agencies. Such relationships must exist in one organizational context or another. Organizational arrangements may significantly affect such relationships and indeed this is one of the considerations in choosing one arrangement rather than another. Four aspects or organizational arrangements of mental health services at the State level will be considered: (1) the location of the "mental health authority," (2) the degree of closeness between the mental institutions and the public health departments, (3) the joint or separate administration of the institutional and community mental health programs, and (4) a general characterization of the separateness and autonomy of the mental health programs. Only the fourth aspect will be used in discussing the organizational arrangements at the local level.

The State Organizational Arrangements

An understanding of the "mental health authority" is crucial in any discussion of the State organizational arrangements. The National Mental Health Act, passed in 1946, provided authority for the Federal Government to allocate funds to the States on a matching basis for the support of community mental health programs. Each State designates one of its agencies or departments as the "mental health authority" with responsibility for receiving and allocating funds. At the time the study was in the field, twenty-five States had each designated a public health department as the mental health authority; twelve States had each designated a department of mental

health or hygiene; five States had each designated a department of welfare; four States had each designated a hospital or a department of hospitals; three States had each designated a department of health and welfare; and one State had designated a department of institutions. It is necessary to say "at the time the study was in the field" because within a year of that time, six States had already or were reported to be about to change the designation. Three States in which a department of health was designated as the authority have already or are soon to change: two to a department of welfare and one to a department of mental health. One State had changed from having its authority located in a department of welfare to one located in a mental health department; another State is reported to be likely to change the location of the authority to a mental health and corrections department from a department of health and welfare; one State in which the authority was located in a department of mental health has shifted it to a department of health and welfare.

The variation and shifts in the location of the authority suggest that there is no ideal location for all States or even for any one State. We can also surmise that the location of the authority does have consequences. Various consequences of different departmental designations of the authority will be discussed in succeeding chapters; now we will examine the organizational arrangements associated with different locations of the authority.

One aspect of organizational arrangements is the degree to which the mental institutions and public health departments have close relations with each other. The growing convergence between public health and mental health activities was discussed in the Introduction. This convergence means that the relations between the mental institutions and the public health departments are particularly important. These two programs are old ones in the States and have developed within separate organizations. The emergence of

community mental health programs and the changing conceptions and practices for the implementation of the older programs make their relationships vital.

In order to characterize the relationship between the mental institutions and public health programs in the States, each respondent was asked, "Would you say the mental institutional program in this State has (a) close relations with public health departments generally, (b) close relations with a specific part or parts of public health departments, such as nursing, community clinics, or hospital inspection, or (c) few or no relations with public health departments." The answers of all the respondents from each State were combined to yield the State characterization. This summarization was not done mechanically; judgment was used giving extra weight to the answers of respondents who were considered particularly well informed on this topic.

There is one possible difficulty in this measure. The measure is based upon the respondents' judgments about the degree of closeness, but we cannot be certain that all the respondents are using the same standard of judgment. Thus, in some States, there may be relatively close relations, but many persons in those States feel there should be much closer relations and therefore report that the relations actually are not very close. Of course, we tried to minimize this difficulty by presenting three alternatives which have some objective references, but we cannot be certain that this obviated the difficulty entirely.

The mental institutional programs in seven States were characterized as having "close relations with public health departments generally"; in thirty-two States the relations were characterized as "close relations with a specific part or parts of public health departments" and in eleven States the institutional programs were categorized as having "few or no relations." There is no clear tendency for the relationship to be categorized as closer in States in which the authority is located in a department of public health

than in other States. Thus, in the twenty-five States in which the authority is in a department of public health, five are categorized as having institutional programs with close relations with public health departments generally; among the twenty-five other States, two are categorized as having close relations generally.

The third organizational aspect we are considering is the joint or separate administration of the institutional and community mental health programs. In recent years there has been a growth of out-patient services for mentally ill patients. One line of development "has been the independent clinic supported by contributions or tax funds, established frequently to function without direct association with any medical institution--public health, mental hospital, or other hospital."[1] Another line of development has been the clinics of the mental hospitals providing "continued care of patients discharged from the hospitals; these operate either at the hospital or in locations more convenient to the former hospital patients."[2] In conjunction with this latter development, there has been some effort to establish smaller mental hospitals which are not isolated from the patients' communities but are in or near their communities.

As a result of these developments, then, another organizational issue is whether the community and institutional mental health programs should be in the same or separate departments. At present, the two programs are administered by the same department in twenty-six States and administered separately in twenty-four States.[3] In States in which the mental

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[1]Paul V. Lemkau, Mental Hygiene in Public Health (New York: McGraw-Hill Book Co., 1955) p. 101.

[2]Ibid.

[3]The categorization of each State was based upon data kindly made available to us by The Council of State Governments.

health authority is located in a public health department the two mental health programs are much less likely to be administered together than in States in which the authority is located elsewhere. Thus, in each of the twelve States in which the mental health authority is located in a department of mental health, the institutional and community programs are in the same department; of the twenty-five States in which the mental health authority is located in a department of public health, only three have the institutional and community programs administered together; while in each of the twelve States in which the authority is located in a department of mental health, the institutional and community mental health programs are administered together; and among the thirteen States in which the authority is located in another department, eleven have the two programs administered together.

We would also expect, on the basis of the associations already noted, that in States in which the institutional and mental health programs are administered together, the relations between the institutional programs and the public health departments would not be as close as in States in which the two mental health programs are administered separately. Actually, no such association exists. Of the twenty-six States in which the two mental health programs are administered together, the mental institutional programs in five States are reported to be close with public health departments generally; while among the twenty-four States in which the two mental health programs are administered separately, two are reported to have close relations between the mental institutions and the public health departments generally. This lack of association may indicate the inadequacy of the method used in determining the relationship between the mental institutions and the public health departments.

In addition to the particular characteristics of organizational relationships between the mental health programs and the public health programs we have considered thus far, a more general characterization of the States' organizational arrangements was constructed. Each respondent was presented with seven statements concerning possible arrangements between mental health and other health-related and welfare programs. He was first asked to indicate the statement which came closest to expressing his opinion about the best, the next best, and the third best possible relationship in his State or locality. He was then asked to choose which statement came closest to describing the present situation in his State or locality. The seven statements are:

1. Mental health activities are very distinctive and should be organized into separate programs.
2. Mental health activities should be separately and autonomously organized but have provision for consultation with other programs regarding special problems.
3. Mental health activities should be separately and autonomously organized but should have provision for regular and frequent liaison with other programs.
4. Mental health activities are a part of public health and should be a division in the department of public health.
5. There should be a distinct mental health unit within one of the (STATE)(LOCAL) agencies, with a small staff, and other mental health personnel should be assigned to other agencies for varying periods of time.
6. Mental health relates to all programs of health and welfare and mental health personnel should be dispersed among these various programs, with the provision that they meet for periodic conferences, perhaps with a chairman.
7. It really does not matter where the mental health group is placed or who the "mental health authority" is, provided there is an identifiable group and they are willing to work with other agencies as needs and time permit.

We will first consider the way in which the present organizational relationships in the States can be characterized in these terms. The respondents' preferences for these various possible organizational relationships are

examined in the following chapter. The responses of the State respondents from the same State were combined to characterize the State. This combination entailed a coding operation wherein a judgment was made to reconcile any disagreements in the answers among the State respondents reporting about the same State. Generally, the responses of all the respondents in a given State were tallied and the modal choice of these respondents was used to characterize the State. Consideration was also given to the relative knowledgeability of the respondents. In the case of three States, the respondents did not sufficiently agree that any of the first six statements adequately described the situation in their State to permit the State to be categorized. The seventh statement has relevance for the preferences, but could not be used to characterize the present situation in the State.

The first statement describing possible relationships between mental health and other health or health-related programs was used to characterize one State; the second statement characterized twelve States; the third statement, eight States; the fourth statement, nineteen States; the fifth statement, five States; and the sixth statement, two States. For purposes of analysis the first three alternatives may be combined to characterize States in which the mental health program is separate and autonomous; the fourth alternative may remain as a distinct group; and the fifth and sixth may be combined to characterize States in which the mental health programs are somewhat dispersed among agencies.

The ways in which this general characterization of the relationship between mental health and other programs are associated with the other aspects of organizational arrangements being considered are presented in Table 1. The association with the location of the mental health authority is very strong and indicates that the location of the mental health authority, as the previous analysis would already indicate, reflects more than a mere

formal or accidental matter. Thus, States which the respondents characterize as having separate and autonomous mental health programs nearly all have the mental health authority located in a mental health department or some other department or agency, but not in a public health department. States which are characterized as having the mental health program as a division of public health formally have the authority located in a department of public health (with the exception of one State in which it is located in a public health and welfare department). Finally, the States which are characterized as having their mental health programs somewhat dispersed do not have the authority located in a mental health department.

The institutional and community mental health programs are most likely to be within the same department in States in which the mental health programs are separate and autonomous and least likely when the mental health program is a division of public health. It also appears that States characterized as having separate and autonomous mental health programs are slightly less likely to have close relations between the mental institutions and the public health departments generally than are States in which the mental health programs are a division of public health.

TABLE 1

CHARACTERIZATION OF STATE MENTAL HEALTH ORGANIZATION AND THREE ASPECTS OF ORGANIZATIONAL ARRANGEMENTS IN THE FIFTY STATES

Characterization of State Mental Health Organization	Location of Mental Health Authority			Relationship Between Mental Institutional Programs and Public Health Departments			Administration of Institutional and Community Mental Health Programs	
	Public Health Dept.	Mental Health Dept.	Other Dept., Agency	Close, Generally	Close, Part	Few or No	Same Dept.	Separate Depts.
Separate and autonomous . .	1	12	8	2	14	5	18	3
Division of public health .	18	-	1	4	12	3	4	15
Somewhat dispersed	3	-	4	1	4	2	4	3
Not categorized	3	-	-	-	2	1	-	3
Total States	25	12	13	7	32	11	26	24

In summary, we have been discussing three dimensions of organizational arrangements for the provision of mental health services. One dimension is whether or not the mental health programs are separate; the second dimension is whether or not the institutional and community mental health programs are administratively united; and the third is the degree of closeness of relations between the mental health and public health programs. Actually, the way these three dimensions are interrelated suggests that they can be reduced to a single dimension for some purposes. This is the dimension of the degree to which the mental health programs are separate and unified. Thus, we can divide the fifty States into two categories: those characterized as having separate and autonomous mental health programs and those not so categorized. Of the twenty-one States categorized as having a separate mental health program, eighteen have the institutional and community mental health programs administered together and none of these eighteen States has a public health department designated as the mental health authority. On the other hand, of the twenty-nine States not categorized as having separate and autonomous mental health programs, twenty-one have the institutional and community mental health programs in separate departments; all twenty-one of these States have the mental health authority located in a public health department. Thus, it appears that most States can be placed into one of two groups: (1) the mental health programs are separate and unified and the authority is not located in a public health department (eighteen States), or (2) mental health programs are not separate and not unified and the authority is located in a public health department (twenty-one States).

The closeness of relations between the mental institutions and the public health departments does not appear to be associated with the degree to which the mental health programs are separate and unified. This may

validly indicate that the relations between the institutional and public health programs are results of differences in leadership and personnel policies or other factors unrelated to the aspects of organizational arrangements being considered here.[4]

Determinants of the State Organizational Arrangements

There is a great diversity of organizational arrangements for mental health programs among the highly varied fifty States. Some characteristics of the States are associated with organizational arrangements, however. This seems to be the case for certain population characteristics. We can hypothesize that in States with high per capita income, large population size, and high population density there could, and indeed would, be more organizational differentiation. That is, States with a larger population would need to have larger programs in each of the health and health-related fields of governmental activity; if each program were larger, more programs would be separately organized and given greater independent status. States with high per capita income could also support more extensive government programs in these fields. Finally, perhaps States with high densities, being relatively urban, would have greater public interest and support, particularly for mental health activities, and this, too, would make for a separate organization of mental health programs. Given the interrelationship among the aspects of organizational arrangements we have already noted, we would expect that in States with a separate organizational status for mental health programs, the institutional and community mental health programs would be unified and the mental health authority would not be located in a public health department. Thus, we would expect such population characteristics

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[4]To the extent to which the measure of closeness of relations between the mental institutions and public health departments is inadequate, for the possible reason mentioned earlier in the text, the lack of association may be an artifact.

of the States to be related to these aspects of the organizational arrangements of mental health activities also. We would not expect any association between these population characteristics and the degree of closeness in the relationship between the mental institutional programs and the public health departments. All these expectations are borne out (see Tables 2 through 5).

TABLE 2

LOCATION OF THE MENTAL HEALTH AUTHORITY AND PER CAPITA INCOME, POPULATION SIZE, AND POPULATION DENSITY OF THE FIFTY STATES

Location of the Mental Health Authority	Per Capita Income		Population Size		Population Density	
	High	Low	Large	Small	High	Low
Department of public health	10	15	8	17	6	19
Department of mental health	7	5	9	3	12	-
Other department or agency	8	5	8	5	7	6
Number of States	25	25	25	25	25	25

TABLE 3

RELATIONSHIP BETWEEN THE MENTAL INSTITUTIONAL PROGRAMS AND THE PUBLIC HEALTH DEPARTMENTS AND PER CAPITA INCOME, POPULATION SIZE, AND POPULATION DENSITY OF THE FIFTY STATES

Relationship between the Mental Institutional Programs and the Public Health Departments	Per Capita Income		Population Size		Population Density	
	High	Low	Large	Small	High	Low
Close relations with public health departments generally	2	5	3	4	3	4
Close relations with a specific part or parts of public health departments	19	13	17	15	17	15
Few or no relations	4	7	5	6	5	6
Total number of States . . .	25	25	25	25	25	25

TABLE 4

ADMINISTRATION OF INSTITUTIONAL AND COMMUNITY MENTAL HEALTH PROGRAMS IN SAME OR SEPARATE DEPARTMENTS AND PER CAPITA INCOME, POPULATION SIZE, AND POPULATION DENSITY OF THE FIFTY STATES

Administration of the Institutional and Community Mental Health Programs	Per Capita Income		Population Size		Population Density	
	High	Low	Large	Small	High	Low
Same department	16	10	18	8	21	5
Separate departments	9	15	7	17	4	20
Number of States	25	25	25	25	25	25

TABLE 5

CHARACTERIZATION OF STATE MENTAL HEALTH ORGANIZATION AND PER CAPITA INCOME, POPULATION SIZE, AND POPULATION DENSITY OF FIFTY STATES

Characterization of State Mental Health Organization	Per Capita Income		Population Size		Population Density	
	High	Low	Large	Small	High	Low
Separate and autonomous	13	8	13	8	16	5
Division of public health	7	12	8	11	6	13
Somewhat dispersed	3	4	4	3	3	4
Not categorized	2	1	-	3	-	3
Total States	25	25	25	25	25	25

Of course the three population characteristics are highly interrelated and this makes it difficult to determine whether one or another of the characteristics more significantly affect the organizational arrangements of the mental health programs. It would appear from Tables 2, 4, and 5, that population density is of particular importance. Although the number of cases is small, if we examine the relationship between each aspect of

organizational arrangements and population size and density simultaneously, it does appear that density is more important than population size. As a matter of fact, in the case of the joint or separate administration of the institutional and the community mental health programs, holding population density constant, population size almost ceases to be related to the joint or separate administration of the mental health programs. This can be seen in Table 6. To facilitate comparisons, the percentage of States with the mental health programs unified is presented and the small number of cases upon which the percentage is based is placed in parentheses in each cell.

TABLE 6

PERCENTAGE OF STATES WITH INSTITUTIONAL AND COMMUNITY MENTAL HEALTH PROGRAMS IN THE SAME DEPARTMENT, BY POPULATION SIZE AND DENSITY OF THE STATES

Population Size	Population Density	
	High	Low
Large	84 (19)	33 (6)
Small	83 (6)	16 (19)

The finding that population density is so highly related to a separate and unified organization of mental health activities suggests that there is special concern about mental health activities in the more urbanized States and it is this concern, combined with the opportunities for organizational differentiation made possible by the associated conditions of larger population size, which results in the differentiation.

These gross ecological conditions, then, appear to play a major role in determining the organizational aspects of State mental health programs. Perhaps other characteristics of the States also play a role. We would expect

that circumstances in the past may have led to a particular arrangement which has persisted. There is one kind of information which the respondents gave us that is relevant in this connection. The heads of the State and local programs were asked: "Is there a separately organized government office, department, bureau, or division which has primary responsibility for community mental health programs in (STATE)(LOCALITY)?" If an official said yes, he was then asked to tell us the year in which it was organized. The answers of all the respondents from the same State were combined to provide us with the date. Of the fifty States, respondents in forty-three States said there was a separately organized community mental health agency. Of those forty-three States, eight were reported to have had it organized in 1944 or earlier; sixteen were organized between 1945 and 1949; six were organized between 1950 and 1954; and in thirteen States it was reported to have been organized in 1955 or more recently. Clearly, the establishment of a government agency with primary responsibility for community mental health programs is largely a post-World War II development.

One might expect that States with a longer established separately organized agency for community mental health programs would be more likely to have developed a unified mental health department. On the other hand, one might expect that in States with a longer established separate agency the agency would have been located in a public health department at first and, once located there, would not be moved out into a separate department and unified with the mental institutional programs, while the more recently established agencies would have been organized together with mental institutional programs. The evidence from this study lends some support to the second hypothesis. Thus, among the twenty-four States with a separately organized agency established before 1950, thirteen (fifty-four per cent) have the mental health authority located in a public health department;

while among the nineteen States with a separately organized agency established in 1950 or more recently, eight (forty-two per cent) have the authority located in a public health department. The distribution of the States with the institutional and community mental health programs in separate departments is identical.

The positive association between recency of establishing a separate community mental health agency and a separate and unified mental health program is not very marked. The States with high population density and large populations, however, tend somewhat to have had a separately organized community mental health program established earlier than the States with small populations and low densities. We already have seen that the more populous and urban States tend to have a separate and unified mental health organizational arrangement and this, then, may attenuate the association between the age of the separately organized agency and the organizational arrangement. Although the number of cases is small, if we hold density of population constant, it does seem that the association is more definite. Thus, as can be seen in Table 7, the proportion of States with the institutional and community mental health programs in the same department is greater in the States with a more recently established, separately organized community mental health agency; the relationship within the more urbanized States and within the less urbanized States appears to be slightly greater than the relationship when density of population is not held constant.

TABLE 7

PERCENTAGE OF STATES WITH INSTITUTIONAL AND COMMUNITY MENTAL HEALTH PROGRAMS IN THE SAME DEPARTMENT BY POPULATION DENSITY AND YEAR IN WHICH A SEPARATELY ORGANIZED COMMUNITY MENTAL HEALTH AGENCY WAS ESTABLISHED

Population Density	Year in Which Separate Agency Was Established		
	Before 1950	1950 or Later	No Separate Agency
Low	9 (11)	33 (10)	25 (4)
High	77 (13)	89 (9)	100 (3)

These data suggest, then, that there is some organizational inertia. The older community mental health agencies, presumably first located within an existing department, and most likely in a public health department, tend to remain there, while a more recently organized agency may be established in combination with the institutional mental health programs.[5] Since the more populous and urban States tend to have a separately organized community mental health agency established relatively early, this modifies the high degree to which such population characteristics determine organizational arrangements. This inference could be drawn with greater confidence were we certain that the same definition of a separate government agency was used by the respondents in providing information about the year in which it was established.

Another possible determinant of organizational arrangements for State mental health programs is the influence of neighboring States. That is, it is possible that States within each region of the United States model themselves after each other in seeking for the best organizational arrangements. First of all, it is clear that there are regional differences. For example, among the nine States in the North East region, only one has the mental health authority located in a department of public health; at the other extreme, among the thirteen States in the West, ten States have a department of health designated as the authority; the States in the North Central region tend to have the authority outside of a public

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[5] In January, 1950, twenty-nine of the forty-eight States, and Alaska and Hawaii, had designated a board or department of health as the mental health authority; only five States had designated a department of mental health or hygiene. Council of State Governments, The Mental Health Programs of the Forty-Eight States (Chicago, 1950), p. 86.

health department and the States in the South tend to have the authority located in a public health department (see Table 8).[6]

The population characteristics of the States in the different regions also differ, of course. Can these regional differences be explained by the population characteristics, or, indeed, do the regional patterns account for the association between population characteristics and organizational arrangements? We must point out again that, given the number of cases involved, it is difficult to answer these questions definitively nevertheless, let us see whether or not the regional patterns are maintained if we hold population density constant. In order to have somewhat more cases in each category, we have combined the States of the North East and North Central regions together and combined the States of the South and the West together. In the case of the location of the mental health authority, there seems little doubt that regional patterns or traditions do have some importance, independently of the population density of the State (see Table 9). The regional patterns do not seem to be as strongly associated with whether or not the institutional and community mental health programs are in the same department (see Table 10). Population density continues to be highly associated with these aspects of organizational arrangements within each of the two major regional groupings.

Finally, we examined whether or not the political party affiliation of the Governor and the political party composition of the State legislature

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[6]The States included in each region are as follows: (1) North East: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, Pennsylvania; (2) North Central: Ohio, Indiana, Illinois, Michigan, Wisconsin, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, Kansas; (3) South: Delaware, Maryland, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida, Kentucky, Tennessee, Alabama, Mississippi, Arkansas, Louisiana, Oklahoma, Texas; and (4) West: Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada, Washington, Oregon, California, Alaska, and Hawaii.

TABLE 10

PERCENTAGE OF STATES WITH THE INSTITUTIONAL AND COMMUNITY MENTAL HEALTH PROGRAMS IN THE SAME DEPARTMENT BY POPULATION DENSITY AND REGION

Density	Region	
	North East and North Central	South and West
Low	22 (9)	19 (16)
High	100 (12)	69 (13)

The Local Organizational Arrangements and Their Determinants

In addition to the information from State respondents about organizational arrangements at the State level, respondents with responsibility at the local or community level also were asked about the organizational arrangements for mental health services in their community. The localities in which interviews were conducted are not a sample of all localities in the United States; rather they are a selection of cities and counties in which there is a mental health as well as a public health program. All the largest cities are represented among the localities; those with fewer than 25,000 persons are not included. Usually, one mental health and one public health respondent was interviewed in each locality; in some, only one person was interviewed, and in a few, more than two were interviewed. In all, 120 local mental health and 120 local public health officials were interviewed, representing 123 localities. The responses to factual questions were combined for all the respondents from the same locality. In order to obtain more valid information, a broad definition of the "same" locality was used. Thus, a person reporting about a city and one reporting about the county in which the city was located could be combined into the same locality. Usually, of course, the same political jurisdiction was

pertinent for both respondents; in some cases, one person had a clear jurisdictional responsibility and another person (for example, a director of a mental health clinic) may not have had a clear jurisdiction.

As a measure of the degree to which the mental health programs are separate and autonomous, the local respondents were asked the same question as the State respondents: to choose one of the seven alternative descriptions which best fit their locality (see p. 16). Combining the answers of the respondents from the same locality, sixty-one per cent of the localities were characterized as having a separate mental health organization, thirty-one per cent were characterized as having one in which the mental health programs were a division of public health, and eight per cent were characterized as having the mental health programs dispersed. The localities apparently tend to have a separate organization for mental health programs more often than do the States; the corresponding percentages for the forty-seven States which could be characterized on this dimension are: forty-five, forty, and fifteen.

A "separate" organization of mental health programs means something different at the State than at the local level, of course. At the State level it usually means a government agency of departmental status. At the local level it usually means that there is a community mental health center or clinic which is often quasi-governmental; in a few cases it may mean a separately organized mental health government agency with departmental status. Thus, among the local mental health respondents in communities characterized as having a separate organization of mental health programs, seventy-six per cent have positions as heads of mental health centers or clinics compared to fifty-eight per cent of the respondents in communities in which the mental health programs are part of the public health departments (see Table 11). Furthermore, in communities in which the localities are

characterized as having mental health activities separately organized, sixty-two per cent of the mental health respondents say they are responsible to some private board of directors, compared to forty-two per cent of those in localities not so characterized. On the other hand, in the localities in which the mental health activities are not separate, sixty-one per cent are responsible to some local government official as compared to only eighteen per cent in the localities which do not have the mental health activities separately organized. It is also significant that in the localities which have a separate organization of mental health activities, respondents are more likely than in the other communities to be responsible to a State government official (thirty-four per cent compared to seventeen per cent, respectively). Note that a person may be responsible to more than one of these kinds of authority.

TABLE 11

JOB TITLES OF LOCAL MENTAL HEALTH RESPONDENTS BY CHARACTERIZATION OF LOCAL MENTAL HEALTH ORGANIZATION, IN PERCENTAGES

Job Titles	Characterization of Local Mental Health Organization		
	Separate and Autonomous	Division of Public Health	Somewhat Dispersed
Head, community mental health department, bureau, or division	8	24	-
Head, community mental health, hygiene, guidance or psychiatric center . . .	30	10	25
Head, community mental health, hygiene, guidance, psychiatric or out-patient clinic	21	24	12
Head, community adult or child guidance, psychiatric or mental health clinic .	25	24	38
Head, university department of psychiatry	4	10	-
Head, university mental health psychiatric clinic	5	4	12
Head, university child or adult psychiatric clinic	3	-	12
Other local mental health official . .	4	4	-
Total per cent	100	100	99
Base for percentages	(76)	(29)	(8)
No information*.	(-)	(-)	(-)
Total number	(76)	(29)	(8)

*This refers to no information concerning job titles; seven local mental health respondents are omitted because the mental health organization for their localities could not be categorized because of inadequate information.

In short, a separate organization of mental health activities at the local level usually means that the mental health activities are provided by a mental health center or clinic which is most likely responsible to non-governmental officials, such as a private board of directors or university officials, and secondarily, they often are responsible to State government officials. In a few cases it entails a government agency with departmental status. Where the mental health programs are organized as a division of public health, the heads of the mental health programs are government officials; in many cases, here, too, the services are provided by a mental health clinic or center. The heads of these programs usually report to a local government official, frequently to non-government officials, and only in a few cases to a State government official. These characteristics of the separate and non-separate mental health programs at the local level, as found in the communities selected for study, will help us understand the meaning of any associations we find between organization of mental health programs at the local level and characteristics of their community or State.

The communities selected for study were within three categories: (1) medical school communities, (2) metropolitan communities (over 75,000 population and not a medical school community), and (3) smaller communities (25,000 - 75,000 population and not a medical school community). Surprisingly, there is no clear relationship between the type of community so categorized and the organization of mental health programs; there is an indication, however, that in medical school communities mental health programs are less likely to be separate than in non-medical school communities (see Table 12).

TABLE 12

CHARACTERIZATION OF LOCAL MENTAL HEALTH ORGANIZATION BY TYPE OF COMMUNITY, IN PERCENTAGES

Characterization of Local Mental Health Organization	Type of Community		
	Medical School Community	Metropolitan Community	Smaller Community
Separate and autonomous	53	66	65
Division of public health	39	28	26
Somewhat dispersed	8	6	9
Total per cent	100	100	100
Base for percentages	(36)	(35)	(43)
No information	(2)	(5)	(2)
Total number	(38)	(40)	(45)

More significantly, the organization of mental health programs at the community level is highly related to the organization of mental health programs at the State level. Localities in States in which the mental health authority is in a public health department, in which the mental institutional programs and the public health departments have generally close relations, or in which the mental health programs are a division of public health, tend to have their local mental health programs organized as a division of public health rather than separately (see Table 13). It appears that in States in which there are close organizational relationships between the mental health and public health programs, a similar relationship exists at the local level.

We have already noted that, in localities with separately organized mental health programs, mental health respondents, more frequently than in other communities, are responsible to State officials. Furthermore, local mental health respondents in States in which the mental health authority is located in a mental health department are more likely than those in States with the authority in a public health or other department to be responsible to a State-level official (forty-four per cent compared to twenty-two and twenty-seven per cent, respectively). It appears, then, that in States with a separate mental health organization there are more direct relations with mental health personnel at the local level. There is also likely to be a tendency for States with a separate mental health department to help establish local mental health centers and clinics.[7]

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[7]The interview data do not make it possible to assess the relationship between the State organization of mental health activities and the number of local mental health clinics since two or three localities were selected from each State; the localities are not a sample of all communities.

TABLE 13

CHARACTERIZATION OF LOCAL MENTAL HEALTH ORGANIZATION BY ASPECTS OF THE ORGANIZATION OF STATE MENTAL HEALTH PROGRAMS, IN PERCENTAGES

Characterization of Local Mental Health Organization	Location of Mental Health Authority			Relationship Between Mental Institutional Programs and Public Health Departments			Administration of Institutional and Community Mental Health Programs		Characterization of State Mental Health Organization		
	Public Health Dept.	Mental Health Dept.	Other Dept., Agency	Close, Generally	Close, Part	Few or No	Same Dept.	Separate Depts.	Separate and Autonomous	Division of Public Health	Somewhat Dispersed
Separate and autonomous .	48	87	60	44	61	75	68	53	84	42	53
Division of public health	45	10	27	44	31	21	25	39	9	52	29
Somewhat dispersed . . .	7	3	13	11	8	4	8	8	7	6	18
Total per cent.	100	100	100	99	100	100	101	100	100	100	100
Base for percentages . .	(54)	(30)	(30)	(18)	(72)	(24)	(65)	(49)	(45)	(50)	(17)
No information . .	(3)	(1)	(5)	(-)	(6)	(3)	(4)	(5)	(5)	(1)	(2)
Total number .	(57)	(31)	(35)	(18)	(78)	(27)	(69)	(54)	(50)	(51)	(19)

Before concluding this chapter, we will also consider the possible effects of having, for various lengths of time, a separate government agency with responsibility for community mental health activities. The local respondents, like the heads of State programs, were asked, "Is there a separately organized government office, department, bureau, or division which has primary responsibility for community mental health programs in . . . .?" If they replied that there was, they were asked in what year it was organized. The answers of respondents from the same localities were combined to characterize the locality. First of all, it is important to note that forty-four per cent of the localities are reported not to have any separately organized government agency for mental health activities. Furthermore, only twenty per cent of the localities are reported to have had one organized before 1950 (compared to forty-eight per cent of the States).

It appears that communities in which a separately organized government agency for community mental health has existed for a relatively long time tend to have a mental health organization which is characterized as separate rather than a part of public health. This seems to be an artifact, however. States in which the mental health authority is located in a mental health department are more likely to have a separately organized government agency. We therefore need to hold the location of the authority constant for analytical purposes. We find that there is no longer any relationship between the length of time a separate local government agency has existed and the organizational arrangements in the localities when we examine the relationship among those localities in States in which the mental health authority is variously located.

The evidence available from the interview material, then, indicates that the organizational arrangements for local mental health activities are

largely determined by the State arrangements. We have previously noted that the State arrangements seem largely determined by population density. Thus, the relative size of the communities within a State affects the State arrangements and this has an impact upon the local arrangements to some extent, regardless of the type of community.

CHAPTER II

PREFERENCES CONCERNING ORGANIZATIONAL ARRANGEMENTS

Controversy abounds in discussions of the most appropriate organizational arrangement for the provision of mental health services. We have already seen that there is considerable variation within the United States. Different arrangements may be urged to meet different problems in States and localities with varying conditions. People differ in the importance they assign to various goals and differ in their beliefs about the best organizational arrangement to achieve those objectives; and the goals and means at one time and place may be different from those at a different time and place. In addition, there are differences arising from concerns about one's own position and profession in various arrangements.

For one or more of the above reasons, the key officials interviewed for this study are likely to differ in their preferences about organizational arrangements. The respondents are occupants of crucial positions in the mental health and public health programs in each State and in selected localities throughout the nation. In the following analysis, the respondents usually will be grouped together in terms of their program responsibilities: State, public health; local, public health; State, mental health; and local, mental health. It will be well to keep in mind the kinds of persons who are included in each grouping; this is shown in Appendix B, Table B-1.

In the first half of this chapter, we will describe the respondents' preferences concerning each of the aspects of the organizational arrangements discussed in the previous chapter. As each is taken up in turn, we will briefly review the relationship between the respondents' preferences and the actual arrangements in their State or locality, their program responsibilities, and their preferences concerning other aspects of the organizational

arrangements. In the second half of the chapter we will analyze in more detail how these and other factors may affect the respondents' preferences.

An Overview of the Respondents' Preferences

The Location of the Mental Health Authority

Each respondent with responsibility for State programs was asked where the mental health authority was located and then where he thought it should be located. The responses, by type of respondent, are presented in Table B-21. There are marked differences between respondents with public health and those with mental health responsibilities. The heads of public health programs and others with public health responsibilities overwhelmingly prefer its location in a department of public health. The mental health officials prefer that the authority be located in a department of mental health rather than a department of public health. This preference is expressed most overwhelmingly by the mental health officials in hospital-based mental health programs (sixty per cent prefer a department of mental health location and eleven per cent prefer a department of public health).

The finding that respondents with different program responsibilities differ markedly in their preferences about the location of the mental health authority suggests that they are motivated by fears of being dominated by persons with other program responsibilities, or, perhaps, are organizationally expansionist themselves. There are other possible interpretations, however, and we shall consider them.

First of all, we must consider the respondents' preferences in relationship to the actual location of the mental health authority. The pertinent data are presented in Table 14; the number of cases in some of the columns is extremely small; however, since they constitute almost all the officials of a particular type within the given setting, the results are presented.

TABLE 14

PREFERENCES CONCERNING LOCATION OF MENTAL HEALTH AUTHORITY BY TYPE OF STATE RESPONDENT WITHIN STATES WITH AUTHORITY VARIOUSLY LOCATED

A. Authority Located in Department of Mental Health

Preferred Location of Mental Health Authority	State Public Health		State Alcoholism	State Mental Health		
	Head	Other		Head	Other Community Base	Other Hospital Base
Department of mental health	33	37	60	92	87	91
Department of public health	56	53	20	-	5	-
Other department or agency.	-	10	10	8	8	9
Don't know	11	-	10	-	-	-
Total per cent . . .	100	100	100	100	100	100
Base for percentages	(9)	(30)	(10)	(12)	(39)	(23)
No answer	(1)	(3)	(-)	(-)	(2)	(2)
Total number of cases	(10)	(33)	(10)	(12)	(41)	(25)

B. Authority Located in Department of Public Health

Department of mental health	5	10	14	31	41	53
Department of public health	91	77	79	49	57	20
Other department or agency.	5	11	7	15	2	27
Don't know	-	2	-	5	-	-
Total per cent . . .	101	100	100	100	100	100
Base for percentages	(22)	(62)	(14)	(39)	(42)	(30)
No answer	(-)	(5)	(2)	(1)	(8)	(2)
Total number of cases	(22)	(67)	(16)	(40)	(50)	(32)

C. Authority Located in Other Department or Agency

Department of mental health	-	10	50	28	45	46
Department of public health	55	74	17	-	19	-
Other department or agency.	45	16	33	72	36	54
Don't know	-	-	-	-	-	-
Total per cent . . .	100	100	100	100	100	100
Base for percentages	(11)	(19)	(6)	(18)	(31)	(26)
No answer	(-)	(9)	(1)	(2)	(4)	(4)
Total number of cases	(11)	(28)	(7)	(20)	(35)	(30)

The respondents tend to prefer the authority to be located where it is. The heads of mental health programs in States in which the authority is located in a department of mental health almost uniformly like it where it is; similarly, heads of public health programs in States in which the authority is located in their departments almost uniformly prefer it where it is. Overall, sixty-four per cent of the respondents say they prefer the authority to be located where they believe it to be, rather than located elsewhere.

Nevertheless, there are many persons who do wish the location were different from where it is. Heads of public health programs and other State public health officials generally prefer the authority to be located in the public health department even where it is not. Heads of alcoholism programs generally believe a mental health department is the appropriate department. Of course, the respondents with mental health program responsibilities generally prefer that a department of mental health be designated as the authority; but there are also some interesting variations among respondents with different mental health program responsibilities. Some of those in community-based programs do prefer the authority to be located in a public health department, particularly if it is located there already. On the other hand, respondents in hospital-based programs consistently reject this alternative. The overwhelming preference by hospital-based mental health respondents for the authority not to be located in a public health department may reflect their desire not to be isolated from other mental health personnel and programs. They recognize that mental health programs are more likely to be unified if they are separate or at least not located within a public health department.

The same kind of reasoning may explain the preferences of the other respondents. After all, what is perhaps most significant about the location

of the mental health authority is the programs which are likely to be joined together or separated. Different types of respondents may assign varying importance to having one set rather than another set of programs closely joined. It is also reasonable to suppose that the respondents are aware that the location of the mental health authority has implications for which set of programs will be closely joined.

We would, therefore, expect that preferences about the location of the authority would be affected by preferences about which programs should be administered together. This expectation is supported by two kinds of data: (1) the relationship between preferences about the location of the authority and preferences about other aspects of the organizational arrangements being considered, and (2) the reasons given by the respondents for their preferences concerning the location of the authority.

First, respondents who believe the institutional and community mental health programs should be in the same department, compared to those who do not think so, are more likely to prefer that the authority be located in a department of mental health or other department or agency rather than in a department of public health. Of the persons preferring that the mental health programs be administered together, thirty-six per cent prefer the public health department as the location for the authority; among those preferring separate administrations, the percentage is sixty-four. Similarly, among respondents who prefer close relations between the mental institutions and the public health department generally, forty-seven per cent prefer that the authority be located in a department of public health, while among the respondents who do not believe that there should be close relations with the entire health department, twenty-nine per cent prefer that the authority be located in a public health department.

Second, we can consider the respondents' own explanations of their preferences concerning the location of the mental health authority. Respondents whose preferred location differed from the one they believed to be the actual one were asked, "Why do you think the other location is better?" The results are presented in Table 15. Persons preferring that the authority be located in a department of mental health, rather than elsewhere as it is in their State, mention the greater coordination among the mental health programs and the decreased burden of other programs. As one respondent said, "People can't pass the buck. To have it in the department of mental health would coordinate all programs and have data available to all people planning programs." Another respondent said, "Being attached to a department of public welfare, we have the burden of welfare--philosophy and professional standards--like a millstone around your neck."

On the other hand, persons preferring the authority's location in a department of public health rather than where it is presently located, mention particularly the possibilities of better coordination between mental health and related programs. As one respondent said, "All health should be in one agency. It pools your efforts and total effect will be better." Another respondent emphasized that mental health is part of public health in these words: "Should be in public health department. Mental health is only part of total problem or we should have a department of stomach troubles, department of whatever the problem should be. It's ridiculous to have this separation of mental health activities from the public health department."

The Relationship Between Mental Institutions and Public Health Departments

As we have already seen, in most States the mental institutions have close relations with only parts of the public health departments, and in many States there are few or no relations. How close relations would the

TABLE 15

REASONS FOR PREFERRING DIFFERENT LOCATION OF MENTAL HEALTH AUTHORITY THAN PRESENT ONE, IN PERCENTAGES

Reasons for Preference	Present and Preferred Location of Mental Health Authority			
	Presently Public Health, Prefer Mental Health	Presently Other, Prefer Mental Health	Presently Mental Health, Prefer Public Health	Presently Other, Prefer Public Health
Mental health would be less burdened by responsibilities for other programs, by their rules	14	39	-	-
Mental health could get more funds, support	19	22	4	-
There would be better coordination among mental health activities	57	39	4	13
Mental health programs are large enough to warrant separate departmental status	11	11	-	-
Would increase public understanding of mental health programs	3	8	4	3
There would be better coordination, integration between mental health and related programs	3	3	43	30
Mental health is part of public health	-	3	36	43
Public health has the proper, preventive orientation	-	-	18	20
Other specific reasons	6	6	21	13
Vague, general responses	11	11	4	3
Total per cent (some give more than one reason)	124	142	134	125
Base for percentages	(37)	(36)	(28)	(30)
No answer	(8)	(-)	(-)	(-)
Total number of cases	(45)	(36)	(28)	(30)

respondents like to have in their States? After being asked about the degree of relationship that exists in their State, the respondents were asked, "Which of the three alternatives do you consider most desirable: (1) close relations with public health departments generally, (2) close relations with a specific part or parts of public health departments, such as nursing, community clinics, or hospital inspection, or (3) few or no relations with public health departments?" Almost none of the respondents say that few or no relations are desirable, and most respondents say there should be close relations with public health departments generally (see Table B-23).

There are some differences in the degree of closeness desired among the respondents with different program responsibilities. Heads of State alcoholism programs, hospital-based mental health respondents, and, particularly, local mental health respondents are less in favor of generally close relations than are the other respondents. There is also a slight tendency for State heads of public health programs to be more likely to favor close relations generally than are the other public health respondents. The State heads of mental health programs are also more likely to favor close relations generally than are the other mental health respondents.

On the whole, obviously, respondents generally think desirable closer relations than is presently the case. There is a slight tendency for respondents in States characterized as having closer relations between the mental institutional programs and the public health departments to be more likely to prefer close relations generally than for persons in States not having such close relations. Thus, in States categorized as having close relations generally, seventy-two per cent of the respondents prefer close relations generally; in States categorized as having close relations with part or parts of the public health department, sixty-eight per cent prefer

close relations generally; and in States categorized as having few or no relations, sixty-four per cent say they think the relations should be close generally.

Since we did not find a clear association between the location of the mental health authority in a State and the degree of relationship between the mental institutions and the public health departments, we would not expect that the respondents' preferences about these two programs would be associated. Actually, as can be seen in Table 16, respondents who prefer that the authority be located in a public health department are slightly more likely than the others to favor generally close relations between the mental institutions and the public health departments. By the same reasoning, we would expect no association between preferences concerning the administration of the institutional and the community mental health programs and preferences concerning relations between mental institutions and the public health departments. As can be seen in Table 17, there is actually a tendency for respondents who prefer the two mental health departments to be administered together to be more likely to prefer closer relations between the mental institutions and the public health departments. Perhaps some respondents favor "integration"whenever an apparent alternative is offered.

TABLE 16

PROPORTION OF STATE RESPONDENTS PREFERRING CLOSE RELATIONS BETWEEN THE MENTAL INSTITUTIONS AND THE PUBLIC HEALTH DEPARTMENT GENERALLY BY REPORTED LOCATION OF THE MENTAL HEALTH AUTHORITY AND BY PREFERENCES CONCERNING THE LOCATION OF THE AUTHORITY

Preferred Location of the Mental Health Authority	Reported Location of the Mental Health Authority		
	Department of Public Health	Department of Mental Health	Other Department or Agency
Department of public health .	85 (127)[a]	68 (28)	76 (29)
Department of mental health .	80 (44)	66 (96)	56 (36)
Other department or agency .	69 (13)	[b] (4)	60 (65)

[a]Number in parentheses is the number of cases upon which percentaging is based.
[b]Too few cases to percentage.

TABLE 17

PREFERENCES CONCERNING CLOSENESS OF RELATIONS BETWEEN MENTAL INSTITUTIONS AND PUBLIC HEALTH DEPARTMENTS, BY PREFERENCES FOR THE JOINT OR SEPARATE ADMINISTRATION OF THE INSTITUTIONAL AND COMMUNITY MENTAL HEALTH PROGRAMS, IN PERCENTAGES

Preferred Closeness Between Mental Institutions and Public Health Departments	Administration of the Institutional and Community Mental Health Programs		
	Same	Separate	Don't Know
Generally close	70	61	63
Close with parts	27	36	23
Few or no relations	1	1	4
Don't know	2	2	10
Total per cent . . .	100	100	100
Base for percentages	(518)	(160)	(52)
No answer	(4)	(1)	(1)
Total number of cases	(522)	(161)	(53)

Joint or Separate Administration of the Institutional and Community Mental Health Programs

We noted in the previous chapter that in twenty-six of the fifty States the institutional and community mental health programs are administered by the same department of State government. The respondents were asked, "Do you think the institutional and community mental health programs in this State should be in the same department or in separate departments?" There is generally overwhelming support for their joint administration (see Table B-22). This preference is most marked among State respondents in hospital-based mental health programs (ninety per cent favor joint administration); they are also most likely to favor a department of mental

health as the location of the mental health authority and are least likely to favor close relations between mental institutions and the public health departments generally. On the whole, mental health respondents more frequently favor joint administration than do the public health officials. It is noteworthy that in States in which the programs are in the same department, most respondents (seventy-six per cent) favor this arrangement, while in States in which the programs are in separate departments, somewhat fewer, but well over half (sixty-five per cent), prefer that they be in the same department.

Respondents who expressed a preference were asked, "Why do you think they should be in (the same)(separate) departments?" The most frequent kind of explanation given by those preferring that they be in the same department is that there would be more continuity of services or better follow-up of patients. Some examples of such answers follow:

> I think it provides for better integration and better follow-up of patients.
>
> They'd work together, related together, cooperate and get a better program. Treatment and follow-up would be combined.
>
> There is considerable unanimity of purpose in getting and keeping people well. The community health program should fit in with the institutions. They have gotten the maximum benefit when they work together helping the same patient as he goes from one to another; as the institutionalized patient improves, he needs continuity in care from one program to the other. (This response is multiple-coded with the category "Goals are the same....")

The distribution of responses by broad categories of respondents is presented in Table 18. Responses such as those given above are mentioned most frequently by persons in each of the four groupings of respondents. Interestingly, State mental health officials relatively frequently also refer to the idea that the patient would be treated as a whole person or that the treatment would be in the community or that the hospital would be integrated into the community. Some answers so coded are:

TABLE 18

REASONS GIVEN FOR PREFERRING THAT THE INSTITUTIONAL AND THE COMMUNITY MENTAL HEALTH PROGRAMS BE IN THE SAME DEPARTMENT BY TYPE OF RESPONDENT, IN PERCENTAGES

Reasons	Type of Respondent			
	Public Health		Mental Health	
	State[a]	Local	State	Local
More continuity of services, of treatment of patients, better follow-up	34	40	34	40
Patient would be treated as whole person, treatment would be in community, would be integrated into community	7	11	18	5
More effective treatment of patients, general or other specific reasons	18	16	13	16
Could avoid duplication, competition, jurisdictional disputes	11	14	15	19
More efficient use of manpower	11	21	14	14
Greater economy of operations, easier financing	10	14	11	14
More extensive programs possible, better planning possible	9	4	10	6
Goals are the same, programs are similar, are aspects of the same program	11	23	19	9
Unspecified better coordination, cooperation[b]	9	10	13	8
Other specific responses	5	4	3	6
Vague, don't know	8	1	5	4
Total per cent (some give more than one reason)	133	158	155	141
Base for percentages	(126)	(73)	(238)	(77)
No answer	(2)	(1)	(5)	(-)
Total number of cases	(128)	(74)	(243)	(77)

[a]State alcoholism heads are included with heads and other State public health respondents. (Wherever the types of respondents are divided among State and local public health and State and local mental health, State alcoholism heads are not included among the State public health respondents unless otherwise indicated.)

[b]Not coded with first six categories.

> My conception of the eventual answer to at least the medical care of patients mentally ill is to design adequate care on a community basis rather than on a big hospital basis. Communities should work through the hospital and medical profession.
>
> If you don't, there is no liaison between the two .... They get things so mixed up..... Patients who are sent to institutions are so frequently lost as far as the community is concerned.
>
> Even though the focus is different, you can't separate them. The local people know more about these people and their backgrounds and can help more in directing treatment and also in preventing some.

The respondents who prefer that the institutional and the community mental health programs be in separate departments also give a wide range of explanations for their preferences. Interestingly, one of the more frequent kinds of responses is similar to the one given by persons preferring that the programs be administered together. They also value the community-oriented therapy; but rather than believing that the hospital programs would be modified if integrated with the community programs, they seem to fear, as one person said, that at the present time the community programs would be held back and dominated by the institutional programs. As another person said, "Prevention isn't very popular at best--gets lost when it is tied in with the treatment part. If it is in separate departments it is geared more toward health--preventive treatment." These kinds of explanations are relatively often given by mental health respondents, while public health officials are more likely to refer to the essentially different characters of the two programs (see Table 19). As one respondent phrased it, "Because they are two different kinds of work. Public health is geared toward prevention..... the institutional personnel look at the people from the curative standpoint and not always from the preventive standpoint. The problems of both are quite different and it is better if they are separated."

TABLE 19

REASONS GIVEN FOR PREFERRING THAT THE INSTITUTIONAL AND THE COMMUNITY MENTAL HEALTH PROGRAMS BE IN SEPARATE DEPARTMENTS BY TYPE OF RESPONDENT, IN PERCENTAGES

Reasons	Type of Respondent			
	Public Health		Mental Health	
	State[a]	Local	State	Local
Patient treatment would be better, avoid stigma of institutions	2	-	8	6
More community responsibility, involvement	-	3	5	9
Community mental health programs could be more preventive, could grow more freely, easily	20	17	36	22
Coordination, cooperation with other programs could be better	5	6	8	6
Public health should not be responsible for institutions, community mental health should be related to public health	18	14	13	3
Institutions are curative, community mental health programs are preventive; institutions are custodial, community programs provide short-term therapy; therefore too different to combine	31	23	26	25
Staffs of programs too different	9	9	10	13
Would be less duplication, more efficiency, less difficulty in coordination, better utilization of personnel	11	11	15	22
Programs too different, general or other specific reasons	18	11	15	22
Other specific responses	11	17	10	19
Vague, don't know	4	9	-	3
Total per cent (some give more than one reason)	129	120	146	150
Base for percentages	(55)	(35)	(39)	(32)
No answer	(-)	(-)	(-)	(-)
Total number of cases	(55)	(35)	(39)	(32)

[a]State alcoholism heads are included with heads and other state public health respondents.

The respondents, in explaining their preferences, often acknowledge the dilemmas of either alternative. Those preferring that the institutional and the community mental health programs be administered together tend to emphasize the benefits for the patient of continuous treatment in the community and presumably changes in the institutional programs. Some of those preferring the programs to be in separate departments offer a similar explanation but believe this approach is most likely if the community mental health programs are free to develop on their own. Others emphasize the essentially different nature of the two programs.

Autonomy of mental health programs.--The respondents were presented with a list of seven statements concerning possible arrangements between mental health and other health-related and welfare programs. They were asked to choose the statement which best described the organizational arrangement in their State or locality; their choices were used to characterize the general organizational arrangement of mental health programs as discussed in the previous chapter. The respondents were also asked to indicate which statement came closest to expressing their opinion about the best, the next best, and the third best possible arrangement in their State or locality. The seven statements are:

1. Mental health activities are very distinctive and should be organized into separate programs.

2. Mental health activities should be separately and autonomously organized but have provision for consultation with other programs regarding special problems.

3. Mental health activities should be separately and autonomously organized but should have provision for regular and frequent liaison with other programs.

4. Mental health activities are a part of public health and should be a division in the department of public health.

5. There should be a distinct mental health unit within one of the (STATE)(LOCAL) agencies, with a small staff, and other mental health personnel should be assigned to other agencies for varying periods of time.

6. Mental health relates to all programs of health and welfare, and mental health personnel should be dispersed among these various programs, with the provision that they meet for periodic conferences, perhaps with a chairman.

7. It really does not matter where the mental health group is placed or who the "mental health authority" is, provided there is an identifiable group and they are willing to work with other agencies as needs and time permit.

The respondents with different program responsibilities differ considerably in their choices of the best possible arrangement (see Tables B-14a through B-14c).[1] The public health respondents' first choice of the best possible relationship between mental health and other health, health-related, and welfare programs is overwhelmingly Statement 4: "Mental health activities are a part of public health and should be a division in the department of public health." Two-thirds of the State public health heads, of the other State public health officials, and of local public health respondents make this their first choice. On the other hand, this statement is chosen by only twenty-nine per cent of the heads of State mental health programs and by twenty-five per cent of the respondents in State, community-based, mental health programs. More respondents with mental health

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[1]The Joint Commission of Mental Illness and Health recommends that the National Institute of Mental Health should award grants "according to criteria of merit and incentive to be formulated by an expert advisory committee appointed by the National Institute of Mental Health. In arriving at such a formula, such a committee would establish conditions affecting various portions of the available grant." Among the conditions suggested by the Joint Commission is the following: "Establish State mental health agencies with well-defined powers and sufficient authority to assume overall responsibility for the State's services to the mentally ill, and to coordinate State and local community health services." Joint Commission on Mental Illness and Health, Action for Mental Health (New York: Basic Books, Inc., 1961), pp. 288-289.

responsibilities choose Statement 3 as the best arrangement than choose any other statement. Forty to forty-eight per cent of them choose as their first choice "Mental health activities should be separately and autonomously organized but should have provision for regular and frequent liaison with other programs." As earlier findings would lead us to expect, State respondents in hospital-based mental health programs are the most likely to choose alternatives in which the mental health activities are separate and autonomous.

In order to obtain a more stable measure of the respondents' attitudes concerning the best possible organizational relationship between mental health and other programs, we wanted to use all three of the respondent's choices to indicate his preference. As a first step in determining how to summarize the respondent's three choices, we tried to determine whether or not the seven statements represented a single underlying dimension. Coombs's "unfolding" procedure was used.[2] The number of respondents choosing each of the combinations of the three first choices was examined. Following the unfolding procedure, we tried various models, assuming different distances between the alternatives to see whether or not most of the respondents' choices could be explained by one model or another. The fourth statement, that mental health activities be a division of public health, did not conform to any unidimensional model. On the basis of this examination, it was decided to order the respondents largely in terms of how they ranked the first three statements--those involving a separate and autonomous mental health program. Seven categories were distinguished, and

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[2]The method was developed by Coombs and his students; it is described in Warren S. Torgerson, Theory and Methods of Scaling (New York: John Wiley & Sons, 1958), pp. 403-417.

then, in order to obtain sizable groupings of respondents, some of the categories were combined to yield a set of four groups. The four groups in terms of their preference for a separate and autonomous mental health program are as follows: (1) Very favorable: those who choose the first three statements for their first three choices; (2) Somewhat favorable: those who choose two of the first three statements; (3) Slightly favorable: those who choose one of the first three statements; and (4) Not favorable: those who did not choose any of the first three statements among their first three choices. If a respondent failed to choose any of the seven statements, he was coded "indeterminate" for this summary measure.

The results of this summary measure, by the program responsibilities of the respondents, can be seen in Table 20. The mental health respondents overwhelmingly favor a separate and autonomous mental health program: among the State heads of mental health programs, sixty-one per cent are somewhat or very favorable, fifty-two per cent of the State respondents in community-based mental health programs fall in these two categories, and, again, those in hospital-based mental health programs are most likely to favor separation and autonomy of mental health programs--sixty-seven per cent are in these two categories. Between forty-five and fifty-five per cent of the public health respondents are in the not favorable category. Respondents who are heads of State alcoholism programs are most likely to be somewhat or slightly favorable.

Although local respondents were asked about their preferences for their localities, it is significant that their preferences do not differ markedly from their professional colleagues' at the State level who were asked about their preferences for arrangements in their States. Further analysis reveals that there are no marked differences among different types of local mental health respondents.

TABLE 20

PREFERENCES FOR A SEPARATE AND AUTONOMOUS MENTAL HEALTH PROGRAM, BY TYPE OF RESPONDENT, IN PERCENTAGES

Preferences for a Separate and Autonomous Mental Health Program	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun. Base	Other Hosp. Base	
Very favorable	2	2	3	6	26	12	28	18
Somewhat favorable . .	17	18	10	32	35	40	39	40
Slightly favorable . .	32	35	32	35	21	37	21	30
Not favorable	49	45	55	27	18	11	12	12
Total per cent .	100	100	100	100	100	100	100	100
Base for percentages . . .	(41)	(126)	(119)	(34)	(68)	(129)	(90)	(120)
Indeterminate .	(2)	(4)	(1)	(-)	(6)	(-)	(-)	(-)
Total number . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

Respondents who are very favorable toward a separate and autonomous mental health program, compared to those who are not favorable, are much more likely to prefer that the mental authority be located in a department of mental health (seventy-five per cent compared to ten per cent); they are less likely to prefer close relations between the mental institutions and the public health departments generally (fifty-six per cent compared to seventy-seven per cent), and they are more likely to prefer that the institutional and the community mental health programs be in the same department (eighty-six per cent compared to sixty-four per cent). Again, we see that the preferences concerning one aspect of the organizational arrangements are related to the preferences about the other aspects.

The respondents tend to prefer the arrangement that exists in their State or, in this case, locality. Thus, local respondents in communities in which the mental health programs are characterized as being separate are more likely to be very or somewhat favorable to a separate mental health organization than are those in localities in which the programs are characterized as being a division of public health (forty-three per cent compared to twenty-four per cent; thirty-one per cent in localities characterized as having a somewhat dispersed organization of mental health programs). The relationship is not so marked among the State respondents. State officials in States characterized as being separate and autonomous are slightly more likely to be very or somewhat favorable to a separate mental health organization than are respondents in States in which the mental health programs are characterized as being organized as a division of public health (forty-two per cent compared to thirty-seven per cent; thirty-nine per cent in States characterized as having a somewhat dispersed organization of mental health programs).

Finally, all the respondents were asked one question pertaining to the organization appropriate for the provision of mental health services at the local level: "Among the possible arrangements for meeting mental health needs in local communities or--in sparsely populated areas--regions, which one of the following should have the highest priority? 1. Local health centers, including mental health centers; 2. Separate mental health centers; 3. Separate mental health clinics; 4. Separate child guidance clinics; or 5. Working through other agencies to effect treatment." The responses, by type of respondent, are presented in Table B-26. Clearly, the public health respondents overwhelmingly favor local health centers including mental health centers: about eighty-five per cent of them choose this alternative. Among the State mental health respondents, this is the most

frequently chosen alternative, but only somewhat more than half choose it; the local mental health respondents are least likely to choose this alternative (forty-four per cent choose it). Further analysis reveals that among the local mental health respondents, the heads of clinics or centers are least likely to give highest priority to local health centers (forty-two per cent do, compared to fifty-four and fifty-three per cent, respectively, for heads of government bureaus or departments of mental health and for university-associated respondents).

Note that this question is concerned with the arrangement of centers for the direct provision of mental health services; this is not necessarily identical with the way in which the administrative responsibility for mental health programs should be organized. Nevertheless, seeing the way in which respondents with varying program responsibilities state their preferences concerning the arrangement of local mental health services, we would expect that respondents who prefer a separate and unified organization for mental health programs would disproportionally favor separate mental health clinics or centers for meeting local mental health needs. This expectation is borne out. Among respondents preferring that a mental health department be designated as the mental health authority, thirty-one per cent favor separate mental health centers or clinics, compared to six per cent of those who prefer that the authority be located in a public health department. Similarly, among those preferring few or no close relations between mental institutions and the public health departments, thirty-four per cent favor separate centers or clinics, while, among those preferring generally close relations, eighteen per cent favor separation. Twenty-six per cent of the respondents preferring that the institutional and community mental health programs be in the same department favor separate mental health centers or clinics, compared to nineteen

per cent of those preferring that the two programs be in separate departments. Finally, among the respondents who are very or somewhat favorable to a separate and autonomous mental health organization, thirty-eight per cent favor separate mental health centers or clinics, compared to seven per cent of those who are not favorable.

Since the question of how local mental health needs should be served is not quite the same as the overall organization of local mental health programs, we do not necessarily expect that local respondents in localities with separately organized mental health programs would favor separate mental health centers or clinics. As a matter of fact, there is a tendency in this direction. In localities in which the mental health programs are organized separately, sixty-two per cent of the respondents think there should be health centers including mental health centers, and in localities with a somewhat dispersed organization of mental health programs, forty-four per cent think so; but in localities in which the mental health programs are organized as a division of public health, seventy-five per cent of the respondents think highest priority should be given to local health centers including mental health centers.

Determinants of Preferences Concerning Organizational Arrangements

Thus far, in describing the preferences of key public health and mental health officials concerning the organizational arrangements for mental health programs, we have briefly noted the possible effects of three factors upon the respondents' preferences. We have seen that the actual arrangements in their States or localities are related to their preferences. We have noted the marked variation in preferences among respondents with varying program responsibilities and also that preferences concerning one aspect of the organization of mental health activities are related to other

preferences. Now it is necessary to examine these and other possible determinants of the preferences in more detail if we are to draw any conclusions about the bases of the preferences.

We will consider first the relative importance of the respondents' program responsibilities and of their preferences for various aspects of organizational arrangements. We have seen that persons who favor a separate and autonomous mental health organization tend to prefer a unified mental health program. Does this explain the strong association we have seen between program responsibilities and organizational preferences, or, on the contrary, is this a spurious association due to the great importance of program responsibilities as a determinant of preferences? After all, the respondents' preferences for each of the aspects of organizational arrangements are associated with the respondents' program responsibilities. It is necessary to hold each variable constant. In Table 21 A, we can examine the percentage of State public health and mental health respondents who wish to have the institutional and community mental health programs in the same department, holding constant their preferences concerning the location of the mental health authority. We can look at this table in two ways. First, let us consider whether or not the preferences concerning the location of the mental health authority are related to preferences concerning a unified mental health program, holding program responsibilities constant (i.e., by looking across the rows). Among the State mental health respondents, it does appear that those who prefer the authority to be located in a public health department are less likely to want a unified institutional and community mental health department than are those who desire a mental health department or another department or agency to be designated as the authority. Among the State public health respondents, however, there is no clear association between the two preferences.

TABLE 21

ASSOCIATION BETWEEN PREFERENCES CONCERNING THE LOCATION OF THE MENTAL HEALTH AUTHORITY AND THE JOINT OR SEPARATE ADMINISTRATION OF INSTITUTIONAL AND COMMUNITY MENTAL HEALTH PROGRAMS, BY TYPE OF RESPONDENT[a]

A. Proportion of Respondents Preferring the Institutional and Community Mental Health Programs in the Same Department by Preferences Concerning the Location of the Mental Health Authority, by Type of State Respondent

Type of State Respondent	Preferred Location of Mental Health Authority		
	Public Health Department	Mental Health Department	Other Department or Agency
Public health . . .	63 (110)	56 (23)	74 (19)
Mental health . . .	72 (64)	90 (143)	86 (59)

B. Proportion of Respondents Preferring the Mental Health Authority Be Located in a Public Health Department, by Preferences Concerning the Joint or Separate Administration of the Institutional and Community Mental Health Programs, by Type of State Respondent

Type of State Respondent	Preference for Joint or Separate Administration of Institutional and Community Mental Health Programs	
	Same Department	Separate Departments
Public health	72 (96)	72 (46)
Mental health	20 (226)	47 (34)

[a]State alcoholism heads are not included; there are too few cases to percentage.

Now let us look at the same table to see whether or not the respondents' program responsibilities affect their preferences for a unified mental health program, regardless of their preferences for the location of the authority. We can see that in each column the mental health respondents are more likely than the public health respondents to prefer that the institutional and the community mental health programs be in the same department.

Before drawing any conclusions about these associations, let us look at the same information percentaged in the other direction. In Table 21 B, we can see the percentage of the respondents preferring the authority to be located in a public health department among those preferring that the institutional and community mental health programs be in the same and in separate departments. The results are similar to those noted in Table 21 A. It seems safe to say that the respondents' program responsibilities affect their preferences concerning organizational arrangements. Only among the mental health respondents do the preferences for one aspect of the arrangements seem to affect their preferences concerning another aspect; but even among them, regardless of their preference for the location of authority, they tend to want a unified mental health program, and regardless of their preference concerning a unified mental health program, they tend not to want the authority located in a public health department.

Another way of testing the inferences drawn from the data presented in Table 21 is to see the association between the preferences for a unified mental health program and the degree of favorableness for a separate mental health organization. This will also make it possible to consider the association among local as well as State respondents. The data are presented in Table 22. In Part A of the table, holding constant the respondents' program responsibilities, we see that respondents who are favorable to a

separate organization of mental health programs tend to think the institutional and community mental health programs should be in the same department. Among the local public health respondents, this tendency practically disappears. Note that the local respondents were asked about their preferences about a separate mental health organization in their locality and about the joint or separate administration of the two mental health programs in their State. The preferences about having a separate and autonomous mental health organization apparently are related to preferences for joint or separate administration of the institutional and community mental health programs, regardless of the respondents' program responsibilities. Nevertheless, we can also see (looking down the columns) that, regardless of preferences about a separate mental health organization, State mental health respondents are more likely than State public health respondents to favor the joint administration of the institutional and community mental health programs; there are no consistent differences between local mental health and local public health respondents.

Part B of Table 22 shows the same information percentaged in the other direction. Among the State respondents, those who prefer that the institutional and community mental health programs be in the same department are more likely than those who do not to favor an autonomous mental health organization, whether they have mental health or public health responsibilities. On the other hand, program responsibilities, among local as well as State respondents, are still highly related to favoring an autonomous mental health organization, holding constant preferences about the joint or separate administration of the two mental health programs.

The same kind of analysis was made of the relationship between preferences concerning the degree of close relations between mental institutions and public health departments and favoring a separate and autonomous mental health program (see Table 23). Only among the local

TABLE 23

ASSOCIATION BETWEEN PREFERENCES CONCERNING CLOSENESS OF RELATIONS BETWEEN STATE MENTAL INSTITUTIONS AND PUBLIC HEALTH DEPARTMENTS AND PREFERENCES FOR A SEPARATE AND AUTONOMOUS MENTAL HEALTH PROGRAM[a]

A. Proportion of Respondents Preferring Close Relations Between the Mental Institutions and the Public Health Department Generally, by Preferences for a Separate and Autonomous Mental Health Program, by Type of Respondent

Type of Respondent	Preference for a Separate and Autonomous Mental Health Program					
	Very or Somewhat Favorable		Slightly Favorable		Not Favorable	
State, public health .	76	(33)	81	(57)	77	(77)
Local, public health .	50	(16)	68	(38)	78	(65)
State, mental health .	64	(169)	75	(81)	80	(35)
Local, mental health .	48	(69)	44	(34)	60	(15)

B. Proportion of Respondents Very or Somewhat Favorable Toward a Separate and Autonomous Mental Health Program, by Preferences Concerning Closeness of Relations between Mental Institutions and Public Health Departments, by Type of Respondent

Type of Respondent	Preference Concerning Closeness of Relations between Mental Institutions and Public Health Departments			
	Close Generally		Close with Parts or Few or No Relations	
State, public health .	19	(130)	21	(33)
Local, public health .	9	(85)	24	(33)
State, mental health .	55	(197)	69	(83)
Local, mental health .	58	(57)	57	(56)

[a]State alcoholism heads not included; there are too few cases to percentage.

public health and the State mental health respondents is one preference related to the other. The respondents' program responsibilities strongly affect whether or not they favor a separate organization of mental health programs, regardless of their preferences about the relations between mental institutions and public health departments. On the other hand, respondents with different program responsibilities do not differ markedly in their preferences about relations between mental institutions and public health departments, holding constant the degree to which they favor a separate and autonomous organization of mental health programs.

In short, the respondents' program responsibilities appear to affect their preferences for each aspect of the organizational arrangement of mental health programs to some extent independently of their preferences about other aspects of the organizational arrangements. This is particularly true of their preferences for a separate and autonomous mental health organization, and it is most clearly the case for their preferences about the location of the mental health authority. The latter finding suggests that the location of the authority particularly arouses identification with the respondents' official organizational commitment. Yet we cannot write off the preferences about organizational arrangements simply as expressions of organizational loyalties or concerns. We have seen that some preferences about organizational arrangements are related to other preferences, holding program responsibilities constant; for example, we noted that among State respondents there is some relationship between favoring a separate and autonomous mental health organization and preferring that the institutional and community mental health programs be in the same department.

In the first section of this chapter we have noted that the key officials interviewed for this study tend to prefer the existing alternative

for each aspect of the organizational arrangements considered. One might conjecture that this is because they have determined which alternative exists; however, we have seen in Chapter I that population characteristics, particularly density, seem largely to determine the organizational arrangements at the State level and the State organizational arrangements seem strongly to affect the organizational arrangements at the local level. We must conclude that the respondents have not determined the arrangements but, working within the system that they do, see benefits in it. If this is the case, we would expect that respondents would tend to prefer not only the alternative of each aspect of organizational arrangement as it is, but also the form of the other aspects which usually are associated with that alternative. That is, they tend to favor the interlocking set of arrangements.

An opposing hypothesis is tenable. The findings indicate that if one aspect of the arrangements is organized one way, another aspect is usually determined. Every dimension cannot be maximized at the same time. Perhaps, then, in a State in which one aspect is one way, officials feel that something is neglected and tend to prefer that another aspect be organized differently from the way it is. For example, in States in which the institutional and community mental health programs are in the same department, perhaps the respondents tend to favor the designation of the mental health authority in a public health department (where it is not likely to be).

The evidence supports the first hypothesis. For example, as can be seen in Table 24, respondents in States in which the mental health programs are unified are less likely to want the authority in a public health department than are respondents in States in which the mental health programs are not unified. This is true of both public health and mental health respondents. It appears, then, that not only do respondents like the particular form of

each aspect of the organizational arrangements as it exists, but they prefer the total set of arrangements as it is.

TABLE 24

PROPORTION OF STATE RESPONDENTS PREFERRING THAT THE MENTAL HEALTH AUTHORITY BE LOCATED IN A PUBLIC HEALTH DEPARTMENT, BY WHETHER OR NOT THE INSTITUTIONAL AND COMMUNITY MENTAL HEALTH PROGRAMS ARE JOINTLY OR SEPARATELY ADMINISTERED, BY TYPE OF RESPONDENT

Type of State Respondent	Administration of the Institutional and Community Mental Health Programs	
	Same Department	Separate Departments
Public Health[a]	57 (93)	78 (90)
Mental Health	5 (147)	43 (113)

[a]Includes State alcoholism heads.

Given these findings, a related issue deserves comment. Although there is a tendency for respondents to like each aspect of the organizational arrangements as it exists in their State or locality, and even a tendency to like those alternatives which are usually associated with the existing alternative that they prefer, we do find a substantial number of respondents who prefer that the arrangements be different from what they are. Two major explanations are indicated by the evidence already presented. First, the respondents' program responsibilities influence their organizational preferences to some extent, regardless of the existing arrangements in their States or localities. Second, certain alternative forms of organizational arrangement have generally wide support. Thus, there is common support for having the institutional and community mental health programs in the same department even in States in which they are in separate departments (sixty-five per cent of the respondents in such States prefer this), and there is widespread

support for close relations between mental institutions and public health departments even in States which are reported to have few or no close relations (sixty-four per cent of the respondents in States so characterized prefer this).

In Chapter I we saw the high degree to which population characteristics of the States, particularly density, are related to the way State mental health programs are organized. Are the respondents' preferences about organizational arrangements affected by consideration of the population characteristics of their States? There is a tendency for respondents in high density States, compared to those in low density States, to favor a separate and unified organization of mental health programs. This may, however, be due simply to the fact that such organizational arrangements are usually found in high density States and the respondents tend to favor the existing arrangements. It is necessary to hold the existing arrangements constant. If we do so, the relationship between population density and preferences for a separate and unified mental health program disappears. For example, in Table 25 we can see that respondents in high density States are no more likely than those in low density States to favor the joint administration of the institutional and community mental health programs, if we hold constant whether or not the two programs are in the same or separate departments.

TABLE 25

PROPORTION OF RESPONDENTS PREFERRING THAT THE INSTITUTIONAL AND COMMUNITY MENTAL HEALTH PROGRAMS BE IN THE SAME DEPARTMENT, BY STATE POPULATION DENSITY AND BY THE JOINT OR SEPARATE ADMINISTRATION OF THE TWO MENTAL HEALTH PROGRAMS

Population Density	Current Administration of Institutional and Community Mental Health Programs	
	Same Department	Separate Departments
Low	79 (77)	65 (269)
High	76 (222)	62 (58)

In the case of organizational arrangements at the local level, we will simply examine the relationship between the local respondents' preferences for a separate and autonomous mental health organization and the type of community in which they work, without holding the present organizational arrangements constant. There is a slight tendency, as can be seen in Table 26, for respondents in smaller communities to favor a separate and autonomous organization of mental health programs more often than respondents in larger communities or in medical school communities.[3] At first appearance this may seem to be contrary to the findings about the determinants of organizational arrangements at the State level presented in Chapter I. There it was argued that larger and more urban States tended to have a separate organization of mental health programs because there was a sufficient base and support for such organizational differentiation. It appears that at the local level there is respondent support for greater organizational

[3]The same relationship was examined, holding constant whether or not the local mental health programs are separately organized. The relationship persists; there is also an indication that respondents in medical school communities are least favorable to a separate organization of mental health programs, holding constant the actual present organization.

differentiation in the smaller communities. The meaning of a separate mental health organization at the local level should be recalled, however; it often means a quasi-public mental health clinic or center. Apparently, then, in relatively small communities (between 25,000 and 75,000 population), officials tend to favor a separate mental health organization; in larger communities this is less marked, and somewhat more respondents prefer mental health programs not to be organized separately; presumably they would be given more governmental status and less autonomy. Perhaps, then, with a still larger base the governmental organizations can be differentiated again, and there would be support for this among key officials.

TABLE 26

PREFERENCES FOR A SEPARATE AND AUTONOMOUS LOCAL MENTAL HEALTH PROGRAM, BY TYPE OF COMMUNITY, IN PERCENTAGES

Preference for a Separate and Autonomous Mental Health Program	Type of Community		
	Medical School Community	Metropolitan Community	Smaller Community
Very favorable	10	10	12
Somewhat favorable	22	22	31
Slightly favorable	34	30	29
Not favorable	34	38	28
Total per cent . .	100	100	100
Base for percentages	(80)	(81)	(78)
No information . .	(-)	(-)	(1)
Total number . . .	(80)	(81)	(79)

Finally, we can consider the role of population characteristics of the State and community which may affect the priority respondents assign to alternative arrangements of mental health centers and clinics for the provision of local mental health services. We do not have information

about the actual arrangement of such services and therefore cannot hold this constant. Examining the relationship between the type of community in which the local respondent works and his priorities concerning the appropriate organization for local mental health centers, we find that respondents in medical school communities tend to say that local health centers including mental health centers should have the highest priority (seventy-six per cent so replied, compared to fifty-nine and fifty-seven per cent of the respondents in metropolitan and smaller communities, respectively).[4] We can also consider whether or not various population characteristics of the States in which the respondents are employed affect the priority they assign to alternative arrangements of local mental health centers. There is no clear relationship between the per capita income of the respondents' States and the priority they assign. There is an indication that respondents in States with the very smallest population or very lowest density are somewhat more likely than those in the largest or most dense States to give highest priority to "working through other agencies to effect treatment." For example, in the five States with the lowest population density, twenty-two per cent of the respondents choose this arrangement; fourteen per cent of the respondents in the States with the next lowest density make the same choice; at the other extreme, four per cent of the respondents in the five States with the greatest density choose this arrangement.

In short, population characteristics of the States do not seem to affect the respondents' preferences concerning organizational arrangements at the State level, holding present arrangements constant. Concerning

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[4]It should be remembered that medical school communities tend not to have separate mental health organizations (see Chapter I); respondents in such communities tend not to favor a separate mental health organization; and the preferences about a separate mental health organization are highly related to the priority assigned to separate mental health centers or clinics.

arrangements at the local level, considerations of the ecological or population base for the organizational arrangements do seem to have at least some effect upon preferences. On the whole, however, the respondents' own program responsibilities seem to be most highly related to their preferences.

Among the respondents' background characteristics, their professional identifications must be considered. It is not possible to compare respondents with the same professional identifications but with different program responsibilities to see the part each plays in affecting their preferences; this cannot be done because the two are so highly related (see Table B-39). We can, however, see whether or not among public health or mental health respondents professional identifications are related to these preferences. Thus, we can compare public health respondents who consider themselves public health nurses or public health professionals generally. We can compare mental health respondents who consider themselves psychiatrists, clinical psychologists, mental health or psychiatric nurses, or psychiatric social workers. There are some differences among the public health respondents. Public health professionals are somewhat more likely than public health nurses to be very or somewhat favorable to a separate mental health organization (fourteen per cent compared to eight per cent), to prefer having the institutional and community mental health programs in the same department (sixty-one per cent compared to forty-five per cent), and to prefer close relations between the mental institutions and the public health departments generally (seventy-eight per cent compared to sixty-seven per cent). Among the mental health professions there are no marked consistent differences. It should be noted, however, that mental health and psychiatric nurses tend to give highest priority to local health centers including mental health centers to meet local mental health needs (seventy-six per cent, compared to forty-six per cent of the psychiatrists, fifty-six

per cent of the clinical psychologists, and sixty-three per cent of the psychiatric social workers).

Another background characteristic examined was whether or not the respondent is or ever was in private practice (see Table B-42). Holding program responsibilities constant, the only notable marked relationship is among local mental health respondents.[5] Persons with experience in private practice, compared to those without such experience, are more likely to be very or somewhat favorable to a separate mental health organization (sixty-three per cent compared to forty-five per cent). This is not due to the fact that heads of clinics, more than other local mental health respondents, are likely to have been in private practice, since heads of clinics do not disproportionally tend to favor a separate organization of local mental health programs. Apparently the experience itself predisposes the respondents to favor separate organizational mental health programs.

The changing conditions for the provision of mental health needs and the changing ideas about the way in which such needs should be met might result in some variations in judgment between older and younger respondents. The different types of respondents vary considerably in age (see Table B-36); therefore it is necessary to hold the respondents' program responsibilities constant to determine whether or not there are any age differences in expressed preferences. As can be seen in Table 27, younger respondents, compared to older ones, generally tend to believe that the institutional and community mental health programs should be in

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[5]One other relationship deserves mentioning, if only in a footnote: among local public health respondents, those with experience in private practice are more likely to prefer having the institutional and community mental health programs in the same department than are those without such experience (sixty-nine per cent compared to fifty-two per cent).

the same department; only among the local mental health respondents does this relationship not hold.

TABLE 27

PROPORTION OF RESPONDENTS PREFERRING THAT THE INSTITUTIONAL AND COMMUNITY MENTAL HEALTH PROGRAMS BE IN THE SAME DEPARTMENT, BY AGE AND BY TYPE OF RESPONDENT[a]

Type of Respondent	Age of Respondent		
	Under 45 Years	45 to 54 Years	55 or Older
State, public health	68 (34)	60 (66)	53 (70)
Local, public health	63 (30)	68 (44)	53 (45)
State, mental health	83 (139)	87 (97)	79 (53)
Local, mental health	61 (79)	78 (23)	61 (18)

[a]State alcoholism heads not included; too few cases to percentage.

Among State public health respondents, younger respondents are somewhat more likely than older ones to believe that the mental health authority should be located in a mental health department (twenty-three per cent of those under forty-five, fourteen per cent of those forty-five to fifty-four, and twelve per cent of those fifty-five or older). Similarly, among State public health respondents, younger officials are relatively more favorable to a separate and autonomous organization of mental health programs (thirty-one per cent of the officials under forty-five are very or somewhat favorable; as are twenty-one per cent of those forty-five to fifty-four years old; and thirteen per cent of those fifty-five or older are very or somewhat favorable). There is no relationship between age and preferences about the degree of close relations between the mental institutions and public health departments. In the case of the priority assigned to different arrangements for the provision of local mental health services, there is

a tendency among State and local mental health respondents for the older respondents to give highest priority to separate mental health centers or clinics. Nevertheless, the differences in age among the types of respondents does not account for their differences in preferences.

The respondents were also asked three questions which might indicate general orientations about basic issues related to the preferences under study. One question involved the degree to which special training is necessary to help persons with emotional problems. The respondents were asked:

> Which statement comes closest to expressing your judgment:
>
> 1. Emotional problems are so complex that only persons who have been especially trained for many years can give help which will not do more harm than good. [or]
>
> 2. Although emotional problems are very complex, persons with even a little training--and good common sense--can provide considerable help to many people.

The second alternative is chosen by most respondents with each kind of program responsibility (see Table B-33). One might expect that mental health personnel would choose the alternative stressing the importance of training more often than would the public health officials. Actually, there is no marked difference among the types of respondents; if there is any tendency, it is that the State mental health personnel tend to choose the alternative that even a little training and common sense make it possible to help many people with emotional problems, compared to State public health officials who are not heads, or compared to local respondents.

Holding the respondents' program responsibilities constant, those who choose the lengthy-training alternative do not differ from those who choose the little-training-and-common-sense alternative in their preferences for the joint or separate administration of the institutional and community mental health programs or in their preferences concerning the

degree of close relations between the mental institutions and public health departments. Among the State mental health respondents, those who choose the lengthy-training alternative tend to prefer the mental health authority to be located in a mental health department (sixty-eight per cent compared to fifty per cent of those choosing the little-training alternative). There is also some evidence that the belief that only lengthy training can make it possible to help persons with emotional problems is positively related, at least among local respondents, with favoring a separate and autonomous mental health organization. Similarly, those respondents who believe that only lengthy training is helpful give highest priority to separate mental health centers or clinics for meeting local mental health needs. As can be seen in Table 28, this is true for each type of respondent except State public health officials.

TABLE 28

PROPORTION OF RESPONDENTS GIVING HIGHEST PRIORITY TO SEPARATE MENTAL HEALTH CENTERS OR CLINICS FOR MEETING LOCAL MENTAL HEALTH NEEDS, BY BELIEFS ABOUT AMOUNT OF TRAINING NEEDED TO HELP PERSONS WITH EMOTIONAL PROBLEMS AND BY TYPE OF RESPONDENT

Type of Respondent	Beliefs About Amount of Training Needed	
	Lengthy Training	Little Training
State, public health . . .	4 (40)	8 (127)
Local, public health . . .	16 (31)	10 (86)
State, mental health . . .	41 (56)	26 (226)
Local, mental health . . .	68 (34)	43 (84)

These findings indicate that respondents who believe that considerable expertness is required to help persons with emotional problems tend to prefer a separate organization of mental health programs and services;

this is the case, at least, for organizational arrangements at the local level and among mental health respondents. This suggests that concerns about organizational loyalty and official role commitments are not so determining of preferences about local arrangements as State ones and not so determining among mental health respondents as among public health respondents.[6] Nevertheless, it is clear that such beliefs do not explain why the respondents' program responsibilities are so highly related to their preferences concerning organizational arrangements.

The respondents were asked one question about the extent to which public health departments should provide direct treatment services to patients. Each respondent was asked:

> Do you think public health departments should be:
>
> 1. concerned primarily with preventive programs, leaving actual treatment to other public agencies or private practitioners [or]
>
> 2. although maintaining their present preventive functions, they should assume more responsibility for the actual treatment of patients [or]
>
> 3. although maintaining their present preventive functions, they should greatly increase their treatment activities?

The distribution of choices by type of respondent is shown in Table B-34. The third alternative is least likely to be selected (about one person in five does); the first and second alternatives are selected equally often (by about two persons out of five). There is only a little variation in choices among the types of respondents: State public health respondents are somewhat less likely than State mental health heads or hospital-based mental health personnel to choose the more restricted mission entailed by the first alternative.

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[6] This may be due to a greater variety of organizational roles among the mental health respondents than among the public health officials.

Holding the respondents' program responsibilities constant, respondents with differing conceptions of the mission of public health departments do not markedly differ in their preferences about organizational arrangements at the State level. There is one exception--respondents preferring a more limited preventive policy are less likely than the others to want close relations between the mental institutions and public health departments generally.[7] These conceptions, however, do seem to affect preferences about local organizational arrangements. Thus, among the local public health respondents, and particularly among the local mental health respondents, persons believing that the public health departments should be primarily concerned with preventive functions tend to think that the local mental health programs should be separate and autonomous. Similarly, for each type of respondent, those who believe in the more restricted mission of the public health departments tend to think highest priority should not be given to local health centers including mental health centers (see Table 29). Again, it is clear that these orientations do not account for the differences in organizational preferences among types of respondents.

TABLE 29

PROPORTION OF RESPONDENTS GIVING HIGHEST PRIORITY TO LOCAL HEALTH CENTERS INCLUDING MENTAL HEALTH CENTERS FOR MEETING LOCAL MENTAL HEALTH NEEDS, BY ATTITUDES TOWARD GENERAL MISSION OF PUBLIC HEALTH DEPARTMENTS AND BY TYPE OF RESPONDENT

Type of Respondent	Attitude Toward Mission of Public Health Departments		
	Primarily Preventive	Preventive and Increased Treatment	Preventive and Greatly Increased Treatment
State, public health	80 (55)	88 (78)	91 (35)
Local, public health	84 (55)	82 (45)	88 (16)
State, mental health	50 (129)	63 (109)	66 (50)
Local, mental health	42 (52)	45 (42)	54 (22)

[7]This is true for each type of respondent except the State public health respondents; among them, there is no relationship.

Finally, the respondents were asked about the responsibility of public and mental health agencies for treating the non-institutionalized mentally ill. The question was:

> In the case of non-institutionalized persons with severe personality disturbances which seriously interfere with work or marital relations, should public health and mental health agencies--
>
> 1. not try to provide actual therapy, but work on programs which will reduce the incidence of such illnesses (e.g., counseling in well-child clinics) or which will create a climate supportive for seeking therapy (e.g., public education campaigns) [or]
>
> 2. place major emphasis upon preventive programs, but provide some therapeutic services [or]
>
> 3. maintain preventive programs, but provide extensive therapeutic services?

The distribution of choices by type of respondent is shown in Table B-35. There is somewhat more support for treating the mentally ill than is found for the general question about the mission of the public health departments. About one of four respondents choose the first alternative, one-half choose the second, and one out of four choose the third. There are no marked differences among the types of respondents--only a slight tendency for mental health respondents to choose the third alternative more frequently than do public health respondents. Respondents with different conceptions about the responsibility of public agencies for preventive or direct therapeutic services for the mentally ill do not differ in their preferences for any of the aspects of organizational arrangements being considered. Apparently such orientations do not have any implications for preferences concerning organizational arrangements.

In summary, in this chapter we have seen that the key officials interviewed for this study generally prefer more unification between the institutional and community mental health programs than is currently the

case, and they prefer closer relations between mental institutions and the public health departments than is presently true. There are also some notable differences among the respondents: the mental health personnel, particularly those in hospital-based programs, are likely to desire unification of the mental health programs; the wish for closer relations between the mental institutions and the public health departments is particularly likely among the State heads of public health departments. The divergences among the respondents are most marked in answers to questions about the location of the mental health authority and the degree to which the mental health programs should be separate and autonomous.

The differences among the respondents seem in large measure to be due to their organizational and official role commitments and loyalties. This is modified to some extent by preferring the existing arrangements. To some extent, too, their preferences reflect a concern about which programs should be close together. In relationship to preferences for local organizational arrangements, other considerations such as characteristics of the State or locality affect the respondents' preferences. Apparently, at the local level the organizational lines are not so clearly drawn. This last conclusion is supported by the finding that general orientations about the amount of training required for helping emotionally-disturbed persons and the mission of the public health departments are more related to organizational preferences about local arrangements than about State arrangements. Finally, we have seen that younger respondents, independently of program responsibilities, tend to prefer a separate and unified mental health organization. In later chapters we will be able to consider other possible considerations of the respondents which are related to their preferences for various organizational arrangements. For example, in the next part of the

report we turn to an examination of personnel integration, and in Chapter V we will see whether or not preferences about organizational arrangements are related to preferences about the integration of public health and mental health personnel.

CHAPTER III

PRESENT EXTENT OF PERSONNEL INTEGRATION

The organizational arrangements are significant insofar as they affect the ability of an organization to accomplish its mission. Of course there are many missions to be accomplished by such complex organizational structures as those concerned with mental health, public health, and related services: for example, economy of manpower and of money, morale of the staff, and the effectiveness of the services provided. In this report we are particularly concerned with the way in which mental health and public health personnel are utilized in an integrated attack on the tasks of their respective programs.

Such personnel integration in the pursuit of public health and mental health goals is desired because, as noted in the introduction, their activities are converging and their cooperation can improve the services of each profession. The officials' belief in such benefits is documented in the next chapter.

In this chapter we will be concerned with describing the extent of such personnel integration in the States and localities and analyzing the way in which organizational arrangements (as described in Chapter I) affect the extent of personnel integration.

Public health respondents were asked, "Are there any mental health personnel . . . . with whom you personally have any dealings or interaction in the course of your professional work?" Mental health respondents were asked a parallel question about their interaction with public health personnel. There is no doubt that extensive integration exists for the key officials interviewed. Ninety-eight per cent of the State heads of public health programs and ninety-one per cent of the other State public health

respondents reported that they interact with mental health personnel in the course of their professional work; among the local public health officials, the percentage is somewhat smaller: eighty-six per cent (see Table B-6). Conversely, ninety-four per cent of the State heads of mental health programs and ninety per cent of the State mental health persons in community-based programs report interacting with public health personnel; the State mental health respondents in hospital-based programs are relatively more isolated although even eighty per cent of them report such interaction; about the same percentage of local mental health respondents report interaction with the other profession as do the local public health respondents: eighty-seven per cent of them report such interaction (see Table B-7).

But with whom does this interaction occur? The variation among the types of respondents is revealing (see Tables B-8 and B-9). The State heads of public health programs most frequently report interacting with the heads of mental health programs (forty-three per cent of those reporting any interaction mention such persons) or other administrators or boards of mental health agencies (thirty-one per cent mention them). The other State public health respondents also mention the heads of mental health programs (thirty-five per cent mention them) and other administrators or boards of mental health agencies (thirty-three per cent mention them); but they mention mental health or psychiatric nurses as frequently (thirty-two per cent). Among the local public health respondents, psychiatrists, psychiatric social workers, and psychologists are most frequently mentioned (by forty-eight, forty, and thirty-nine per cent, respectively). The pattern among the local public health respondents probably reflects the fact that these three kinds of mental health personnel are usually the core of a local mental health center or clinic. At the State level, the psychiatric nurse, among

the mental health professions, is most likely to be the contact for the public health respondents who are not heads. The State alcoholism respondents usually report interaction with the psychiatric social workers.

In the case of the mental health respondents, the persons with whom they interact were reported and therefore categorized by administrative position and profession and also by the public health program in which the persons with whom they interact are employed (see Table B-9; the public health professions are listed at the top and the public health programs below). Among the professions, the public health nurse is certainly the most frequently mentioned public health person with whom each type of mental health respondent interacts. This may be due to the fact that they constitute such a large proportion of the public health personnel, but it probably also reflects their pivotal role in the cooperation between public health and mental health personnel. As discussed in the next chapter, nursing is one of the public health programs felt to be most in need of increased services of mental health personnel. The State heads of mental health programs most frequently report interacting with the heads of the public health programs. Among the public health programs mentioned, local health services are most frequently mentioned by other State mental health respondents in community-based programs and by local public health respondents. Maternal and child health programs are also relatively frequently mentioned.

The respondents were also asked, "What is the purpose of the interaction?" The detailed results are presented in Tables B-10 and B-11. Among respondents at the State level, the purpose most frequently mentioned is consultation concerning program planning or development; except that State mental health respondents in hospital-based programs are more likely

to mention coordination of treatment or provision of services. We noted earlier that the hospital-based mental health respondents appear to be more isolated from public health personnel than the community-based mental health personnel. If they do interact with public health personnel, they are less likely than the community-based personnel to interact with the heads of the public health programs (nineteen per cent compared to thirty-two per cent; see Table B-9). Related to this, we now see that the hospital-based respondents are less likely than the community-based respondents to consult about program planning or development (twenty-six per cent compared to forty-nine per cent in Table B-11).

At the local level, respondents are more likely to mention referral of cases as the purpose of interaction somewhat more than program planning. The local mental health respondents are most likely to mention case consultation as the purpose of their interaction with public health personnel.

In general, mental health personnel are somewhat more likely than public health officials to mention in-service training as the purpose of the interaction while public health persons are more likely to mention regular administrative liaison, reporting, and supervision.

Certainly a wide gamut of matters is dealt with in the interaction among the types of respondents interviewed for this study. Some of this interaction is required by the administrative organizations within which they function, but most of them report interaction dealing with program planning and coordination and the day-to-day provision of their professional services.

The responses to the question about the purpose of the interaction were also categorized in terms of explicit references to the direction of any aid, training, or consultation given. Thus, a public health person who

said, "They are doing this for us with our problem children, we refer them [the children] for treatment of the problem between the parent and the child," was categorized as receiving aid, training, or consultation; a mental health person who said, "We provide them with written audio-visual material, participants for programs, we are a resource for the State board of health," was coded as giving help. A third category was for mutual aid, training, or consultation. For most respondents, however, there was no explicit indication of the direction of help and these responses were coded indeterminate. As we can see in Table 30, State heads of public health and of mental health are much more likely to indicate that they give rather than receive help. Otherwise, mental health persons are somewhat more likely to indicate that they give help rather than receive it, while public health persons are less likely than mental health respondents to say that they give help; in fact, local public health persons are somewhat more likely to say that they receive help than give it.

TABLE 30

RESPONDENT-INDICATED DIRECTION OF HELP IN INTERACTION BETWEEN PUBLIC HEALTH AND MENTAL HEALTH RESPONDENTS, AMONG RESPONDENTS REPORTING INTERACTION, IN PERCENTAGES

Problems	Respondents Reporting About Interaction with Mental Health Persons				Respondents Reporting About Interaction with Public Health Persons			
	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Comm. Base	Other Hosp. Base	
Receives aid, training, consultation	-	11	16	18	6	1	7	5
Gives aid, training, consultation	14	14	10	18	16	30	11	22
Mutual aid, training, consultation	24	17	12	18	24	28	14	24
Indeterminate	62	58	62	46	54	41	68	49
Total per cent	100	100	100	100	100	100	100	100
Base for percentages	(42)	(116)	(102)	(28)	(63)	(113)	(72)	(101)
Inapplicable and no answer	(1)	(14)	(18)	(6)	(11)	(16)	(18)	(19)
Total number	(43)	(120)	(120)	(34)	(74)	(129)	(90)	(120)

Mental health respondents tend to say that they give aid, but perhaps this should be viewed as servicing others and subordinating themselves rather than the opposite. We have already seen that the manifest purpose of the interaction frequently reported by public health officials is administrative liaison, reporting, and supervision. Perhaps here is one of the bases for the mental health respondents' preference for a separate and autonomous mental health organization.

The Utilization of Public Health Personnel in Mental Health Programs

In this section we will review the extent to which public health personnel are reported to participate in direct mental health programs. In each State, the heads of the public health and mental health programs were asked to report whether or not persons from certain public health departments were in any way involved in certain direct mental health programs. In the first part of the questionnaire the definition for direct mental health programs that was to be used in answering the questions was provided:

> By "direct" mental health programs are meant agency programs in which the primary responsibility is either: 1) care, treatment or rehabilitation, on an in-patient or out-patient basis, of persons whose primary disorder has been labeled as mental or emotional disorder; or 2) mental health education and promotion for the general public; or 3) some combination of the above two types of functions. (Thus, a vocational rehabilitation agency which concerns itself with the rehabilitation of some mental patients does not have that responsibility as its primary or major function, and would not be defined as a "direct" mental health program. If mental health personnel talk with parent-teacher groups on occasion, that would be defined as part of a "direct" mental health program, but if they consult, provide in-service training, or mental health education for the school or other agency program, that will be considered as the use of mental health personnel, with their concepts and techniques, in other health or health-related programs.)

This definition should be kept in mind for the entire discussion of direct mental health programs in this report.

The reports by the several respondents of each State were combined to yield a summary description for the State as a whole. In most States there were two or three respondents whose reports were used. In a few instances persons who were not heads of public health or mental health programs were asked to provide the information if the heads were not available for interviews. In some States persons who were not heads provided such information in addition to reports from the heads; this additional information was used in the preparation of the summaries. In a few States we had to depend upon a single informant. In each case we used all the information available to us from the entire interview in order to reconcile any discrepancies among the reports. There were discrepancies and their resolution was often difficult. More often than not, if one person reported cooperation in a particular program while another person did not, and we had no direct evidence to the contrary, the State was categorized as having cooperation in that program. As a result, if there is any systematic bias in the summaries, it is in the direction of overstating the extent to which public health personnel help provide direct mental health services and, in the next sections, the extent to which mental health personnel work in public health and other non-direct mental health programs.

The results are presented in Table 31. Mental health education is reported to involve the most extensive participation of persons from public health programs. This involvement is most likely to be by persons from the health education departments; persons from the public health nursing departments are almost as frequently involved. Supportive services for patients receiving therapy and supportive services for families of patients are the two other direct mental health programs which are reported to involve relatively extensive use of public health personnel. In these programs it is

TABLE 31

UTILIZATION OF PUBLIC HEALTH PERSONNEL IN DIRECT MENTAL HEALTH PROGRAMS, SUMMARY OF REPORTS FROM FIFTY STATES

Mental Health Program	Public Health Department						No Such Personnel Used	No Such State Program	No Information	Total Number of States
	Maternal and Child Health	Nursing	Health Education	Vital Statistics and Research	Hospital and Medical Facilities	Local Health				
Diagnosis	31	20	10	15	20	28	9	-	1	50
Therapy	20	22	10	10	21	20	13	-	1	50
Supportive services for patients receiving therapy .	21	42	12	10	22	31	5	-	-	50
Supportive services for families of patients	22	42	13	10	18	32	2	-	-	50
Services for patients leaving or formerly in mental hospitals	12	41	7	9	22	34	2	1	-	50
24-hour emergency service . .	1	6	1	2	11	7	17	16	2	50
Mental health education . . .	24	38	45	19	19	29	1	-	-	50
Utilization of nursing homes, half-way houses, sheltered work shops, etc.	7	22	9	7	28	21	5	6	1	50

personnel from the nursing departments who are most likely to be utilized. Persons from the local health departments are also frequently reported to be involved. Finally, two other direct mental health programs are relatively frequently reported to utilize public health personnel: diagnosis and services for patients leaving or formerly in mental hospitals. On the whole, few States are reported to have no utilization of personnel from the public health departments specified in the questionnaire in the specified direct mental health programs.

It is also worth noting that of the public health departments being considered, personnel from the nursing departments are reported to be most extensively used in the various mental health programs. This is certainly consistent with what we have seen of the mental health respondents' reports about the kinds of public health personnel with whom they interact. Persons from the local health services are reported to be utilized almost as extensively. Persons from hospital and medical facilities and persons from maternal and child health departments are reported third and fourth, respectively.

Similar information was obtained from the respondents in local communities. Their reports were summarized as were those from State respondents; the summaries for each of the 123 localities are usually based upon two informants but there are fewer localities than States in which more than two respondents provided information. The results of the summaries for the localities are presented in Table 32; the results are presented in percentages and the figures in the State summary (Table 31) should be doubled to make them comparable. Thus, for thirty-one of the fifty States, or sixty-two per cent of the States, there is some utilization of personnel from maternal and child health departments in diagnosis; thirty-three per cent of the localities are reported to have such utilization. Note, too, that Local Health Services is omitted from the public health departments in the localities because it is a State program.

TABLE 32

UTILIZATION OF PUBLIC HEALTH PERSONNEL IN DIRECT MENTAL HEALTH PROGRAMS, SUMMARY OF REPORTS FROM 123 LOCALITIES, IN PERCENTAGES

Mental Health Program	Public Health Department					No Such Personnel Used	No Such Local Program	No Information	Total per cent	Total Number of Localities
	Maternal and Child Health	Nursing	Health Education	Vital Statistics and Research	Hospital and Medical Facilities					
Diagnosis	33	36	10	12	33	29	3	4	160	123
Therapy	18	28	9	7	28	38	3	6	137	123
Supportive services for patients receiving therapy	27	69	9	8	25	15	2	4	159	123
Supportive services for families of patients	28	63	11	7	22	17	3	6	157	123
Services for patients leaving or formerly in mental hospitals	15	56	12	7	23	21	5	5	144	123
24-hour emergency service	1	6	-	2	23	31	33	10	106	123
Mental health education	33	52	42	8	18	20	5	6	184	123
Utilization of nursing homes, half-way houses, sheltered work shops, etc.	9	34	6	2	18	30	20	6	135	123

The reports from the local respondents clearly indicate that there is less utilization of public health persons in mental health programs at the local level than at the State level. For nearly every mental health program and for personnel from nearly every public health department, there are a substantially larger proportion of States than localities in which utilization is reported. The patterns of relative utilization, however, are similar. Mental health education relatively frequently has some utilization of public health personnel and particularly from the nursing and health education departments; persons from the health education are more often used at the State level than at the local level, presumably because localities are less likely to have such relatively large public health education departments as do the States. Supportive services for patients receiving therapy and supportive services for families of patients also relatively frequently involve public health personnel, and again, as at the State level, personnel from the nursing departments are most likely to be used. Again,too, diagnosis and services for patients leaving or formerly in mental hospitals relatively often use public health personnel.

Of the public health department personnel being considered, as among the States, personnel from the nursing departments are most frequently mentioned as being utilized in direct mental health programs at the local level. Personnel from the hospital and medical facilities and the maternal and child health departments are next most frequently utilized.

Now we can examine whether or not the State and local organizational arrangements for the provision of mental health services are associated with different degress of utilization of public health personnel in direct mental health programs. We will consider the relationships at the State level first. In order to facilitate the analysis of the determinants and consequences of the utilization of public health personnel in direct mental health programs,

a score was constructed for each State.[1] Looking at question 10 in the interview schedule in Appendix C will aid in understanding the procedure. Of the remaining seven mental health programs, a score was derived by first counting the number of public health departments reported to be involved in each of the mental health programs. Then this sum was divided by the highest possible sum (forty-two) minus six for each program for which we had no information. The resulting percentage is not decreased by lack of information for a particular program, but it is reduced by the absence of any of the seven mental health programs used in the calculations.

The States were ranked in the order of their percentage score for the use of public health personnel in mental health programs. Then the States were divided into four approximately equal quartiles: the highest quartile (thirteen States) with a score of fifty-four per cent or higher, the second quartile (twelve states) scored forty per cent to fifty-two per cent, the third quartile (thirteen States) scored thirty per cent to thirty-eight per cent, and the fourth quartile (twelve States) scored twenty-six per cent or lower.

This categorization of the States makes it possible to see whether there is any association between the utilization of public health personnel in direct mental health programs and the organizational arrangements previously considered. The data are presented in Table 33. We can see that States in which the mental health authority is located in a department of mental health are least likely to have extensive utilization of public health personnel in mental health programs. Thus, of the States in which the authority is located in a department of mental health, twenty-five per cent (three out of twelve States) are ranked in the upper half in terms

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[1]The 24-hour emergency service program was not included in the score.

TABLE 33

UTILIZATION OF STATE PUBLIC HEALTH PERSONNEL IN DIRECT MENTAL HEALTH PROGRAMS AND ASPECTS OF THE ORGANIZATION OF STATE MENTAL HEALTH PROGRAMS

Utilization of Public Health Personnel in Direct Mental Health Programs, States Ranked in Quartiles	Location of Mental Health Authority			Relationship Between Mental Institutional Programs and Public Health Departments			Administration of Institutional and Community Mental Health Programs		Characterization of State Mental Health Organization		
	Public Health Dept.	Mental Health Dept.	Other Dept., Agency	Close, Generally	Close, Part	Few or No	Same Dept.	Separate Depts.	Separate and Autonomous	Division of Public Health	Somewhat Dispersed
First quartile	7	-	6	1	10	2	5	8	3	6	4
Second quartile . . .	7	3	2	2	9	1	7	5	5	5	1
Third quartile	7	5	1	4	4	5	7	6	5	5	2
Fourth quartile . . .	4	4	4	-	0	3	7	5	8	3	-
Number of States . . .	25	12	13	7	32	11	26	24	21	19	7

of utilization; of the States in which the authority is located in the public health department, fifty-six per cent (fourteen out of twenty-five States) are ranked in the upper half; and of the States in which the authority is located in another department or agency, sixty-two per cent (eight out of thirteen States) are ranked in the upper half.

Utilization is also relatively high in States in which the mental health programs are characterized as being a division of public health and particularly, if they are dispersed rather than separate and autonomous. There is only a small tendency for relatively high utilization to be more likely in States in which the institutional and community mental health programs are in different departments rather than in the same department. Finally, it appears that the utilization of public health personnel in direct mental health programs is not consistently associated with the degree to which the mental institutions have close relations with the public health departments.

In general, in States in which the mental health programs are administratively separate, there is least likely to be relatively high utilization of public health personnel in direct mental health programs. More surprisingly, perhaps, the utilization is highest in States in which the mental health programs are dispersed rather than a division of public health or in which the authority is not located in a public health or mental health department. Whether or not the mental health programs are unified is not markedly related to the utilization of public health personnel.

We can review the possible effects of other State characteristics upon the extent to which persons in various public health departments provide services in direct mental health programs. We have reports from each State concerning the year in which a separately organized government agency

responsible for community mental health activities was organized. States with longer-established agencies are no more likely than States with recently established agencies to have relatively high utilization of public health personnel in mental health programs.

The population characteristics of the States, population size and per capita income are also unrelated to this measure of utilization. There is a tendency for States with low densities to be more likely to have relatively high utilization. Given the high degree of association between density and the organization of mental health programs and the relationship between these organizational arrangements and utilization, however, the relationship between density and utilization may be an artifact. The small number of cases, the high association between density and organizational arrangements, and the moderate association between each and utilization make it impossible to determine whether or not density independently affects utilization.

Finally, the number of psychiatrists per 100,000 population in each State was compared to the extent of utilization.[2] This characteristic is also unrelated to the degree of utilization of public health personnel in mental health programs.

Are the findings concerning the relationship between the utilization of public health personnel in direct State mental health programs and the State organizational arrangements for the provision of mental health services similar among the localities? A summary score for each locality was established using the same procedure as for the States, although the number of public health departments was reduced from six to five because the Local Health Services was omitted. Since the utilization is generally lower among

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[2]The information was for 1959; it was taken from Table 6 of Fifteen Indices: An Aid in Reviewing State and Local Mental Health and Hospital Programs, Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, January, 1960.

the localities than among the States, the resulting percentages are lower. The localities were divided into four approximate quartiles as were the States; but the first quartile of localities consists of those with percentage scores of twenty-eight or above; the second quartile are those with scores of fifteen through twenty-seven; the third quartile are those with scores of eight through fourteen; and the lowest quartile consists of localities with scores of seven or less.

TABLE 34

UTILIZATION OF LOCAL PUBLIC HEALTH PERSONNEL IN DIRECT MENTAL HEALTH PROGRAMS BY CHARACTERIZATION OF LOCAL MENTAL HEALTH ORGANIZATIONS, IN PERCENTAGES

Utilization of Public Health Personnel in Direct Mental Health Programs, Localities Ranked in Quartiles	Characterization of Local Mental Health Organization	
	Separate and Autonomous	Not Separate and Autonomous
First quartile	21	32
Second quartile	26	20
Third quartile	23	34
Fourth quartile	30	14
Total per cent	100	100
Base for percentages . . .	(70)	(44)
No information[a]	(-)	(-)
Total number	(70)	(44)

[a]The organization of the mental health programs could not be characterized for nine localities.

Comparing localities with differently organized mental health programs, as we did with the States, we find that in localities in which the mental health programs are not separate and autonomous there tends to be relatively higher utilization of public health personnel in mental health

programs (see Table 34). This replication of the association found at the State level gives added support to the interpretation that organizational arrangements do affect the extent to which public health personnel are used in programs concerned with mental hygiene.

Unlike the finding in the analysis of the States, there is a tendency for localities with longer existing separately organized community mental health government agencies, compared to those with no or more recently established agencies, to report more extensive use of public health personnel in local mental health programs (see Table 35). Presumably, with the passage of years, more personnel integration develops--at least at the local level; apparently other factors are of more overwhelming importance at the State level.

TABLE 35

UTILIZATION OF LOCAL PUBLIC HEALTH PERSONNEL IN DIRECT MENTAL HEALTH PROGRAMS BY ESTABLISHMENT OF A SEPARATE GOVERNMENT AGENCY WHICH HAS PRIMARY RESPONSIBILITY FOR COMMUNITY MENTAL HEALTH PROGRAMS, IN PERCENTAGES

Utilization of Public Health Personnel in Direct Mental Health Programs, Localities Ranked in Quartiles	Establishment of Separate Government Agency		
	No Separate Agency	Established 1950 or Later	Established 1949 or Earlier
First quartile . . .	20	25	39
Second quartile . .	30	18	17
Third quartile . . .	24	32	22
Fourth quartile . .	26	25	22
Total per cent . . .	100	100	100
Base for percentages	(50)	(40)	(23)
No information[a] . .	(-)	(-)	(-)
Total number.	(50)	(40)	(23)

[a]Information about the establishment of a separate government agency was unavailable for ten communities.

Different types of communities do vary in the extent to which personnel from various public health departments are used in direct mental health programs. As can be seen in Table 36, medical school communities are most likely to have relatively extensive utilization. The large metropolitan communities, although they are not reported to have as extensive utilization as the medical school communities, tend to have more than the smaller communities. We have seen in Chapter I that mental health programs are somewhat less likely to be separate and autonomous in medical school than in other communities and this can help explain their relatively high utilization. The differences among the community types also may be due to greater experimentation and innovation in personnel integration in medical school communities and in larger as compared to smaller communities. There is a tendency for new developments in the use of mental health personnel outside of direct mental health programs to be reported more often in medical school communities than in large metropolitan communities and least in smaller communities (see Part V of the report).

TABLE 36

UTILIZATION OF LOCAL PUBLIC HEALTH PERSONNEL IN DIRECT MENTAL HEALTH PROGRAMS BY TYPE OF COMMUNITY, IN PERCENTAGES

Utilization of Public Health Personnel in Direct Mental Health Programs, Localities Ranked in Quartiles	Type of Community		
	Medical School Community	Metropolitan Community	Smaller Community
First quartile	37	20	20
Second quartile	24	30	20
Third quartile	18	32	27
Fourth quartile	21	18	33
Total per cent . .	100	100	100
Base for percentages	(38)	(40)	(45)
No information . .	(-)	(-)	(-)
Total number . . .	(38)	(40)	(45)

In summary, at both the State and local level, organizational arrangements for the provision of mental health services appear to be related to the utilization of public health personnel in mental health programs. Utilization is likely to be lower when the mental health programs are separately organized than when they are not. At the local level, communities with relatively long-established separate government agencies with responsibility for mental health programs tend to have more utilization of public health personnel; medical school communities have the most and the smaller communities the least utilization.

The Utilization of Mental Health Personnel in Public Health Programs

The heads of the mental health and public health programs in each State and each of the localities selected for study were asked to report the extent to which mental health personnel are being utilized in various public health, welfare, and other programs. For purposes of this study, the respondents were given this definition of "mental health personnel":

> By "mental health personnel" we mean a person who is employed in an agency (hospital or community, public or private) full- or part-time, and who has at least some professional training in one of the following fields: psychiatry, clinical psychology, psychiatric social work, psychiatric or mental health nursing, or mental health education. "Mental health personnel" includes generic social workers if they have had some experience in a "direct" mental health program; it also includes social scientists if they have had some experience in a "direct" mental health program. (This definition excludes persons in private practice, unless they spend some of their time in work with an agency.)

This definition will be the one used throughout the report. In this section of the report we will examine the extent of utilization of such mental health personnel in public health programs; in the next section of this chapter we will examine their utilization in other non-direct mental health programs. The respondents were asked to report the extent of utilization in the following terms: full-time person(s) employed, part-time person(s) employed,

frequent consultation (at least once a week), occasional consultation, and in-service training (see question 11 of the interview schedule). By employment was meant that one or more persons gave full- or part-time services, regardless of who employed him, in the program being considered. Of course, in a given State or locality, for a given program, various mental health personnel might be used as occasional consultants and others to provide in-service training; in that case, both kinds of utilization would be indicated.

The reports from all the respondents in the same State or the same locality were combined to give a complete picture of utilization in each State and locality. Information from other portions of the interviews and information from published sources about the programs were used to help reconcile discrepancies.

The summary of reports about the utilization of mental health personnel in public health programs in the fifty States is presented in Table 37. Utilization is reported to be most extensive in the public health nursing program, in the alcoholism program, and in the hospitals and medical facilities program. Thus, only one of the fifty States is reported not to be using any mental health personnel in any way in the nursing program, while thirty-one of the States are reported to have at least one mental health person working full-time in that program and twenty-four States report frequent consultation. Utilization is also relatively extensive in the aging, maternal and child health, school health, local health services, and health education programs. It is clear that "no utilization" is reported most frequently in the environmental sanitation and dental health programs. No utilization is also relatively frequently reported for the occupational health and communicable disease programs.

TABLE 37

EXTENT OF UTILIZATION OF MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS, SUMMARY OF REPORTS FROM FIFTY STATES

Public Health Program	Extent of Utilization						No uch State Program	No Information	Total Number of States
	Full-time Person Employed	Part-time Person Employed	Frequent Consultation	Occasional Consultation	In-service Training	No Utilization			
Communicable diseases . .	9	4	4	17	3	21	-	-	50
Chronic diseases	15	5	9	21	10	10	-	-	50
Aging	20	10	11	26	12	4	-	-	50
Dental health	5	4	1	12	4	32	-	1	50
Maternal and child health.	19	12	17	22	12	3	-	-	50
Nursing	31	7	24	13	20	1	-	-	50
Environmental sanitation .	3	3	-	7	3	39	-	1	50
Occupational health . . .	5	3	3	15	5	28	1	1	50
Health education	19	7	22	21	12	3	-	-	50
Hospitals and medical facilities	28	9	17	24	12	5	-	1	50
Vital statistics and research	21	11	9	15	8	16	-	-	50
Drug addiction	19	8	11	24	6	2	4	2	50
Alcoholism	28	16	16	21	10	3	1	-	50
School health	12	16	22	20	12	1	-	-	50
Crippled children	12	12	12	25	7	9	-	-	50
Local health services . .	16	15	20	23	11	4	-	-	50

Mental health personnel appear to be used most frequently to provide occasional consultation. In-service training is most widely used in the nursing programs. Mental health persons are used on a full-time basis most commonly in the nursing, hospitals and medical facilities, and alcoholism programs.

The reports by respondents in the same localities were also combined to yield a description of the use of mental health personnel in public health programs in the localities selected for this study. In the localities, however, the Local Health Services program was omitted because it is a State public health program.

The summary of the reports of the localities is presented in Table 38. As in the use of public health personnel in mental health programs discussed in the preceding section, it is clear that there is more personnel integration at the State level than at the local level. For every public health program reported upon, a larger proportion of the States than of the localities is reported to have some utilization of mental health personnel.

Nevertheless, the pattern of utilization is similar. Utilization is most frequently reported in the nursing and school health programs in the localities. Utilization is also relatively frequently reported for the health education, hospitals, and alcoholism programs, followed by the maternal and child health and aging programs. Utilization is least, as among the States, in dental health and environmental sanitation programs.

Occasional consultation, as among the States, is the most common form of utilization, in-service training is not very widespread except in the nursing programs; thirty-seven per cent of the localities are reported to use some mental health personnel to provide in-service training. Mental health personnel are used on a full-time basis most commonly in the school health, hospitals, and alcoholism programs.

TABLE 38

EXTENT OF UTILIZATION OF MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS, SUMMARY OF REPORTS FROM 123 LOCALITIES, IN PERCENTAGES

Public Health Program	Extent of Utilization						No Such Local Program	No Information	Total Percentage	Total Number of Localities
	Full-time Person Employed	Part-time Person Employed	Frequent Consultation	Occasional Consultation	In-Service Training	No Utilization				
Communicable diseases	11	4	2	27	7	56	6	2	115	123
Chronic diseases	19	12	12	33	13	30	9	2	130	123
Aging	19	13	8	41	11	24	12	4	132	123
Dental health	6	2	2	5	3	67	17	2	104	123
Maternal and child health	24	17	27	30	24	24	2	3	151	123
Nursing	26	16	30	30	37	13	2	3	157	123
Environmental sanitation	4	2	1	11	4	67	11	5	105	123
Occupational health	2	2	2	18	2	54	19	3	102	123
Health education	19	15	18	41	18	19	2	5	137	123
Hospitals and medical facilities	36	15	15	24	13	22	7	3	135	123
Vital statistics and research	17	11	6	18	2	43	8	4	109	123
Drug addiction	16	9	5	19	2	33	28	3	115	123
Alcoholism	30	15	15	28	7	22	12	3	132	123
School health	37	20	40	23	15	13	2	2	152	123
Crippled children	18	11	15	34	8	27	10	3	126	123

Now let us see if organizational arrangements or other factors are related to the extent of utilization of mental health personnel in public health programs. In order to make such an analysis, it is necessary to develop a summary score for the extent of utilization. In the case of the States, the following procedure was used: For each mental health program, the use of full-time person(s) was weighted four; part-time person(s) three; frequent consultation, two; occasional consultation, one; and in-service training, two. The highest possible sum for each program is thus twelve and for all sixteen public health programs, the highest possible sum would be 192. The utilization of mental health personnel was thus summed and divided by 192, minus twelve for any program about which we lacked information. The States were then ranked in terms of the resulting percentages and divided into four approximately equal groups: the highest quartile (twelve States) had scores of thirty-five per cent or higher; the second quartile (twelve States) had scores of twenty-five per cent to thirty-four per cent; the third quartile (thirteen States) had scores of fifteen to twenty-four per cent; and the fourth quartile (thirteen States) had scores of eleven per cent or less.

The location of the mental health authority is related to the participation of mental health personnel in public health programs similarly to the way we have seen it is related to the participation of members of the public health departments in direct mental health activities. In each case, personnel integration is least extensive in States in which the authority is located in a mental health department (see Table 39). The effect of whether the authority is located in a public health or "other" department or agency, however, differs for the two kinds of personnel integration.

TABLE 39

UTILIZATION OF STATE MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS AND ASPECTS OF THE ORGANIZATION OF STATE MENTAL HEALTH PROGRAMS

Utilization of Mental Health Personnel in Public Health Programs, States Ranked in Quartiles	Location of Mental Health Authority			Relationship Between Mental Institutional Programs and Public Health Departments			Administration of Institutional and Community Mental Health Programs		Characterization of State Mental Health Organization		
	Public Health Dept.	Mental Health Dept.	Other Dept., Agency	Close, Generally	Close, Part	Few or No	Same Dept.	Separate Depts.	Separate and Autonomous	Division of Public Health	Somewhat Dispersed
First quartile	6	2	4	3	7	2	7	5	5	6	1
Second quartile . . .	8	2	2	2	6	4	5	7	3	7	1
Third quartile	6	5	2	1	10	2	8	5	7	4	2
Fourth quartile . . .	5	3	5	1	9	3	6	7	6	2	3
Number of States . . .	25	12	13	7	32	11	26	24	21	19	7

We saw that public health personnel are most likely to participate in mental health programs in States in which the authority is located in an "other" department or agency; but in such States, mental health personnel appear to be less likely to be utilized in public health programs than in States in which the authority is in a public health department. Furthermore, while we saw that public health personnel are most likely to be utilized extensively in mental health programs in States in which the mental health programs are somewhat dispersed, mental health personnel are least likely to be used extensively in public health programs in such States. In addition, while members of the public health departments are more likely to participate in mental health programs if the institutional and community mental programs are not in the same department, there is no relationship between this aspect of organizational arrangements and the utilization of mental health personnel in public health programs.

Perhaps it is easier for public health personnel to become involved in mental health activities when those activities are dispersed, but difficult for mental health personnel to become involved in public health programs if the mental health personnel are in dispersed programs. Perhaps too, the desire to become involved in other programs is affected by the officials' satisfaction with their organizational arrangements and any given organizational arrangement would satisfy members of the two kinds of professions differently. As a matter of fact, as we will see in Chapter V, public health officials in States in which the mental health programs are characterized as organized as a division of public health are most likely to favor increased utilization of mental health personnel, while mental health respondents in States in which the mental health programs are autonomously organized are most likely to favor increased utilization of mental health personnel in public health and other-related programs.

The many ways in which organizational arrangements may affect personnel integration makes it likely that not all aspects of the arrangements will be related in the same way to all measures of personnel integration. Some of these effects may be consistent enough so that a particular form of one aspect of the organizational arrangements may affect the extent of integration of mental health and public health personnel in each others' programs. Thus, we have seen that public health personnel are least likely to participate extensively in States in which the mental health authority is located in a mental health department and mental health personnel are least likely to be involved extensively in public health programs in such States.[3]

There is another kind of data from the interviews which may help clarify the possible relationships between organizational arrangements and the degree of personnel integration. In Tables 40 and 41 we can see the proportion of public health respondents who reported interacting with mental health personnel and the proportion of mental health respondents who reported interacting with public health personnel in States with different organizational arrangements. The results are not definitive. There is only a slight tendency for a greater proportion of respondents to report interaction in States in which the mental health programs are a division of public health or in which the public health department is designated as the mental health authority.

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[3]Although we found no association between utilization of public health personnel in mental health programs and the degree of close relations between mental institutions and public health departments, we do find that in States in which the relations between mental institutions and the public health departments are close generally, utilization of mental health personnel in public health departments tends to be higher than in States in which there are few or no relations.

TABLE 40

PROPORTION OF STATE PUBLIC HEALTH RESPONDENTS REPORTING INTERACTION WITH MENTAL HEALTH PERSONS AND PROPORTION OF STATE MENTAL HEALTH RESPONDENTS REPORTING INTERACTION WITH PUBLIC HEALTH PERSONS IN STATES WITH DIFFERENT LOCATIONS OF THE MENTAL HEALTH AUTHORITY

Location of the Mental Health Authority	Proportion of State Respondents Reporting Interaction	
	Public Health[a]	Mental Health
Department of public health	97 (103)[b]	90 (121)
Department of mental health	86 (50)	91 (77)
Other department or agency.	93 (45)	79 (78)

[a]Includes heads of alcoholism programs.

[b]Number in parentheses is the number of cases upon which percentage is based.

TABLE 41

PROPORTION OF STATE PUBLIC HEALTH RESPONDENTS REPORTING INTERACTION WITH MENTAL HEALTH PERSONS AND PROPORTION OF STATE MENTAL HEALTH RESPONDENTS REPORTING INTERACTION WITH PUBLIC HEALTH PERSONS IN STATES WITH DIFFERENT CHARACTERIZATIONS OF THE MENTAL HEALTH ORGANIZATIONS

Characterization of the State Mental Health Organization	Proportion of State Respondents Reporting Interaction	
	Public Health[a]	Mental Health
Separate and autonomous . .	90 (79)[b]	85 (133)
Division of public health .	96 (82)	91 (90)
Somewhat dispersed	94 (31)	81 (37)

[a]Includes heads of alcoholism programs.

[b]Number in parentheses is the number of cases upon which percentage is based.

We must conclude that the organizational arrangements are not as clearly associated with the utilization of mental health persons in public health programs as they are associated with the utilization of ~~mental~~ public health persons in ~~public~~ mental health programs. There is only a tendency for utilization of mental health persons in public health programs to be more extensive in States in which the mental health programs are part of public health rather than separate.

Now let us consider whether other State characteristics are associated with the extent to which persons trained in the mental health professions are used in various public health programs. The number of years a separately organized government agency with primary responsibility for community mental health programs has been established is not related to this measure of personnel integration. The number of psychiatrists per 100,0000 population in the State is also not related. Among the population characteristics of the States, population density and per capita income are not related. Population size, however, is somewhat associated: States with larger populations tend to have more extensive utilization of mental health personnel in public health programs than do smaller-population States.

The localities were categorized by a procedure similar to the one used to categorize the States for the extent to which mental health personnel are used in public health programs. In the case of the localities, the Local Health Services was omitted from the public health programs and a slight modification of the weighting method was followed.[4]

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[4]The modification was adopted because of the possibility that a few respondents considered the various possible uses of mental health personnel as a scale rather than as independent of each other. Thus, they may have reported that some mental health persons worked full-time in a particular program; since that was listed first among the possible kinds of utilization, they may have felt it unnecessary to say that other mental health personnel were also used to provide occasional consultation in that program. On the other hand, a respondent may have said: "all uses" and every one of the kinds of uses would have been checked when that was an exaggeration. These

In localities in which the mental health organization is separate, compared to those in which it is not, the use of mental health personnel in public health programs tends to be less extensive (see Table 42). There is more clearly confirming evidence for this relationship at the local level than at the State level. Public health and mental health respondents in localities in which the mental health organization is separate are less likely to interact with each other than are those in localities in which it is not (see Table 43).

TABLE 42

UTILIZATION OF LOCAL MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS BY CHARACTERIZATION OF LOCAL MENTAL HEALTH ORGANIZATIONS, IN PERCENTAGES

Utilization of Mental Health Personnel in Public Health Programs, Localities Ranked in Quartiles	Characterization of Local Mental Health Organization	
	Separate and Autonomous	Not Separate and Autonomous
First quartile	19	30
Second quartile	26	27
Third quartile	24	23
Fourth quartile	31	20
Total per cent . . .	100	100
Base for percentages.	(70)	(44)
No information[a] . . .	(-)	(-)
Total number of cases	(70)	(44)

[a]The organization of the mental health programs could not be characterized for nine localities.

problems are less significant for the State summaries because we usually had more than one and often more than two informants for each State. It was felt best, however, to make a slight modification in the case of the localities and, in the next chapter, in the case of an individual's preferences. In all comparisons of percentages between the State and the locality or between the individual and his State or his locality, the same modified procedure was used. That is, the State scores were also computed in the modified way for comparison purposes.

The modification was as follows: If a State, locality, or individual reported only "full-time person(s) employed" for a given program, instead of getting a weight of four for that program, it was raised to six. If only a "part-time person(s) employed" was reported, then instead of a weight of three, a weight of four was given for that program. On the other hand, if each and every kind of use was given, instead of the total weight of twelve, a total weight of eleven was given.

TABLE 43

PROPORTION OF LOCAL PUBLIC HEALTH RESPONDENTS REPORTING INTERACTION WITH MENTAL HEALTH PERSONS AND PROPORTION OF STATE MENTAL HEALTH RESPONDENTS REPORTING INTERACTION WITH PUBLIC HEALTH PERSONS IN LOCALITIES WITH DIFFERENT CHARACTERIZATIONS OF THE MENTAL HEALTH ORGANIZATIONS

Characterization of the Local Mental Health Organization	Proportion of Local Respondents Reporting Interaction	
	Public Health	Mental Health
Separate and autonomous . .	82 (66)	83 (76)
Not separate and autonomous.	96 (45)	94 (36)

In addition to the organizational arrangement of mental health programs, the length of time that a separately organized government agency primarily responsible for community mental health activities has existed is related to the degree to which mental health personnel are used in public health programs. As can be seen in Table 44, localities with longer established government agencies responsible for mental health programs are slightly more likely to have relatively high utilization of mental health personnel in public health programs than are localities with no such agency.

The relationship between the type of community and extent of utilization of mental health personnel in public health programs is shown in Table 45. Clearly, medical school communities are most likely to have relatively high utilization of persons trained in the mental health professions used in public health programs; smaller communities are least likely to have relatively high utilization. This may be due to greater experimentation with personnel integration, as noted in the discussion of the relationship between community type and the utilization of public health personnel in direct mental health programs in the previous section. There may also be more interest in personnel integration in medical school communities; as we shall see in the next chapter, mental health personnel who are

university-associated are much more likely than other local mental health respondents to desire greater use of mental health personnel outside of direct mental health programs than is currently the case in their localities. In addition, the association may be due to the presence of most mental health personnel per capita in the medical school communities and least in the smaller communities. Also, as was noted in Chapter I, medical school communities tend not to have separately organized mental health programs.

TABLE 44

UTILIZATION OF LOCAL MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS BY ESTABLISHMENT OF A SEPARATE GOVERNMENT AGENCY WHICH HAS PRIMARY RESPONSIBILITY FOR COMMUNITY MENTAL HEALTH PROGRAMS, IN PERCENTAGES

Utilization of Mental Health Personnel in Public Programs, Localities Ranked in Quartiles	Establishment of Separate Government Agency		
	No Separate Agency	Established 1950 or Later	Established 1949 or Earlier
First quartile	20	22	30
Second quartile	24	33	22
Third quartile	20	25	22
Fourth quartile	36	20	26
Total per cent	100	100	100
Base for percentages .	(50)	(40)	(23)
No information[a] . . .	(-)	(-)	(-)
Total number	(50)	(40)	(23)

[a]Information about the establishment of a separate government agency was unavailable for ten communities.

TABLE 45

UTILIZATION OF LOCAL MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS BY TYPE OF COMMUNITY, IN PERCENTAGES

Utilization of Mental Health Personnel in Public Health Programs, Localities Ranked in Quartiles	Type of Community		
	Medical School Community	Metropolitan Community	Smaller Community
First quartile	34	28	13
Second quartile	24	32	22
Third quartile	24	18	27
Fourth quartile	18	22	38
Total per cent . . .	100	100	100
Base for percentages.	(38)	(40)	(45)
No information . . .	(-)	(-)	(-)
Total number	(38)	(40)	(45)

The Utilization of Mental Health Personnel in Other-Related Programs

In addition to information about the activity of mental health personnel in public health programs, the respondents were asked to report about the extent of utilization of mental health personnel in the following programs: rehabilitation, accident prevention, juvenile delinquency, family service, mental health in education, health and welfare council, public assistance, and correctional and penal system. Note that several of these programs are large ones, more encompassing than some of the more specific programs considered part of the general public health service.

The State reports of the utilization of mental health persons in each of these other-related, but non-direct mental health, programs are summarized in Table 46. Among these programs, several are reported to have about as extensive utilization as many of the public health programs. This is the case for the mental health in education, correctional and penal

system, rehabilitation, and juvenile delinquency programs. In many States mental health persons are employed on a full-time basis in these broad programs. On the other hand, little utilization is reported for the accident prevention, and, significantly, for the public assistance and the health and welfare council programs.

TABLE 46

EXTENT OF UTILIZATION OF MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS, SUMMARY OF REPORTS FROM FIFTY STATES

Other Programs	Extent of Utilization						No Such State Program	No Information	Total Number of States
	Full-time Person Employed	Part-time Person Employed	Frequent consultation	Occasional consultation	In-service training	No utilization			
Rehabilitation . . .	24	9	17	17	9	5	-	-	50
Accident prevention .	4	5	3	18	6	19	2	2	50
Juveline delinquency.	18	15	12	24	8	4	1	2	50
Family service . . .	15	12	10	22	10	6	4	-	50
Mental health in education	22	15	16	20	13	-	-	1	50
Health and welfare council	8	4	8	24	4	10	2	1	50
Public assistance . .	3	2	14	24	7	12	-	1	50
Correctional and penal system . . .	25	8	18	20	7	4	-	1	50

The reports from the local communities are presented in Table 47. Again, there is less extensive utilization of mental health personnel reported at the local than at the State level. Nevertheless, the pattern of utilization is only a little different. Utilization is relatively high in juvenile delinquency, mental health in education, family service and rehabilitation programs. On the other hand, there are few localities reporting any utilization of mental health personnel in accident prevention programs.

TABLE 47

EXTENT OF UTILIZATION OF MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS, SUMMARY OF REPORTS FROM 123 LOCALITIES, IN PERCENTAGES

Other Programs	Extent of Utilization						No Such Local Program	No Information	Total Percentage	Total Number of Localities
	Full-time Person Employed	Part-time Person Employed	Frequent Consultation	Occasional Consultation	In-Service Training	No Utilization				
Rehabilitation	26	13	20	33	11	17	8	2	130	123
Accident prevention . . .	4	1	2	11	4	53	24	6	105	123
Juvenile delinquency . .	34	18	36	29	9	9	3	2	140	123
Family service	34	20	29	29	11	15	5	2	145	123
Mental health in education	35	20	29	20	14	13	5	3	139	123
Health and welfare council	16	6	16	33	7	24	10	4	116	123
Public assistance	16	10	24	33	8	25	5	2	123	123
Correctional and penal system	19	12	18	33	4	26	10	3	125	123

The relationship between certain State and locality characteristics and the utilization of mental health personnel in these related programs was also analyzed. The State score for the utilization of mental health personnel was computed by the same weighting procedure as that used in the case of their utilization in State public health programs. The States were again divided into four approximately equal quartiles: in the first quartile (twelve States) are the States with scores of thirty-five per cent or higher; in the second quartile (thirteen States) are those scored between thirty-two and twenty-two per cent; in the third quartile (twelve States) are States scored between sixteen and twenty-one per cent; and in the fourth quartile (thirteen States) are those with scores of fifteen per cent or less.

The associations between the utilization of mental health personnel in other non-direct mental health programs and various State organizational arrangements are presented in Table 48. There are no consistent and clear associations. This indicates that mental health personnel are used in education, welfare, correction and other programs about as extensively when the mental health programs are organized one way as another.

Furthermore, there is no relationship between the degree of utilization and (1) the length of time a separately organized government agency with responsibility for community mental health activities has been established, or (2) the population size, density, or per capita income of the State, or (3) the number of psychiatrists per 100,000 population of the State.

In order to examine the factors which may be associated with the extent to which local mental health personnel are used in other-related programs, it is necessary to categorize the localities in terms of their extent of utilization. The same procedure was followed as in the case of

TABLE 48

UTILIZATION OF STATE MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS AND ORGANIZATION OF STATE MENTAL HEALTH PROGRAMS

Utilization of Mental Health Personnel in Other-Related Programs, States Ranked in Quartiles	Location of Mental Health Authority			Relationship Between Mental Institutional Programs and Public Health Departments			Administration of Institutional and Community Mental Health Programs		Characterization of State Mental Health Organization		
	Public Health Dept.	Mental Health Dept.	Other Dept., Agency	Close, Generally	Close, Part	Few or No	Same Dept.	Separate Dept.	Separate and Autonomous	Division of Public Health	Somewhat Dispersed
First quartile . . .	6	3	3	2	8	2	7	5	4	6	2
Second quartile . . .	6	2	5	2	6	5	7	6	6	4	2
Third quartile . . .	9	1	2	2	9	1	3	9	3	7	2
Fourth quartile . . .	4	6	3	1	9	3	9	4	8	2	1
Number of States . . .	25	12	13	7	32	11	26	24	21	19	7

the utilization of mental health persons in local public health programs. Whereas personnel integration between public health and mental health programs is related to the organizational arrangements for mental health programs, this is not true of the use of mental health personnel in other programs (see Table 49). This lack of relationship was also noted in the analysis of the States.

TABLE 49

UTILIZATION OF LOCAL MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS BY CHARACTERIZATION OF LOCAL MENTAL HEALTH ORGANIZATION, IN PERCENTAGES

Utilization of Mental Health Personnel in Other-Related Programs, Localities Ranked in Quartiles	Characterization of Local Mental Health Organization	
	Separate and Autonomous	Not Separate and Autonomous
First quartile	28	23
Second quartile	19	32
Third quartile	26	20
Fourth quartile	27	25
Total per cent . . .	100	100
Base for percentages	(70)	(44)
No information[a] . .	(-)	(-)
Total number	(70)	(44)

[a]The organization of the mental health programs could not be characterized for nine localities.

The length of time a separate government agency has had responsibility for community mental health programs is also unrelated to the extent of utilization of mental health persons in other-related programs. The type of community, however, is clearly associated with the utilization of mental health personnel in these programs (see Table 50). Medical

school communities and metropolitan communities are more likely to have extensive utilization than are the smaller communities. The explanation is probably due to some of the same reasons as those suggested to explain the relationship between community type and the utilization of mental health personnel in public health programs: the relative per capita presence of mental health personnel, the relative tendency for innovation, and the greater desire of university-associated mental health persons for more personnel integration.

TABLE 50

UTILIZATION OF MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS BY TYPE OF COMMUNITY, IN PERCENTAGES

Utilization of Mental Health Personnel in Other-Related Programs, Localities Ranked in Quartiles	Type of Community		
	Medical School Community	Metropolitan Community	Smaller Community
First quartile	32	25	20
Second quartile	26	35	16
Third quartile	21	18	31
Fourth quartile	21	22	33
Total per cent . . .	100	100	100
Base for percentages.	(38)	(40)	(45)
No information . . .	(-)	(-)	(-)
Total number	(38)	(40)	(45)

Summary

Clearly, there is less personnel integration at the local level than at the State level: less utilization of public health personnel in mental health programs, less utilization of mental health personnel in public health programs, and less utilization of mental health personnel

in other-related programs.[5] It should be noted that the localities from which we have reports for this study are ones in which there are mental health programs; obviously if we had a sample of all localities, including those with no such programs, the amount of personnel integration at the local level would be found to be much lower than that indicated by our reports.

There are probably several reasons for the difference in the degree of personnel integration between the States and localities. It may be due to the fact that the mental health programs at the local level are more often organized separately than at the State level. This may help explain the relative degree of integration of public health and mental health programs but not the relative degree to which mental health personnel are used in other non-direct mental health programs, since organizational arrangements are not related to this kind of integration. Of course, many of the local mental health programs are quasi-public and this may lessen the degree of cooperation with other government programs. Another possible explanation of the difference is that the separately organized government agencies for community mental health are more recently established at the local than at the State level and personnel integration gradually develops, at least at the local level. The difference in the

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[5]Using the procedure described for scoring the extent to which public health persons are used in mental health programs in the States and localities, the median State has a percentage score of thirty-nine; the median locality has a score of twenty. In comparing the percentage scores for the use of mental health personnel outside of direct mental health programs, the same modified procedure used in scoring the localities was used: for the use of mental health personnel in public health programs, fifty per cent of the States had a score of thirty or more, the median locality had a score of fifteen; for the use of mental health personnel in other non-direct programs, fifty per cent of the States had a score of twenty-seven per cent or more, the median locality had a percentage score of eighteen. Note that for the first two measures "local health services" were omitted for the localities.

degree of personnel integration may also be due to differences in leadership and the willingness and opportunity to experiment. Perhaps the most important reason for the difference is the relative size of the mental health programs at the local as compared to the State level.

The attempt to explain the differences in the degree of personnel integration among the States and among the localities has been only partly successful. It appears that among the States and among the localities, the integration between public health and mental health personnel and programs tends to be greater where the mental health programs are not separately organized. The straightforward interpretation of these relationships is that where the mental health and public health programs are administered together, there will, of course, be more personnel integration between both sets of programs. But the issue is more complex than that. We have seen that there is most extensive use of personnel from public health departments in mental health programs in States (1) in which the mental health authority is located in an "other" department or agency, or (2) in which the mental health programs are somewhat dispersed. In the case of mental health personnel in public health programs, at the State level, we found that utilization tended to be lowest in States (1) in which the mental health authority is located in an "other" department or agency, or (2) in which the mental health programs are somewhat dispersed. This suggests that the greater personnel integration between these personnel and programs is affected by the absence of a separately organized mental health program and not merely because this usually means administrative unification with a public health department. The effects differ, however, for the participation of each kind of personnel in the others' programs.

The aspects of the organizational arrangements considered here are not related among the States or among the localities, with the extent

to which mental health personnel are used in education, welfare, and other-related, but non-direct mental health, programs.

The length of time which a separately organized government agency with responsibility for community mental health programs has existed is not related to the degree of personnel integration among the States. Among the localities, however, where an agency has been in existence for a longer period of time, there is somewhat greater utilization of mental health personnel in public health programs.

Among the States, the number of psychiatrists per 100,000 population in the State is not related to personnel integration. Per capita income of the States is not related to integration. The low density States appear to have somewhat higher utilization of public health personnel in mental health programs. The States with large populations tend to have relatively extensive use of mental health personnel in education, welfare, correctional, and other-related programs. On the whole, these characteristics of the States do not help explain the variation in personnel integration among the States.

In the case of the localities, the type of community seems to be an important determinant of the degree of personnel integration. Medical school communities have the highest degree of integration for each of the three measures and the smaller communities the least. We have suggested some possible explanations for this finding: the presence of more mental health personnel, more innovating leadership, and a greater interest in personnel integration among key persons in medical school and metropolitan communities. Evidence supporting the last explanation for medical school communities was mentioned: local mental health personnel who are university-affiliated tend to favor much greater personnel integration than already exists in their locality.

There is another kind of evidence suggesting that the interests of the personnel themselves may be a very important determinant of the degree of personnel integration which exists among the States or among the localities. We did not find one variable which is related to each measure of personnel integration among the States; only the type of community is consistently related to each measure of integration among the localities. Nevertheless, there is a very high relationship among the three measures of integration (see Tables 51 - 56). Thus, States ranked high in the use of public health personnel in direct mental health programs are also ranked high in the use of mental health personnel in other non-direct mental health programs.[6] This suggests that there may be more desire for integration in some States and localities than in others, and it is this desire which is an important determinant.

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[6]Perhaps this is due to a tendency for some respondents to report generally high integration for their States or localities, while other respondents systematically report less, and these respondent differences would affect all the measures of integration from each State or locality. Having reports from more than one respondent from each State and locality should reduce this source of bias.

The fact that (1) the question wording and scoring procedure for the use of public health personnel in mental health programs and for the use of mental health personnel outside of direct mental health programs are quite different, and yet (2) we find a high relationship between them indicates that the relationship is substantive and not a methodological artifact.

The summary reports of the States and localities may also result in some States and localities being ranked either high or low for all the measures of integration because there is a slightly varying number of informants from some of the States and localities (typically we have two from each locality and two or three from each State). Since the reports of all the respondents from the same State or locality were combined, there may be a slight tendency for States or localities with more informants to be ranked higher than those with fewer. Such biases are likely to be small. Insofar as they do exist, they tend to reduce the degree of association between each measure of personnel integration and the variables being considered.

TABLE 51

UTILIZATION OF STATE PUBLIC HEALTH PERSONNEL IN MENTAL HEALTH PROGRAMS AND UTILIZATION OF MENTAL HEALTH PERSONNEL IN STATE PUBLIC HEALTH PROGRAMS

Utilization of Public Health Personnel in Mental Health Programs, States Ranked in Quartiles	Utilization of Mental Health Personnel in Public Health Programs, States Ranked in Quartiles			
	First Quartile	Second Quartile	Third Quartile	Fourth Quartile
First quartile	7	3	2	1
Second quartile	2	3	4	3
Third quartile	2	5	3	3
Fourth quartile	1	1	4	6
Number of States.	12	12	13	13

TABLE 52

UTILIZATION OF STATE MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS AND UTILIZATION OF PUBLIC HEALTH PERSONNEL IN STATE MENTAL HEALTH PROGRAMS

Utilization of Mental Health Personnel in Other-Related Programs, States Ranked in Quartiles	Utilization of Public Health Personnel in Mental Health Ptograms, States Ranked in Quartiles			
	First Quartile	Second Quartile	Third Quartile	Fourth Quartile
First quartile	7	1	3	1
Second quartile	4	3	4	2
Third quartile	1	4	2	5
Fourth quartile	1	4	4	4
Number of States.	13	12	13	12

TABLE 53

UTILIZATION OF STATE MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS AND UTILIZATION OF MENTAL HEALTH PERSONNEL IN STATE PUBLIC HEALTH PROGRAMS

Utilization of Mental Health Personnel in Other-Related Programs, States Ranked in Quartiles	Utilization of Mental Health Personnel in Public Health Programs, States Ranked in Quartiles			
	First Quartile	Second Quartile	Third Quartile	Fourth Quartile
First quartile	10	2	-	-
Second quartile	2	6	4	1
Third quartile	-	3	6	3
Fourth quartile	-	1	3	9
Number of States.	12	12	13	13

TABLE 54

UTILIZATION OF LOCAL PUBLIC HEALTH PERSONNEL IN MENTAL HEALTH PROGRAMS BY UTILIZATION OF MENTAL HEALTH PERSONNEL IN LOCAL PUBLIC HEALTH PROGRAMS, IN PERCENTAGES

Utilization of Public Health Personnel in Mental Health Programs, Localities Ranked in Quartiles	Utilization of Mental Health Personnel in Public Health Programs, Localities Ranked in Quartiles			
	First Quartile	Second Quartile	Third Quartile	Fourth Quartile
First quartile	47	31	25	-
Second quartile	37	31	18	12
Third quartile	13	31	36	24
Fourth quartile	3	6	21	64
Total per cent . .	100	99	100	100
Base for percentages	(30)	(32)	(28)	(33)
No information . .	(-)	(-)	(-)	(-)
Total number . . .	(30)	(32)	(28)	(33)

TABLE 55

UTILIZATION OF LOCAL MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS BY UTILIZATION OF PUBLIC HEALTH PERSONNEL IN LOCAL MENTAL HEALTH PROGRAMS, IN PERCENTAGES

Utilization of Mental Health Personnel in Other-Related Programs, Localities Ranked in Quartiles	Utilization of Public Health Personnel in Mental Health Programs, Localities Ranked in Quartiles			
	First Quartile	Second Quartile	Third Quartile	Fourth Quartile
First quartile	48	32	17	3
Second quartile	42	19	24	13
Third quartile	10	36	24	34
Fourth quartile	-	13	35	50
Total per cent .	100	100	100	100
Base for percentages	(31)	(31)	(29)	(32)
No information .	(-)	(-)	(-)	(-)
Total number . .	(31)	(31)	(29)	(32)

TABLE 56

UTILIZATION OF LOCAL MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS BY UTILIZATION OF MENTAL HEALTH PERSONNEL IN LOCAL PUBLIC HEALTH PROGRAMS, IN PERCENTAGES

Utilization of Mental Health Personnel in Other-Related Programs, Localities Ranked in Quartiles	Utilization of Mental Health Personnel in Public Health Programs, Localities Ranked in Quartiles			
	First Quartile	Second Quartile	Third Quartile	Fourth Quartile
First quartile	67	19	11	6
Second quartile	20	56	18	6
Third quartile	7	19	43	27
Fourth quartile	7	6	28	61
Total per cent .	101	100	100	100
Base for percentages	(30)	(32)	(28)	(33)
No information .	(-)	(-)	(-)	(-)
Total number . .	(30)	(32)	(28)	(33)

CHAPTER IV

PREFERENCES CONCERNING THE USE OF MENTAL HEALTH PERSONNEL OUTSIDE OF DIRECT MENTAL HEALTH PROGRAMS

The actual practices of complex organizations may or may not be close to the practices which are deemed desirable by responsible officials within such organizations. In this chapter we are going to examine officials' preferences concerning the extent and form of utilization of mental health personnel. The last chapter, in which we discussed actual practices, will serve as a background against which preferences will be highlighted.

Specifically, the respondents' preferences about three aspects of personnel integration will be examined: (1) the extent to which mental health personnel should participate in public health and other-related programs, (2) which programs are most in need of increased services of members of the mental health professions, and (3) the relative importance of direct and indirect functions of mental health personnel. We will also consider the extent of agreement among types of respondents.

Preferences for the Use of Mental Health Personnel in Public Health and Related Programs

Each respondent was asked about his preferences concerning the utilization of mental health personnel in the public health and other-related programs which we have been considering. The question was prefaced with this introduction: "Now we are interested in your own considered judgment about what use should be made of mental health personnel, as defined earlier, in the programs in (STATE)(LOCALITY). Please answer in terms of realistic developments which could take place within the next five years." The question was, "First, to what extent do you think mental health personnel should be used, if at all, in each of the programs listed?"

Tables B-31a to B-31x present the respondents' answers in detail. For example, we can see in Table B-31a that in the communicable diseases

program, about one-third to about one-half of each type of respondent say they do not believe mental health personnel should be used at all or do not know whether or not they should be used. The other respondents are most likely to say that they prefer occasional consultation. There are no marked differences among the types of respondents except possibly that local mental health respondents and heads of alcoholism programs are least likely to report believing that mental health personnel should be used in the communicable diseases program.

Similar statements can be made for each of the programs. We will proceed, however, to a consideration of several summary measures of these preferences. The twenty-four programs were divided into sixteen public health programs and eight other-related programs, as in the previous chapter.[1]

First, a simple summary scoring system was used for each set of programs. The number of public health programs for which the respondent expressed a preference for any kind of use of mental health personnel was summed; if he said he thought there should not be any utilization, that he did not know whether or not there should be, that no program existed, or if he failed to answer for any program, this was not counted. Thus a respondent might be scored from 0 to 16. The respondents were then divided into six groups: those with scores of 0-8, those with scores of 9-11, those with scores of 12-13, those with scores of 14, those with 15, and those with 16. Note that with this scoring system the local respondents cannot have

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[1]The public health programs are communicable diseases, chronic diseases, aging, dental health, maternal and child health, nursing, environmental sanitation, occupational health, health education, hospitals and medical facilities, vital statistics and research, drug addiction, alcoholism, school health, crippled children, and local health services. The other-related programs are rehabilitation, accident prevention, juvenile delinquency, family service, mental health in education, health and welfare council, public assistance, and correctional and penal system.

scores of 16, since Local Health Services is omitted for them, being a State-level program; comparisons between State and local respondents on this measure must be made with this in mind. Respondents who failed to answer the entire series were categorized as indeterminate.

The number of public health programs in which mental health personnel should be used as stated by respondents with different program responsibilities is presented in Table 57. It is clear that among State-level respondents, those with mental health responsibilities are more likely than those with public health responsibilities to think that mental health personnel should be used in many programs. Among the State mental health personnel, fifty-nine per cent of the heads of State programs, sixty per cent of those in community-based programs, and fifty-five per cent of those in hospital-based programs believe mental health personnel should be used in fourteen or more of the sixteen public health programs listed. Among the State public health respondents, fifty per cent of the heads have the same opinion, and even fewer, forty per cent, of the other public health officials do. Interestingly, among the local respondents the pattern is reversed: mental health respondents are somewhat less likely to favor the use of mental health personnel in most of the public health programs than are the local public health respondents. There is, however, a great range among the local mental health respondents--further analysis reveals that fifty-four per cent of the local government officials mention fourteen or more programs, compared to eighteen per cent of the university-affiliated respondents and thirteen per cent of those who are heads of clinics or centers.

TABLE 57

NUMBER OF PUBLIC HEALTH PROGRAMS IN WHICH MENTAL HEALTH PERSONNEL SHOULD BE USED, BY TYPE OF RESPONDENT, IN PERCENTAGES

Number of Public Health Programs in which Mental Health Personnel Should Be Used	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun. Base	Other Hosp. Base	
0 - 8 programs	2	19	18	17	8	7	11	23
9 - 11 programs	29	17	22	29	14	9	12	28
12 - 13 programs	19	24	28	15	19	24	22	30
14 programs	21	14	16	12	13	15	18	8
15 programs	12	14	16	12	23	19	15	11
16 programs	17	12	-[a]	15	23	26	22	-[a]
Total per cent . .	100	100	100	100	100	100	100	100
Base for percentages	(42)	(127)	(116)	(34)	(73)	(129)	(90)	(120)
Indeterminate . .	(1)	(3)	(4)	(-)	(1)	(-)	(-)	(-)
Total number . . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Local respondents could not choose more than fifteen programs since one, local health services, was considered only a State-level program.

The scoring procedure used for the public health programs was also used for the eight other-related programs. Four groups of respondents are distinguished: those who said that mental health personnel should be used in four or fewer of the eight programs, those who mentioned five or six programs, those who mentioned seven programs, and those who mentioned all eight. Respondents who failed to answer this series of questions were categorized as indeterminate.

The number of other-related programs in which mental health personnel should be used according to respondents with different program responsibilities is presented in Table 58. Again, mental health respondents favor more extensive use of mental health personnel in health-related, welfare, correctional, and other-related programs than is the case for public health personnel. This pattern is true at both the State and local levels. The range among the local mental health respondents is not significant.

TABLE 58

NUMBER OF OTHER-RELATED PROGRAMS IN WHICH MENTAL HEALTH PERSONNEL SHOULD BE USED, BY TYPE OF RESPONDENT, IN PERCENTAGES

Number of Other-Related Programs in which Mental Health Personnel Should Be Used	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun. Base	Other Hosp. Base	
0 - 4 programs . . .	36	24	18	18	7	8	8	10
5 - 6 programs . . .	26	19	25	15	17	7	13	20
7 programs	7	15	17	20	23	23	21	21
8 programs	31	42	40	47	53	62	58	49
Total per cent.	100	100	100	100	100	100	100	100
Base for percentages . .	(42)	(127)	(116)	(34)	(73)	(129)	(90)	(120)
Indeterminate .	(1)	(3)	(4)	(-)	(1)	(-)	(-)	(-)
Total number .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

In addition to the simple summary measure discussed above, a more complex summary measure was constructed. This measure entailed giving weights to the extent of utilization preferred for each program, summing the scores for each program, and then dividing the total by the highest possible score, yielding a percentage score. The weights used in scoring are the same as those described for scoring the reports of actual utilization in the localities. The respondents' scores for the public health programs and for the other-related programs were computed separately. The respondents were divided into four approximately equal-sized groups according to their percentage scores for each set of programs.

In the case of the utilization of mental health personnel in public health programs, as can be seen in Table 59, respondents with mental health program responsibilities are more likely to favor extensive utilization of mental health personnel than are public health respondents. For example, forty-five per cent of the heads of State mental health programs are in the highest quartile of percentage scores, while only twenty-one per cent of the State heads of public health programs are in the first quartile. State mental health officials who are not heads of overall mental health programs tend to have scores which are not so high as the heads of State mental health programs, although they tend to be higher than public health officials. Heads of State alcoholism programs tend to score very high. Local respondents, compared to State officials, tend to have lower percentage scores; among the local mental health respondents, the heads of clinics or centers are most likely to have low scores. In the case of preferences concerning the utilization of mental health personnel in other-related programs, the pattern of responses among the different types of respondents is very similar (see Table 60).

TABLE 59

QUARTILE RANKING OF PERCENTAGE SCORES FOR THE PREFERRED USE OF MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS, BY TYPE OF RESPONDENT, IN PERCENTAGES

Preferences for Use of Mental Health Personnel in Public Health Programs, Quartile Ranking of Percentage Scores	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun. Base	Other Hosp. Base	
First quartile	21	20	13	39	45	28	24	21
Second quartile	17	21	20	39	27	25	30	24
Third quartile	33	33	25	6	14	26	30	26
Fourth quartile	29	26	42	16	14	21	17	29
Total per cent . .	100	100	100	100	100	100	101	100
Base for percentages	(42)	(121)	(114)	(31)	(73)	(129)	(88)	(116)
No information . .	(1)	(9)	(6)	(3)	(1)	(-)	(2)	(4)
Total number . . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE 60

QUARTILE RANKING OF PERCENTAGE SCORES FOR THE PREFERRED USE OF MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS, BY TYPE OF RESPONDENT, IN PERCENTAGES

Preference for Use of Mental Health Personnel in Other-Related Programs, Quartile Ranking of Percentage Scores	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun. Base	Other Hosp. Base	
First quartile	12	20	14	61	37	29	31	25
Second quartile	20	24	20	20	30	26	35	23
Third quartile	17	24	27	3	21	22	20	36
Fourth quartile	51	31	39	16	12	23	14	16
Total per cent . .	100	99	100	100	100	100	100	100
Base for percentages	(41)	(119)	(114)	(31)	(73)	(129)	(88)	(116)
No information . .	(2)	(11)	(6)	(3)	(1)	(-)	(2)	(4)
Total number . . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

Although these percentage scores are excellent summary measures, there is one possible source of difficulty. The respondents were asked to state their preferences "in terms of realistic developments which could take place within the next five years." Perhaps what is realistic in one State or locality may not be so in another. It is very likely that the respondents' preferences, then, would be affected by the extent of utilization already present in their State or locality. Let us see whether this is the case.

In Tables 61 and 62 we can see the percentage scores of respondents in States and localities ranked differently in terms of the reports of the current extent of utilization of mental health personnel outside of direct mental health programs. It is apparent that respondents in States or localities in which there is more such utilization tend to have higher percentage scores.

In order to take this finding into account, a new measure was developed. The individual's percentage scores indicating his preferences for the utilization of mental health personnel in public health and in the other-related programs were compared to the percentage scores of the current utilization in the two sets of programs as reported for his State or locality. The difference between the two scores was computed. The respondents were again divided into four categories: much greater utilization preferred, somewhat greater, the same amount, and less. The dividing lines between categories were made so that there would be a sizable number of respondents in each category.[2] Therefore, the names of the categories

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[2]The following cutting-points for the establishment of the categories were used: If a respondent's percentage score for his preferences was identical with the score for his State or locality or was eight percentage points more or less, he was considered to want the "same" amount of utilization as was current. If his percentage score was nine or more percentage points less, he was categorized as wanting "less" utilization than was current. If a respondent's percentage score was nine through twenty points more than his State or locality's actual score, he was categorized as wanting "somewhat greater" utilization. If a respondent's preference score was twenty-one or more percentage points higher than his State or locality's score, he was categorized as wanting "much greater" utilization.

TABLE 61.

STATE AND LOCAL RESPONDENTS' PERCENTAGE SCORES FOR THE PREFERRED USE OF MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS, BY CURRENT UTILIZATION OF MENTAL HEALTH PERSONNEL IN STATE AND LOCAL PUBLIC HEALTH PROGRAMS, IN PERCENTAGES

A. State Respondents

Preferences for Use of Mental Health Personnel in Public Health Programs, Quartile Ranking of Percentage Scores	Utilization of Mental Health Personnel in Public Health Programs, States Ranked in Quartiles			
	First Quartile	Second Quartile	Third Quartile	Fourth Quartile
First quartile	34	31	29	13
Second quartile	25	24	28	22
Third quartile	29	22	21	35
Fourth quartile	12	23	22	30
Total per cent	100	100	100	100
Base for percentages	(127)	(113)	(127)	(106)
No information	(1)	(3)	(7)	(5)
Total number	(128)	(116)	(134)	(111)

B. Local Respondents

Preferences for Use of Mental Health Personnel in Public Health Programs, Quartile Ranking of Percentage Scores	Utilization of Mental Health Personnel in Public Health Programs, Localities Ranked in Quartiles			
	First Quartile	Second Quartile	Third Quartile	Fourth Quartile
First quartile	40	8	13	4
Second quartile	26	27	13	21
Third quartile	16	37	23	23
Fourth quartile	18	28	50	52
Total per cent	100	100	99	100
Base for percentages	(62)	(64)	(52)	(52)
No information	(-)	(4)	(2)	(2)
Total number	(62)	(68)	(54)	(54)

TABLE 62

STATE AND LOCAL RESPONDENTS' PERCENTAGE SCORES FOR THE PREFERRED USE OF MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS, BY CURRENT UTILIZATION OF MENTAL HEALTH PERSONNEL IN STATE AND LOCAL OTHER-RELATED PROGRAMS, IN PERCENTAGES

A. State Respondents

Preferences for Use of Mental Health Personnel in Other-Related Programs, Quartile Ranking of Percentage Scores	Utilization of Mental Health Personnel in Other-Related Programs, States Ranked in Quartiles			
	First Quartile	Second Quartile	Third Quartile	Fourth Quartile
First quartile	38	30	26	18
Second quartile	21	33	27	24
Third quartile	21	15	21	27
Fourth quartile	20	22	26	31
Total per cent	100	100	100	100
Base for percentages	(131)	(119)	(116)	(104)
No information	(1)	(5)	(7)	(6)
Total number	(132)	(124)	(123)	(110)

B. Local Respondents

Preferences for Use of Mental Health Personnel in Other-Related Programs, Quartile Ranking of Percentage Scores	Utilization of Mental Health Personnel in Other-Related Programs, Localities Ranked in Quartiles			
	First Quartile	Second Quartile	Third Quartile	Fourth Quartile
First quartile	32	12	23	8
Second quartile	21	26	25	13
Third quartile	32	42	22	30
Fourth quartile	15	20	30	49
Total per cent	100	100	100	100
Base for percentages	(62)	(65)	(56)	(47)
No information	(2)	(1)	(2)	(3)
Total number	(64)	(66)	(58)	(50)

have a relative meaning but not an absolute one. If a broader definition of "same" had been used, more respondents would be so classified and fewer would be in the "less" or in the "more" categories. Furthermore, some respondents may have believed that less utilization was current than our summary of reports from two or more persons would indicate; this is particularly true in the case of the States, since only the heads of programs were asked to report about the actual extent of personnel integration.

The same dividing lines between categories were established for the use of mental health persons in public health programs as for their use in other-related programs. This makes it possible to compare preferences about utilization of mental health personnel in these two sets of programs; that could not be done with the respondents' percentage scores themselves. These measures will be called "net preference" scores.

The resulting distribution of net preference scores for the utilization of mental health personnel in public health programs by type of respondent is shown in Table 63. The variation among types of respondents is similar to the variation shown by the gross percentage scores. This net preference measure indicates that mental health personnel tend to think there should be a greater increase in the use of mental health personnel in public health programs than do public health officials. We now can see that among the mental health personnel, the hospital-based State personnel are least likely to say that there should be much greater utilization.

TABLE 63

NET PREFERENCE SCORES FOR USE OF MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS, BY TYPE OF RESPONDENT, IN PERCENTAGES

Net Preference Scores for Use of Mental Health Personnel in Public Health Programs	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Much greater . .	7	7	18	20	18	18	10	21
Somewhat greater.	21	27	24	23	31	18	18	27
Same	36	28	40	40	30	34	39	43
Less	36	38	18	17	21	30	33	9
Total per cent	100	100	100	100	100	100	100	100
Base for percentages .	(42)	(119)	(114)	(30)	(71)	(126)	(85)	(116)
No information	(1)	(11)	(6)	(4)	(3)	(3)	(5)	(4)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

A particularly important point is brought out clearly by this measure. Examining the gross percentage scores, we saw that local respondents think there should be less extensive utilization than do State respondents, but in the previous chapter we saw that localities tend to have less utilization than the States. As a result, it is now evident that local respondents, although not wanting so extensive utilization as do State respondents, are more likely to want a <u>great deal more utilization than exists</u>.

Additional analysis shows that among different types of local mental health respondents, preference patterns differ. In terms of the gross percentages, the heads of clinics or centers had the lowest scores; in terms of the net preference scores, the heads of government offices are lowest (thirty-one per cent think there should be greater utilization), and the heads of clinics or centers tend to prefer greater utilization (forty-six

per cent want much or somewhat greater utilization); the university-affiliated respondents are most likely to want greater utilization (sixty-seven per cent say much or somewhat greater).

The distribution of net preference scores for the utilization of mental health personnel in other-related programs is shown in Table 64. It is clear that the respondents want a greater increase in utilization in other-related programs than in public health ones. This cannot be accounted for by significant differences in the current extent of utilization in the two sets of programs.

TABLE 64

NET PREFERENCE SCORES FOR USE OF MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS, BY TYPE OF RESPONDENT, IN PERCENTAGES

Net Preference Scores for Use of Mental Health Personnel in Other-Related Programs	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun. Base	Other Hosp. Base	
Much greater . . .	12	22	27	30	25	26	19	28
Somewhat greater .	24	16	15	17	33	22	33	28
Same	20	30	38	40	25	31	29	34
Less	44	32	20	13	17	21	19	10
Total per cent . . .	100	100	100	100	100	100	100	100
Base for percentages . . .	(41)	(117)	(114)	(30)	(71)	(126)	(85)	(116)
No information . .	(2)	(13)	(6)	(4)	(3)	(3)	(5)	(4)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

The distribution of preferences among the respondents is similar to those in the case of utilization in public health programs: mental health personnel tend to want a greater increase of utilization than public health personnel; among the mental health respondents, hospital-based State personnel are least likely to want much greater utilization; local respondents are more likely than State respondents to want much greater utilization; and among local mental health respondents, university-affiliated persons are most likely to want much greater utilization.

Programs Which Are Believed Most in Need of Increased Services of Mental Health Personnel

Each respondent was asked to state which three of the twenty-four health- and other-related programs most need increased services of mental health personnel in his State or locality. The results, by respondents with different program responsibilities, are presented in Table B-32. Among the respondents as a whole, juvenile delinquency, aging, and maternal and child health are most frequently cited. Mental health in education, school health, alcoholism, nursing, correctional and penal system, hospitals and medical facilities, family service, rehabilitation, and local health services are also frequently mentioned, in the order given.

Respondents with different program responsibilities vary somewhat in the programs they cite as being most in need of increased services. Of the four programs most frequently mentioned, State public health heads only mention public health programs: aging, maternal and child health, local health services, and chronic diseases programs. The other State public health officials also mention only public health programs among the four programs they most frequently cite: maternal and child health, aging, chronic diseases, and nursing. The local public health respondents mention

these programs relatively frequently also, but juvenile delinquency is mentioned as frequently as any single public health program. Two-thirds of the heads of State alcoholism programs mention alcoholism, and they are also likely to mention other-related programs, aside from public health programs. The mental health respondents frequently mention aging and maternal and child health among the public health programs, but they also frequently mention juvenile delinquency programs. The State mental health respondents in hospital-based programs frequently mention programs in which institutionalized populations are involved. Interestingly, too, local respondents relatively frequently mention juvenile delinquency, compared to State-level respondents.

The respondents were also asked to say why they thought each of the three programs they selected most need increased services of mental health personnel. The answers for the twelve most frequently mentioned programs are given in Tables 65 and 66. The reasons given, naturally, usually refer to the reasons for the need, particularly the absence of an adequate program at present. Programs were also chosen because of the potential benefits from the use of mental health personnel, particularly in prevention. Relatively fewer respondents state in what way the mental health personnel would be used.

Now let us look at the reasons in more detail. First, we will consider the answers given for the public health programs (see Table 65). In addition to explanation of the need (particularly stressed for the aging program), the preventive potentialities are frequently cited; this is especially true of the maternal and child health, nursing, and school health programs. In the nursing and the school health programs, particularly, the idea that mental health personnel would provide consultation and training is relatively frequently mentioned.

TABLE 65

REASONS GIVEN FOR CHOOSING PARTICULAR PUBLIC HEALTH PROGRAMS AS MOST IN NEED OF INCREASED SERVICES OF MENTAL HEALTH PERSONNEL, IN PERCENTAGES

Reasons	Public Health Programs						
	Aging	Maternal and Child Health	School Health	Alcoholism	Nursing	Hospital and Medical Facilities	Local Health
Incidence of problem increasing . .	46	5	3	16	3	7	2
Mental illness component present; large number of cases; burden of other institutions	42	14	11	38	11	20	13
Insufficient or no mental health personnel used at present; information needed	38	24	33	61	23	68	56
Preventive program possible	7	35	27	7	8	2	15
Could reach many persons; could reach persons not otherwise reached	*	3	8	2	42	3	19
Would or need to engage in primary prevention; educate public, parents	6	33	14	11	8	1	8
Would or need to provide secondary prevention; early detection for patients	2	21	30	1	11	5	5
Would or need to provide therapy, rehabilitation, or aid for emotional problems of patients . . .	30	17	15	27	14	27	14
Would or need to provide consultation, in-service training for other professions; help give proper orientation for policies and programs	10	11	27	9	38	16	14
Would or need to have better organization of care; aid referral services	6	4	9	4	9	6	8
Other specific reasons	3	1	1	3	1	3	3
Vague, general responses (and no answer)	1	3	3	1	2	3	4
Total per cent	191	171	181	180	170	162	161
Base for percentages and total number	(208)	(208)	(158)	(150)	(133)	(118)	(108)

*Less than .05 per cent.

TABLE 66

REASONS GIVEN FOR CHOOSING PARTICULAR OTHER-RELATED PROGRAMS AS MOST IN NEED OF INCREASED SERVICES OF MENTAL HEALTH PERSONNEL, IN PERCENTAGES

Reasons	Other-Related Programs				
	Juvenile Delinquency	Mental Health in Education	Correctional and Penal	Family Service	Rehabilitation
Incidence of problem increasing	20	3	7	5	4
Mental illness component present; large number of cases; burden on other institutions	25	6	35	14	19
Insufficient or no mental health personnel used at present; information needed	53	35	60	45	43
Preventive programs possible	14	23	5	19	2
Could reach many persons; could reach persons not otherwise reached	3	9	2	5	6
Would or need to engage in primary prevention; educate public, parents	11	22	5	14	6
Would or need to provide secondary prevention; early detection for patients	9	22	5	7	2
Would or need to provide therapy, rehabilitation, or aid for emotional problems of patients	34	6	43	20	57
Would or need to provide consultation, in-service training for other professions; help give proper orientation for policies and programs	14	25	15	11	15
Would or need to have better organization of care; aid referral services	4	1	3	12	6
Other specific reasons	2	3	1	4	1
Vague general responses (and no answer)	2	5	3	7	-
Total per cent	191	160	184	183	161
Base for percentages and total number	(228)	(159)	(130)	(112)	(109)

For the other-related programs (see Table 66), the inadequacy of present programs is again most frequently mentioned as the reason for the needed increase in services of mental health personnel. Interestingly, however, the preventive potentialities are relatively less frequently mentioned for the other-related programs than for the public health programs. Relatively frequent references are made for the other-related programs to one of the functions which mental health personnel could and should provide--therapy.

A comparison of the programs which the key officials think are most in need of increased services of mental health personnel with the extent of current utilization in these programs is revealing. Among the public health programs, on the whole the respondents give lowest priority to the programs which currently have relatively little utilization of mental health personnel and high priority to those which have more utilization. Presumably, they feel that what is being done should be done and to a greater degree. For example, in Chapter III we had seen that environmental sanitation, dental health, communicable diseases, and occupational health have relatively little participation of mental health personnel; these programs are mentioned least often among the public health programs as most in need of increased services. On the other hand, utilization is currently relatively high at the State and local level in the nursing, hospitals, alcoholism, school health, aging, and maternal and child health programs; State and local respondents frequently mention these programs as being most in need of increased services. Similarly, local health services has relatively high participation and is given relatively high priority.

The exceptions to this general pattern are even more significant. Health education has high participation of mental health personnel, but few State or local respondents mention this program among the three most in need of increased services of mental health personnel. Chronic diseases programs have moderate current utilization at the State and local levels, but State and local public health respondents frequently mention it as needing increased services.

Among the other-related programs, those programs in which extensive use of mental health personnel is generally reported are also frequently mentioned as most needing increased services, and infrequent references are made to programs in which there is currently little utilization. Thus, public assistance, accident prevention, and health and welfare council programs are reported to make little use of mental health personnel at the State or local level, and few State or local respondents give these programs high priority. Given the size and significance of the public assistance program, at least, this is surprising. On the other hand, State and local programs of juvenile delinquency and mental health in education are reported to have high participation of mental health personnel--at least compared to other programs; and these programs are frequently mentioned by the State and local respondents as most in need of increased services. Similarly, family service has high utilization in the localities, and the local respondents give it high priority; State correctional and penal institutions have relatively high utilization, and the State respondents give this program high priority.

On the whole, it is reasonable that in those programs in which there is some participation of mental health personnel, more would be desired. These programs are the ones which have been given priority

already and have not yet reached the desired level of utilization. Nevertheless, the exceptions to this pattern are particularly significant. One kind of exception is the program which has relatively high utilization and is not frequently mentioned among the three most in need of increased services. Health education was one such program, and among the other-related programs, rehabilitation at the local level is one. This kind of exception may indicate that a program has reached its optimum level of utilization of mental health personnel or that the program is no longer considered especially strategic for the use of such scarce personnel. The other kind of exception is that of programs which currently have relatively low utilization and are frequently mentioned among those most in need of increased services. Among the State public health programs, chronic diseases seem to be such a program for public health officials. Among the other-related programs, local correctional and penal programs and State family service programs are such areas. This kind of exception may indicate an area that has been grossly neglected in the past or one in which changing ideas have led to a new conception of the strategic program in which to place the scarce mental health personnel.

Relative Importance of All Functions of Mental Health Personnel

Another way of considering the preferences about the integration of mental health personnel in programs outside of direct mental health ones is to consider how the respondents rank the relative importance of functions which mental health personnel may provide in direct as well as in non-direct mental health programs. This issue was presented to the

respondents toward the end of the interview, with this introduction: "Up to now we have been considering mental health personnel in programs other than mental health ones. Now we have some questions about the use of mental health personnel in all programs, including 'direct' mental health programs." They were then requested, "Bearing in mind the present supply of mental health personnel, but disregarding their present use, please rank the following functions of mental health personnel according to your judgment of what should be their importance." Nine functions were listed:

1. Mental health education for the public
2. Consultation with other public health or health-related agencies
3. Counseling or guidance for people with emotional problems
4. Individual therapy of persons with manifest psychotic or neurotic symptoms; provision of clinical services
5. Research or program evaluation
6. Community development
7. In-service training for staffs of other agencies
8. Provision of follow-up and other rehabilitative services
9. Case-finding, diagnosis, and referral of persons to whatever therapy resourses are available.

Priority Estimates

The respondents' rankings of these nine functions can be viewed as an indication of the relative priority they assign to these functions. There is considerable variation among the types of respondents in the ranking of the functions. Nevertheless, let us consider the overall ranking of

each item. The average score for each function, based upon those respondents who ranked all of the functions, is shown in Table 67. For the respondents as a whole, the range in mean scores is small, partly because of the dissensus among the respondents. Mental health education for the public seems to be ranked about the middle for all the respondents, but the public health persons rank it highest, and the mental health respondents rank it lowest! On the other hand, the mental health respondents rank individual therapy highest, and the public health personnel rank it toward the bottom. There is more agreement in ranking provision of follow-up and community development toward the bottom. Consultation with other public health or health-related agencies and counseling or guidance for people with emotional problems are ranked high by both public health and mental health respondents.

TABLE 67

MEAN SCORES FOR RANKING OF MENTAL HEALTH PERSONNEL FUNCTIONS FOR ALL RESPONDENTS, PUBLIC HEALTH RESPONDENTS, AND MENTAL HEALTH RESPONDENTS

Item Number	Mean Score All Respondents	Mean Score Public Health Respondents[a]	Mean Score Mental Health Respondents
2 . . .	4.33	4.22	4.42
4 . . .	4.51	5.34	3.88
3 . . .	4.66	4.41	4.84
1 . . .	4.95	4.20	5.52
7 . . .	4.99	4.87	5.07
9 . . .	5.12	4.97	5.23
8 . . .	5.41	5.53	5.32
6 . . .	5.47	5.44	5.49
5 . . .	5.57	6.02	5.23

[a]Includes State alcoholism heads.

More detailed information about the ranking of these functions by respondents with different program responsibilities can be seen in Tables B-24a through B-24i. Another sign of the variation in response is revealed there: the function most frequently ranked first by State heads of public health programs is individual therapy (ranked first by seventeen per cent of the heads; but State public health heads rank some other functions first almost as frequently). Nevertheless, in general, the information in the more detailed tables is consistent with the summary observations which have been made. Among each type of mental health respondent, therapy is most frequently ranked first: by forty-six per cent of the local mental health respondents, by forty-one per cent of the heads of State mental health programs, by thirty-one per cent of the other State hospital-based respondents, and by twenty-seven per cent of the other State community-based respondents.[3] The public health respondents generally rank mental health education first; this is the case for twenty-five per cent of the local public health officials and twenty-three per cent of the other State public health respondents; fifteen per cent of the heads of the State public health programs rank it first.

It should be pointed out that although research or program evaluation (Item 5) has the lowest mean score, a sizable number of respondents (particularly those with mental health program responsibilities) give it one of their

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[3]The Joint Commission on Mental Illness and Health recommends: "A national mental health program should recognize that major mental illness is the core problem and unfinished business of the mental health movement, and that the intensive treatment of patients with critical and prolonged mental breakdowns should have first call on fully trained members of the mental health professions." (Op. cit., p. 262). The Commission also is critical of certain kinds of mental health education and recommends, "The primary responsibility for preparation of mental health information for dissemination to laymen should rest with 'laymen' who are experts in education and mass communications and who will work in consultation with mental health experts." (Op. cit., p. 281)

first three rank positions. Thus, as can be seen in Table B-24e, about one out of three State mental health respondents ranks research or program evaluation first, second, or third in priority; twenty-nine per cent of the State alcoholism heads so rank it; about one out of five State public health officials ranks it among his first three priorities, and one out of ten local respondents so ranks it.

After ranking the nine functions of mental health personnel, the respondents were asked, "Are there any other uses of mental health personnel which you think are as important as those on the list above?" If they said, "Yes," they were asked what it is. The results are presented in Table B-25. Although few respondents volunteered any other functions, of those who did, teaching or training of other mental health personnel, of lay leaders, of physicians, and of medical students, was most likely to be mentioned. If this had been included along with the other functions, it might well have been ranked high by many respondents.

The Intercorrelation of the Ranking of the Functions

The ranking of the nine functions can be used more readily and more validly in the analysis if the results could be meaningfully summarized for each respondent. As a first step in the summarization, the ranking of each function was correlated with the ranking of every other function. The resulting matrix of correlation coefficients is presented in Table 68; it warrants close study.

Since the functions are ranked, when one function is ranked higher, another must be ranked lower, and the correlations are largely negative. The largest negative correlation is between Items 4 and 6. That is, persons who rank individual therapy high tend to rank community development low. Individual therapy also is strongly negatively correlated with consultation with other agencies and with mental health education.

TABLE 68

MATRIX OF CORRELATION COEFFICIENTS FOR THE RANKINGS OF THE FUNCTIONS OF MENTAL HEALTH PERSONNEL

Function	Function								
	4	3	8	9	5	1	6	7	2
4 . .		.32	.14	.07	-.16	-.37	-.42	-.34	-.39
3 . .	.32		-.07	-.01	-.34	-.11	-.36	-.26	-.26
8 . .	.14	-.07		.13	-.12	-.25	-.23	-.13	-.31
9 . .	.07	-.01	.13		-.27	-.25	-.17	-.19	-.29
5 . .	-.16	-.34	-.12	-.27		-.07	.05	-.05	-.01
1 . .	-.37	-.11	-.25	-.25	-.07		-.08	-.12	.01
6 . .	-.42	-.36	-.23	-.17	.05	.08		.00	.02
7 . .	-.34	-.26	-.13	-.19	-.05	-.12	.00		.26
2 . .	-.39	-.23	-.31	-.29	-.01	.01	.02	.26	

The highest positive correlation is between Items 4 and 3. That is, people who rank individual therapy high are likely to rank counseling or guidance high. These two items seem to be related--they both involve direct therapeutic services. The other relatively high positive correlation is between consultation with other agencies (Item 2) and in-service training (Item 7). These two functions seem to be related--they both involve indirect services. There are small but positive correlations between community development (Item 6) and mental health education for the public (Item 1) and between community development (Item 6) and research and program evaluation (Item 5). Although mental health education for the public and research or program evaluation are not positively correlated, in view of the fact that each is positively correlated with community development, and both, like community development, are negatively correlated with Items 4, 3, 8, and 9, these three items can be considered a third dimension in the ranking of functions of mental health personnel. Given the substance of the items

and their patterns of correlation, the characterization of this dimension is not certain; nevertheless, taken together, we will consider this dimension as involving concern with preventive functions.

The next step in summarizing the ranking of the functions of the mental health personnel was to classify each respondent along each of the three dimensions which were distinguished. Three categories of respondents were established for each dimension. In the case of the direct therapeutic services, all respondents who ranked Items 3 and 4 among the functions they ranked first through fourth were classified as giving high ranking to direct therapeutic services; those ranking one item first through fourth and the other one fifth through ninth were classified as giving middle ranking to these functions; and those ranking both functions sixth through ninth were classified as giving low rank to these functions. Respondents who failed to rank any of these items were classified as indeterminate. The same procedure was used to classify respondents along the indirect services dimension, using the respondents' rankings of functions 2 and 7. In the case of preventive services, since three items are involved and they generally were not ranked high, a different scoring procedure was used. The rank numbers for all three items were added together; thus a person ranking these three items among his first three choices would have a score of 1 and 2 and 3, a total of 6; a person ranking all three items at the bottom would have a score of 7 and 8 and 9, a total of 24. Persons with scores of 6 to 14 were classified as giving a high ranking to preventive functions; persons with scores of 16 through 18 were categorized as giving a middle ranking to these functions; and those with scores of 19 through 24 were categorized as giving low ranking to these services. Again, persons who failed to rank any of these three items were considered indeterminate for this dimension.

The results of this classification for respondents with different program responsibilities are presented in Tables 69, 70, and 71. The general pattern of results is consistent with what we have already noted, but certain patterns are sometimes a little different. In the ranking of direct therapeutic functions, we see again that local mental health respondents rank this function relatively high; so do the heads of State alcoholism programs, as well as the State respondents with mental health program responsibilities; we can also see that State heads of public health programs, as well as other State public health respondents, rank it relatively low in importance.

TABLE 69

RANKING OF DIRECT THERAPEUTIC FUNCTIONS OF MENTAL HEALTH PERSONNEL, BY TYPE OF RESPONDENT, IN PERCENTAGES

Ranking of Direct Therapeutic Functions	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun. Base	Other Hosp. Base	
High	29	23	35	40	33	28	31	55
Middle	25	28	40	30	38	38	38	31
Low	46	49	25	30	29	34	31	14
Total per cent	100	100	100	100	100	100	100	100
Base for percentages . .	(41)	(120)	(114)	(33)	(73)	(125)	(90)	(116)
Indeterminate.	(2)	(10)	(6)	(1)	(-)	(4)	(-)	(4)
Total number .	(43)	(130)	(120)	(34)	(73)	(129)	(90)	(120)

TABLE 70

RANKING OF INDIRECT SERVICE FUNCTIONS OF MENTAL HEALTH PERSONNEL, BY TYPE OF RESPONDENT, IN PERCENTAGES

Ranking of Indirect Service Functions	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun. Base	Other Hosp. Base	
High	34	43	29	15	25	36	15	23
Middle	32	42	41	44	37	45	47	48
Low	34	15	30	41	38	19	38	29
Total per cent	100	100	100	100	100	100	100	100
Base for percentages . .	(41)	(120)	(114)	(34)	(73)	(126)	(90)	(118)
Indeterminate.	(2)	(10)	(6)	(-)	(1)	(3)	(-)	(2)
Total number .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE 71

RANKING OF PREVENTIVE SERVICE FUNCTIONS OF MENTAL HEALTH PERSONNEL, BY TYPE OF RESPONDENT, IN PERCENTAGES

Ranking of Preventive Service Functions	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun. Base	Other Hosp. Base	
High	53	46	30	58	41	39	39	26
Middle	22	28	38	21	32	35	36	29
Low	25	26	31	21	27	26	25	45
Total per cent.	100	100	99	100	100	100	100	100
Base for percentages . .	(40)	(116)	(112)	(33)	(73)	(125)	(89)	(116)
Indeterminate.	(3)	(14)	(8)	(1)	(1)	(4)	(1)	(4)
Total number .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

The pattern of ranking indirect service functions is more complex. State public health respondents who are not heads of the overall programs rank this relatively high. Among the State respondents with mental health responsibilities, heads and those in hospital-based programs rank it relatively low, but those in community-based programs rank it relatively high.

Among the local mental health respondents, heads of government offices tend to fall in the middle category (sixty-two per cent) or the low category (twenty-three per cent); while the university-affiliated persons are in the high (thirty-one per cent) or low category (forty-four per cent); twenty-four per cent of the heads of clinics or centers are in the high category and forty-nine per cent in the middle.

In the case of ranking preventive functions, it is the local respondents, particularly the local mental health respondents, who rank this function relatively low. Among the local mental health respondents, it is not the heads of clinics or centers who account for this; although they do not rank it so high as government heads or university-affiliated persons (twenty-three per cent compared to thirty-one and thirty-eight per cent, respectively), they do not rank it so low (forty-four per cent compared to fifty-four and fifty per cent, respectively).

The Contribution of Mental Health Professions for Various Mental Health Functions

Given the high demand for mental health services and the limited supply of mental health personnel, the extent to which personnel with relatively limited training can provide the services is an important issue. In a study of 500 cases at a child guidance clinic, it was concluded that three-fourths of the children in the sample "could have been cared for by

persons less specialized than the psychiatric team."[4] In order to gather information about the respondents' readiness to utilize different kinds of mental health personnel for various services, the respondents were asked another question;[5] after ranking the nine direct mental health services in order of importance, the respondents were asked, "Considering the function you have ranked as the most important one, please tell me whether each of the following kinds of mental health personnel would be essential to the performance of that function, would be adequate, or would make little or no contribution." The kinds of personnel listed were clinical psychologist, mental health nurse, mental health educator, psychiatrist, social scientist, and psychiatric social worker.

Tables 72 through 80 present these evaluations of the professions for each function which the respondents ranked first in importance. Thus, in Table 72, it can be seen that of those ranking mental health education for the public first in importance, fifty-eight per cent consider clinical psychologists essential to the performance of that function, sixty-two per cent think mental health nurses essential, eighty-six per cent believe mental health educators to be essential, and sixty-two per cent see an essential role for psychiatrists. Social scientists are felt to be essential

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[4]Forrest N. Anderson and Helen C. Dean, Some Aspects of Intake Policy and Practices--A Study of 500 Cases at the Child Guidance Clinic of Los Angeles, (Los Angeles, Calif.: Child Guidance Clinic of Los Angeles). Unpublished study, December, 1950; cited in Subcommittee on Evaluation of Mental Health Activities, Community Services Committee, National Advisory Council, Evaluation in Mental Health (U.S. Government Printing Office, 1956, Public Health Service Publication No. 413), p. 35; quotation from ibid.

[5]The Joint Commission on Mental Illness and Health recommends, ".... psychiatry and the allied mental health professions should adopt and practice a broad, liberal philosophy of what constitutes and who can do treatment within the framework of their hospitals and other professional service agencies...." (Op. cit., p. 248.)

by thirty-seven per cent of these respondents, and psychiatric social workers by fifty-nine per cent. Of the 112 respondents who rank this function first, twenty-seven per cent think that clinical psychologists would make an adequate contribution, thirty-one per cent rate mental health nurses as adequate. Only eleven per cent deem the contribution of mental health educators as adequate, and no respondents feel that this profession would make little or no contribution in the performance of that function.

TABLE 72

RELATIVE CONTRIBUTION OF VARIOUS PROFESSIONS IN PROVISION OF MENTAL HEALTH EDUCATION FOR THE PUBLIC, AMONG RESPONDENTS RANKING THAT FUNCTION FIRST, IN PERCENTAGES

Relative Contribution	Profession					
	Clinical Psychologist	Mental Health Nurse	Mental Health Educator	Psychiatrist	Social Scientist	Psychiatric Social Worker
Essential	58	62	86	62	37	59
Adequate	27	31	11	26	42	31
Little or none . .	13	4	-	8	12	9
Don't know	2	3	3	4	9	1
Total per cent	100	100	100	100	100	100
Base for percentages . .	(112)	(112)	(112)	(112)	(112)	(112)
No answer . .	(4)	(4)	(4)	(4)	(4)	(4)
Total number .	(116)	(116)	(116)	(116)	(116)	(116)

TABLE 73

RELATIVE CONTRIBUTION OF VARIOUS PROFESSIONS IN PROVISION OF CONSULTATION WITH OTHER PUBLIC HEALTH OR HEALTH-RELATED AGENCIES, AMONG RESPONDENTS RANKING THAT FUNCTION FIRST, IN PERCENTAGES

Relative Contribution	Profession					
	Clinical Psychologist	Mental Health Nurse	Mental Health Educator	Psychiatrist	Social Scientist	Psychiatric Social Worker
Essential	58	62	28	79	30	71
Adequate	35	30	38	20	44	27
Little or none . .	6	4	28	1	14	1
Don't know	1	4	6	-	12	1
Total per cent	100	100	100	100	100	100
Base for percentages . .	(99)	(99)	(99)	(99)	(99)	(99)
No answer . .	(1)	(1)	(1)	(1)	(1)	(1)
Total number .	(100)	(100)	(100)	(100)	(100)	(100)

TABLE 74

RELATIVE CONTRIBUTION OF VARIOUS PROFESSIONS IN PROVISION OF COUNSELING OR GUIDANCE FOR PEOPLE WITH EMOTIONAL PROBLEMS, AMONG RESPONDENTS RANKING THAT FUNCTION FIRST, IN PERCENTAGES

Relative Contribution	Profession					
	Clinical Psychologist	Mental Health Nurse	Mental Health Educator	Psychiatrist	Social Scientist	Psychiatric Social Worker
Essential	79	31	19	93	15	85
Adequate	13	43	31	4	41	12
Little or none . .	3	20	43	-	31	-
Don't know	5	6	7	3	13	3
Total per cent	100	100	100	100	100	100
Base for percentages . .	(68)	(68)	(68)	(68)	(68)	(68)
No answer . .	(-)	(-)	(-)	(-)	(-)	(-)
Total number .	(68)	(68)	(68)	(68)	(68)	(68)

TABLE 75

RELATIVE CONTRIBUTION OF VARIOUS PROFESSIONS IN PROVISION OF INDIVIDUAL THERAPY OF PERSONS WITH MANIFEST PSYCHOTIC OR NEUROTIC SYMPTOMS; PROVISION OF CLINICAL SERVICES, AMONG RESPONDENTS RANKING THAT FUNCTION FIRST, IN PERCENTAGES

Relative Contribution	Profession					
	Clinical Psychologist	Mental Health Nurse	Mental Health Educator	Psychiatrist	Social Scientist	Psychiatric Social Worker
Essential	92	50	15	100	13	91
Adequate	6	31	34	-	38	8
Little or none . . .	1	15	44	-	38	1
Don't know	1	4	7	-	11	*
Total per cent	100	100	100	100	100	100
Base for percentages . .	(196)	(196)	(196)	(196)	(196)	(196)
No answer . .	(2)	(2)	(2)	(2)	(2)	(2)
Total number .	(198)	(198)	(198)	(198)	(198)	(198)

*Less than one-half of one per cent.

TABLE 76

RELATIVE CONTRIBUTION OF VARIOUS PROFESSIONS IN PROVISION OF RESEARCH OR PROGRAM EVALUATION, AMONG RESPONDENTS RANKING THAT FUNCTION FIRST, IN PERCENTAGES

Relative Contribution	Profession					
	Clinical Psychologist	Mental Health Nurse	Mental Health Educator	Psychiatrist	Social Scientist	Psychiatric Social Worker
Essential	75	30	25	78	79	43
Adequate	21	41	45	18	9	48
Little or none . . .	2	27	25	2	7	7
Don't know	2	2	5	2	5	2
Total per cent	100	100	100	100	100	100
Base for percentages . .	(44)	(44)	(44)	(46)	(44)	(44)
No answer . .	(4)	(4)	(4)	(2)	(4)	(4)
Total number .	(48)	(48)	(48)	(48)	(48)	(48)

TABLE 77

RELATIVE CONTRIBUTION OF VARIOUS PROFESSIONS IN PROVISION OF COMMUNITY DEVELOPMENT, AMONG RESPONDENTS RANKING THAT FUNCTION FIRST, IN PERCENTAGES

Relative Contribution	Profession					
	Clinical Psychologist	Mental Health Nurse	Mental Health Educator	Psychiatrist	Social Scientist	Psychiatric Social Worker
Essential	60	45	55	63	45	72
Adequate	30	42	28	27	42	20
Little or none . . .	7	9	11	6	6	4
Don't know	3	4	6	4	7	4
Total per cent	100	100	100	100	100	100
Base for percentages . .	(70)	(69)	(69)	(70)	(69)	(70)
No answer . .	(1)	(2)	(2)	(1)	(2)	(1)
Total number .	(71)	(71)	(71)	(71)	(71)	(71)

TABLE 78

RELATIVE CONTRIBUTION OF VARIOUS PROFESSIONS IN PROVISION OF IN-SERVICE TRAINING FOR STAFFS OF OTHER AGENCIES, AMONG RESPONDENTS RANKING THAT FUNCTION FIRST, IN PERCENTAGES

Relative Contribution	Profession					
	Clinical Psychologist	Mental Health Nurse	Mental Health Educator	Psychiatrist	Social Scientist	Psychiatric Social Worker
Essential	56	52	44	73	38	63
Adequate	36	42	27	27	29	31
Little or none . . .	8	4	17	-	21	4
Don't know	-	2	12	-	12	2
Total per cent	100	100	100	100	100	100
Base for percentages . .	(48)	(48)	(48)	(48)	(48)	(48)
No answer . .	(-)	(-)	(-)	(-)	(-)	(-)
Total number .	(48)	(48)	(48)	(48)	(48)	(48)

TABLE 79

RELATIVE CONTRIBUTION OF VARIOUS PROFESSIONS IN PROVISION OF FOLLOW-UP AND OTHER REHABILITATIVE SERVICES, AMONG RESPONDENTS RANKING THAT FUNCTION FIRST, IN PERCENTAGES

Relative Contribution	Profession					
	Clinical Psychologist	Mental Health Nurse	Mental Health Educator	Psychiatrist	Social Scientist	Psychiatric Social Worker
Essential	61	77	23	92	23	85
Adequate	31	23	62	8	62	15
Little or none . . .	8	-	15	-	15	-
Don't know	-	-	-	-	-	-
Total per cent	100	100	100	100	100	100
Base for percentages . .	(13)	(13)	(13)	(13)	(13)	(13)
No answer . .	(-)	(-)	(-)	(-)	(-)	(-)
Total number .	(13)	(13)	(13)	(13)	(13)	(13)

TABLE 80

RELATIVE CONTRIBUTION OF VARIOUS PROFESSIONS IN PROVISION OF CASE FINDING, DIAGNOSIS AND REFERRAL OF PERSONS TO WHATEVER THERAPY RESOURCES ARE AVAILABLE, AMONG RESPONDENTS RANKING THAT FUNCTION FIRST, IN PERCENTAGES

Relative Contribution	Profession					
	Clinical Psychologist	Mental Health Nurse	Mental Health Educator	Psychiatrist	Social Scientist	Psychiatric Social Worker
Essential	80	49	26	97	25	79
Adequate	18	41	33	3	26	20
Little or none . . .	2	5	34	-	29	1
Don't know	-	5	7	-	20	-
Total per cent	100	100	100	100	100	100
Base for percentages . .	(61)	(61)	(61)	(61)	(61)	(61)
No answer . .	(-)	(-)	(-)	(-)	(-)	(-)
Total number .	(61)	(61)	(61)	(61)	(61)	(61)

In providing consultation with other public health or health related agencies, the services of clinical psychologists and mental health nurses are seen as essential by the same proportion of the ninety-nine respondents who ranked this function first in importance as of those who ranked mental health in education first: fifty-eight per cent for clinical psycholigists and sixty-two per cent for mental health nurses (see Table 73). Psychiatrists and psychiatric social workers are particularly likely to be considered essential for this function (by seventy-nine per cent and seventy-one per cent of the respondents, respectively).

Among the respondents who ranked counseling or guidance for people with emotional problems as most important, psychiatrists, psychiatric social workers, and clinical psychologists are most frequently viewed as essential; the proportions are ninety-three per cent for psychiatrists, eighty-five per cent for psychiatric social workers, and seventy-nine per cent for clinical psychologists (see Table 74). No respondents feel that psychiatrists and psychiatric social workers would make little or no contribution to this service.

Among the respondents choosing individual therapy as the most important function, there is unanimity that psychiatrists would be essential in its performance (see Table 75). Clinical psychologists and psychiatric social workers are almost unanimously considered essential or adequate. While these three professions are deemed essential with far greater frequency than the remaining three, it is noteworthy that eighty-one per cent of these respondents think mental health nurses would be adequate or essential, forty-nine per cent characterize mental health educators' contributions as adequate or essential, and fifty-one per cent include social scientists among the essential or adequate personnel.

In research and program evaluation, social scientists, psychiatrists, and clinical psychologists are generally considered essential (see Table 76). Fewer than half of the respondents ranking this function as most important view the services of mental health nurses, mental health educators, or psychiatric social workers as essential.

In the field of community development, it is especially interesting to note that the largest number of respondents choosing this function class psychiatric social workers as essential to its performance (see Table 77). Psychiatrists and clinical psychologists are rated essential with almost the same degree of frequency, sixty-three per cent and sixty per cent, respectively.

In the case of in-service training for staffs of other agencies, psychiatrists, mental health nurses, psychiatric social workers, and clinical psychologists are each considered adequate or essential by almost all the respondents considering this function most important (see Table 78).

To provide follow-up and other rehabilitative services, ninety-two per cent of the small number of respondents who rank this activity first think psychiatrists would be essential (see Table 79). In the next order of frequency, psychiatric social workers (eighty-five per cent) and mental health nurses (seventy-seven per cent) are rated essential. None of this group of respondents feels that these three types of personnel would make little or no contribution to follow-up services.

The final function in the list to be ranked was case-finding, diagnosis, and referral. Almost all (ninety-seven per cent) of the respondents placing it first in importance consider psychiatrists essential (see Table 80). Eighty per cent think clinical psychologists would be required in this work, and seventy-nine per cent rate psychiatric social workers

essential. Mental health nurses are called essential by forty-nine per cent and adequate by forty-one per cent; mental health educators are said to be essential by twenty-six per cent and adequate by thirty-three per cent; social scientists are found to be essential by twenty-five per cent and adequate by twenty-six per cent.

Looked at from another perspective, it will be seen that certain professions are far more frequently considered essential in the performance of these various functions than are other professions. Thus, for six of the functions, the largest proportion of those respondents ranking them first in importance choose psychiatrists as essential to their performance. The services in which they are so designated are:

Consultation with other agencies (seventy-nine per cent);

Counseling or guidance (ninety-three per cent);

Individual therapy (one hundred per cent);

In-service training (seventy-three per cent);

Follow-up and rehabilitation (ninety-two per cent);

Case-finding, diagnosis, and referral (ninety-seven per cent).

In three additional functions psychiatrists are specified as essential by the second highest proportion of the respondents ranking these functions first in importance: mental health education (sixty-two per cent); research or program evaluation (seventy-eight per cent); and community development (sixty-three per cent).

It is interesting that, after psychiatrists, psychiatric social workers are most frequently deemed essential. In community development they are named essential by the highest percentage (seventy-two), and in consultation, counseling and guidance, in-service training, and follow-up care, they receive the next highest number of choices as essential. Their

role in individual therapy is considered essential by ninety-one per cent of the respondents ranking that service first.

In general, psychiatrists are seen as essential to the performance of all direct mental health services by the great majority of respondents, regardless of which function they rank as most vital. Psychiatric social workers are viewed as essential in the next order of frequency. Clinical psychologists, although ranking third in the total frequency with which they are named as essential to performance of the various services, appear to be rated highly essential only in individual therapy and case finding. For the most part, such professions as mental health educator and social scientist are thought essential only in certain specialized services, such as mental health education and research. Mental health nurses seem to be thought important principally in mental health education, consultation, and follow-up programs.

Since psychiatrists are considered essential to effective provision of these services, and since there is a shortage of such personnel, it is clear that there will be a serious bottleneck created if the services are made contingent on the availability of personnel considered essential. Of course, they may be considered essential and yet other personnel are often considered adequate--presumably when working in a setting with essential personnel.

Finally, we will briefly review the degree of consensus among the respondents about the role of certain mental health professions in providing three of the functions being considered: health education, consultation, and individual therapy. The respondents are divided into four categories: (1) those with public health program responsibilities with M.D. degrees (usually physicians), (2) public health respondents without M.D.

degrees, (3) mental health respondents with M.D. degrees (usually psychiatrists), and (4) mental health respondents without M.D. degrees. On the whole, there is considerable agreement among these kinds of respondents about the role of various mental health professions for the functions which they rank first.

In the case of individual therapy, as can be seen in Table 81 A, all the respondents agree that psychiatrists are essential; clinical psychologists are also almost as universally considered essential by each group of respondents. Respondents without M.D. degrees are somewhat more likely than the other respondents to consider psychiatric social workers essential, and public health respondents with M.D. degrees are most likely to consider the mental health nurse as essential.

There is less consensus in the case of mental health education than in individual therapy. Among the respondents ranking this function first, mental health officials generally consider the four major mental health professions essential; this is less likely to be the case among the public health respondents (see Table 81 B). There is also a tendency for respondents with M.D. degrees to regard psychiatrists and psychiatric social workers as essential for mental health education.

Among the respondents ranking consultation with other agencies first, there are also some interesting variations (see Table 81 C). Thus, among the mental health respondents, all those with M.D. degrees consider psychiatrists essential and generally do not consider the other mental health professions essential; while mental health respondents without M.D. degrees are not more likely to think psychiatrists are essential than they are to consider the other mental health professions essential. Among the public health respondents, those with M.D.'s, compared to those without

the degree, are somewhat less likely to consider the mental health nurse and the psychiatric social worker essential.

TABLE 81

PROPORTION OF RESPONDENTS CONSIDERING VARIOUS PROFESSIONS ESSENTIAL FOR PROVISION OF CERTAIN MENTAL HEALTH FUNCTIONS RANKED FIRST IN IMPORTANCE, BY TYPE OF RESPONDENT[a] AND BY MEDICAL DEGREE

A. Among Respondents Ranking Individual Therapy of Persons with Manifest Psychotic or Neurotic Symptoms First

Type of Respondent and Medical Degree	Mental Health Profession			
	Clinical Psychologist	Mental Health Nurse	Psychiatrist	Psychiatric Social Worker
Public health, M.D.	93 (29)	69 (29)	100 (29)	86 (29)
Public health, not M.D. . . .	100 (12)	42 (12)	100 (12)	100 (12)
Mental health, M.D.	89 (79)	44 (79)	100 (79)	87 (79)
Mental health, not M.D. . . .	99 (67)	48 (67)	100 (67)	94 (67)

B. Among Respondents Ranking Mental Health Education for the Public First

Public health, M.D.	48 (40)	63 (40)	55 (40)	65 (40)
Public health, not M.D. . . .	55 (20)	55 (20)	50 (20)	45 (20)
Mental health, M.D.	93 (14)	64 (14)	93 (14)	71 (14)
Mental health, not M.D. . . .	68 (25)	68 (25)	68 (25)	64 (25)

C. Among Respondents Ranking Consultation with Other Public Health or Health-Related Agencies First

Public health, M.D.	47 (21)	43 (21)	76 (21)	52 (21)
Public health, not M.D. . . .	48 (23)	87 (23)	78 (23)	78 (23)
Mental health, M.D.	45 (11)	18 (11)	100 (11)	55 (11)
Mental health, not M.D. . . .	72 (42)	67 (42)	74 (42)	79 (42)

[a]Heads of State alcoholism programs are not included.

These findings suggest that there is wide consensus about which professions are essential for various mental health functions, but this is modified to some extent by the tendency to think one's own profession, group of professions, or level of training is particularly essential.

The Preferred Agency Location for the Highest Ranked Mental Health Function

Each respondent was asked for the mental health function he ranked as most important: "In which one government agency do you think personnel serving that function could be most advantageously employed?" The results are shown in Table 82.

It can be seen that for all nine functions the majority of respondents prefer that personnel be employed in either a department of mental health, a division of mental health within a department of public health, or a department of public health. In certain functions, however, substantial minorities are spread among several other types of preferred agency. For example, a total of twenty-seven per cent of the respondents who ranked individual therapy first favor using the personnel for this service in a department of institutions or hospitals, a mental health center, and a department of welfare. Similarly, of those who ranked research first in importance, departments of welfare, a research division or university, and other departments are each selected by nine per cent of the respondents.

There is a tendency toward greater agreement among respondents as to the appropriateness of public health and mental health departments in the provision of consultation and community development services. For consultation, fifty-one per cent prefer a department of public health, while twenty per cent choose a department of mental health, and fourteen per cent consider a division of mental health within a public health department the most suitable location. In community development, a public health department is thought preferable by fifty-three per cent of those respondents ranking this service first. Among respondents who choose follow-up care as most important, twenty-five per cent prefer each of the three public health and mental health locations, and the rest are divided equally among departments of welfare, departments of institutions, and mental health centers.

TABLE 82

GOVERNMENT[a] AGENCY IN WHICH PERSONNEL SERVING VARIOUS MENTAL HEALTH FUNCTIONS COULD BE MOST ADVANTAGEOUSLY EMPLOYED, AMONG RESPONDENTS RANKING THOSE FUNCTIONS AS MOST IMPORTANT, IN PERCENTAGES

Agency	Function Ranked As Most Important								
	Mental Health Education	Consultation with other agencies	Counseling or Guidance	Individual Therapy	Research or Program Evaluation	Community Development	In-service Training	Follow-up and Rehabilitation	Case Finding, Diagnosis and Referral
Wherever the mental health authority or mental health agency is located	9	2	3	6	-	1	2	-	2
Department of mental health .	17	20	21	36	33	23	13	25	19
Bureau, section, division of mental health within department of public health . . .	6	14	12	5	2	4	9	25	5
Department of public health .	47	51	36	15	26	53	49	25	46
Department of welfare	1	1	-	6	9	4	4	8	3
Department of institutions, hospitals; in mental hospitals	-	3	2	11	-	1	4	8	3
Other departments or combinations of departments . . .	6	4	6	4	9	6	9	-	5
Spread among many agencies, departments	-	-	2	-	-	-	-	-	2
Research division; university.	1	-	-	1	9	-	2	-	2
Mental health, treatment center, clinic	2	1	15	10	-	1	-	8	2
U.S. Public Health Service . .	3	1	-	1	4	-	4	-	-
Non-governmental agency[a] . . .	1	-	1	4	2	-	-	-	-
Don't know	7	3	2	1	6	6	4	-	11
Total per cent	100	100	100	100	100	99[b]	100	99[b]	100
Base for percentages .	(108)	(99)	(66)	(187)	(46)	(70)	(47)	(12)	(61)
No answer	(8)	(1)	(2)	(11)	(2)	(1)	(1)	(1)	(-)
Total number	(116)	(100)	(68)	(198)	(48)	(71)	(48)	(13)	(61)

[a]Respondents were asked: "In which one government agency do you think personnel serving that function could be most advantageously employed?" Some respondents volunteered the answer: "Not in a government agency." If this had been included as possible response in the question, the proportion giving this answer would probably have been larger.

[b]Does not equal 100 per cent due to rounding of figures.

It can be speculated that the choices of agency in which particular functions may best be performed might be influenced by the program responsibilities of the respondents who ranked these functions first. By reference to the ranking of functions by type of respondent (see Tables B-24a through B24i), we can see that there does seem to be possible confirmation of this explanation.

For example, mental health respondents are much more likely to rank individual therapy first than are public health persons; for choice of agency, thirty-six per cent of this group prefer a mental health department and fifteen per cent a public health department. Mental health officials rank research first somewhat more frequently than do public health officials; a mental health department is preferred by thirty-three per cent of this group, while twenty-six per cent recommend a public health department. For in-service training, public health personnel are slightly more likely to rank it first than are mental health people; a public health department is preferred by forty-nine per cent of the group and a mental health department by thirteen per cent. A similar pattern is true for those ranking health education first in importance.

Of course, in addition to any consideration of the respondents' program responsibilities and presumed organizational loyalties, there are undoubtedly beliefs about which agency would be the most effective setting for various mental health functions. This is clear, for example, in the case of consultation; although it is ranked first in importance about as frequently by mental health respondents as by public health respondents, fifty-one per cent of this group select a department of public health as the most appropriate agency. The same pattern is true for those ranking community development first. In the case of follow-up and rehabilitation,

mental health respondents are more likely to rank it first in importance than are public health officials, but the appropriate agency location is seen to be in a public health department as frequently as a mental health department.

Summary

There is a general widespread belief among the key officials interviewed for this study that mental health personnel should be used more extensively in public health and other-related programs than is presently the practice. The respondents favor a greater increase in such utilization in other-related programs than in public health ones. Local respondents, compared to State respondents, are somewhat more likely to want an increase in such utilization since there is currently less utilization at the local level than at the State level. Mental health respondents, particularly heads of State programs and other State, community-based personnel, are more likely to favor a greater utilization than are public health respondents.

The respondents, generally, think that those programs in which there is currently relatively high utilization of mental health personnel are most in need of increased services of such personnel. A few programs have relatively low utilization and are relatively frequently considered among the three most in need of increased services. Among the State public health programs chronic diseases programs are so considered by public health officials. Among the other-related programs, local correctional and penal programs and State family service programs are so considered by mental health and public health officials. There is general agreement among the different types of respondents about which programs are most in need of increased services. There is, however, some

tendency for State public health heads to mention public health programs: aging, maternal and child health, local health services, and chronic diseases. The other State public health officials also mention public health programs: maternal and child health, aging, chronic diseases, and nursing. Mental health respondents frequently mention aging and maternal and child health programs and, like the local respondents, juvenile delinquency. The State mental health respondents in hospital-based programs frequently mention programs in which institutionalized populations are involved.

Although there is considerable agreement about the need for increased utilization of mental health personnel outside of direct mental health programs, and to some extent about which programs most need increased services, there is somewhat more disagreement about which functions of mental health personnel are most important. Thus, mental health education is ranked high in importance by public health personnel and low by mental health personnel, while individual therapy is ranked high by mental health personnel and lower by public health personnel; research and program evaluation is ranked somewhat higher by mental health than by public health personnel. There is general agreement about the ranking of the other direct and indirect functions of mental health personnel. Insofar as there is disagreement about which functions are most important, a possible difficulty arises: the officials may agree that mental health personnel should participate in various non-direct mental health programs, but there may be some disagreement about what they should do within those programs.

CHAPTER V

CORRELATES OF PREFERENCES CONCERNING THE USE OF MENTAL HEALTH PERSONNEL

There are reasons for and against increased participation of mental health personnel outside of direct mental health programs. Consideration of the positive reasons may induce the respondents to prefer greatly increased utilization of mental health personnel in non-direct mental health programs and consideration of the negative reasons may make them wary about such developments. The existence of certain conditions in their particular State or locality may also make increased utilization seem more or less desirable. In this and the next two chapters the relevance of these considerations will be explored.

Two reasons are frequently cited for closer cooperation between mental health and other health and related professions. First, there is the belief that a client or patient is a person--not a few symptoms--living in a family and community. To provide any particular set of services, without interrelating them, reduces the effectiveness of those services. Close cooperation of the many professionals providing a wide range of services, then, is vital.[1] Second, in the particular case of mental illness, there is a shortage of mental health personnel and little effort is devoted to the prevention of emotional disorders. One way to help solve these problems is for mental health personnel to consult with, provide in-service training, and otherwise aid other professionals to be more sensitive to emotional problems.[2] Presumably, this would spread the impact of mental

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[1] Paul V. Lemkau, "Community Planning for Mental Health," Public Health Reports, Vol. 76 (June, 1961), pp. 489-497.

[2] Joint Commission on Mental Illness and Health, op. cit., pp. 244-275.

health personnel and also provide some degree of secondary prevention of mental illness.

On the other hand, differences in orientation between members of the mental health professions and other professions may be of such a character that cooperative efforts are extremely difficult and as a result members of these professions are hampered rather than helped in their work. There may be other disadvantages such as organizational and administrative disruption and conflict. The extent to which such problems are believed to exist will be discussed in the next two chapters.

Certain conditions in the officials' State or localities may encourage or discourage the respondents' wish to see an increased utilization of mental health personnel. For example, satisfaction with present organizational arrangements, the extent of public and political support, or the adequacy of financial support may affect the respondents' preferences. Some of these points, too, will be analyzed in Chapter VII.

Relevant beliefs such as the proper mission of the public health departments or the necessity of lengthy training in order to provide help to emotionally disturbed persons may also play a significant part in accounting for the variation among respondents in the extent to which they favor an increased utilization of mental health personnel.

Finally, another kind of consideration must be raised, particularly in light of the findings reported in Chapter II that the respondents' organizational role and associated commitments strongly affect their preferences about organizational arrangements. We have already seen in the previous chapter that mental health respondents are somewhat more likely to favor increased utilization of mental health personnel than are public health respondents. Perhaps this reflects the mental health

respondents' desire to expand their professional realm and concern about this among public health respondents.

The effect of the factors listed above upon three measures of preference concerning the use of mental health personnel will be examined. As measures of the respondents' belief that mental health personnel should participate in non-direct mental health programs, their net preference scores for the use of mental health personnel in public health and in other-related programs will be investigated. These two net preference scores make it possible to analyze the respondents' preferences without holding constant the current utilization in their State or locality--that is already built into the score. Third, the respondents' ranking of indirect service functions will be used as a measure of what the respondents believe is most important for mental health personnel to do--among the entire range of possible functions. The ranking of the indirect service functions, as described in Chapter IV, is based upon the respondents' ranking of two functions: consultation with other agencies and in-service training. In addition, many of the other measures discussed in the previous chapter will be analyzed as a check upon the interpretations which are made.

The interrelationships of the various measures of the respondents' preferences are revealing. All the measures of the extent to which mental health personnel should be used outside of direct mental health programs are strongly and positively related with each other. For example, persons who want much greater utilization of mental health personnel in public health programs also want much greater utilization of mental health personnel in other-related programs. Furthermore, those who want much greater utilization of mental health personnel in public health programs also tend

to want a greater absolute amount of utilization (in public health and other-related programs) as measured by the number of programs in which they think any mental health personnel should be used or as measured by the percentage score for the preferred amount of utilization of mental health personnel.

There appears to be no association between the respondents' ranking of the indirect service functions and their preferences about the extent to which there should be greater utilization of mental health personnel than is currently the practice in their State or locality. The data presented in the previous chapter, however, indicate that there is a tendency for mental health respondents to prefer increased utilization of mental health personnel and to be less likely to give high ranking to indirect services, compared to public health respondents. The apparent lack of association may be the result of these tendencies. If the respondents' program responsibilities are held constant, we do find that (1) among State public health respondents, those who favor an increased utilization of mental health personnel in public health or in other-related programs also tend to rank indirect services high; (2) among local mental health respondents, the opposite is true: those who favor an increased utilization of mental health personnel in either set of programs tend to rank indirect services low; and (3) among the other types of respondents, the relationship between the two preferences is not clear (see Tables 83 and 84). These findings indicate that the preferences about the extent of increased utilization of mental health personnel do not reveal what the mental health personnel should do. Among State public health personnel, apparently, the increased participation of mental health personnel is often desired in the provision of indirect services, while among local mental health

respondents, the increased participation in the form of indirect services is not favored.

TABLE 83

PROPORTION OF RESPONDENTS GIVING HIGH RANKING TO INDIRECT SERVICE FUNCTIONS OF MENTAL HEALTH PERSONNEL BY PREFERENCES FOR INCREASED UTILIZATION OF MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS AND BY TYPE OF RESPONDENT

Type of Respondent	Net Preference Scores for Use of Mental Health Personnel in Public Health Programs			
	Much Greater	Somewhat Greater	Same	Less
State, public health . .	56 (9)	46 (39)	38 (47)	39 (59)
Local, public health . .	30 (20)	38 (26)	25 (45)	28 (18)
State, mental health . .	34 (44)	18 (60)	25 (97)	32 (78)
Local, mental health . .	17 (24)	7 (30)	30 (50)	40 (10)

TABLE 84

PROPORTION OF RESPONDENTS GIVING HIGH RANKING TO INDIRECT SERVICE FUNCTIONS OF MENTAL HEALTH PERSONNEL BY PREFERENCES FOR INCREASED UTILIZATION OF MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS AND BY TYPE OF RESPONDENT

Type of Respondent	Net Preference Scores for Use of Mental Health Personnel in Other-Related Programs			
	Much Greater	Somewhat Greater	Same	Less
State, public health . .	50 (28)	43 (28)	40 (42)	36 (53)
Local, public health . .	34 (29)	18 (17)	33 (42)	24 (21)
State, mental health . .	26 (66)	28 (78)	21 (82)	36 (53)
Local, mental health . .	19 (31)	16 (32)	26 (39)	33 (12)

Before analyzing the correlates of the preferences concerning utilization of mental health personnel, an extremely important consideration must be noted. The measures of the preferred extent of utilization which will be analyzed refer to increased utilization. If gross percentage scores of preferences or the number of programs in which mental health personnel should participate were the focus of the analysis, it would be necessary to hold the current utilization constant in order to assess the degree to which many factors affect the respondents' preferences. This would be necessary because the absolute level of utilization realistically preferred is positively related to the current utilization in a respondent's State or locality (see Tables 61 and 62 in the previous chapter)[3] and the extent of utilization in the States and localities is at least somewhat related to extra-individual factors (see Chapter III).

The fact that the officials in States or localities with relatively high levels of utilization tend to want extensive utilization is in itself very important. This suggests that one of the determinants of the absolute level of utilization preferred is the level which exists. As discussed in Chapter III, the preferences of the respondents may also affect the actual level of utilization. We cannot be certain that the relationship between actual and preferred utilization means that the officials simply prefer the status quo or actively prefer more utilization because they have experienced more such utilization.[4]

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[3]The same finding results if, as the measure of preferences, the number of programs in which mental health personnel are desired to participate is used.

[4]There is an inverse relationship between actual level of utilization and net preference scores. But this may be an artifact of the scores. It is obviously easier for a respondent to be scored as wanting much greater utilization if he is in a State or locality in which utilization is low and it is difficult to be scored as wanting much greater utilization if one is in a State or locality which is already scored as having high utilization.

The analysis in this and succeeding chapters will be concerned particularly with the correlates of preferring an increased participation of mental health personnel outside of direct mental health programs.

The respondents' ranking of the indirect service functions of mental health personnel is not related to the extent to which members of the mental health professions currently participate in public health and other-related programs. The ranking of direct functions and preventive functions is also independent of the current extent of utilization. Thus it appears that where there is relatively high utilization, a relatively high level is preferred; but the current extent of utilization does not appear to affect beliefs about which functions of mental health personnel are most important.

State and Local Characteristics

Where mental health programs are not separately and autonomously organized, one might expect that mental health personnel are likely to provide indirect services and this would tend to be preferred. Actually, at the State level, the organizational arrangements of mental health programs are not related to the officials' ranking of indirect services of mental health personnel functions. At the local level, however, the hypothesis is supported--but only among public health respondents. Thus, among the local public health respondents in localities in which the mental health programs are not separate and autonomous, thirty-seven per cent give high ranking to indirect services, compared to twenty-two per cent among the local public health respondents in localities in which the mental health programs are separate and autonomous. There is no relationship among the local mental health respondents.

In regard to the possible effect of organizational arrangements upon preferences for the increased utilization of mental health personnel, one might hypothesize that if the mental health programs are separate and autonomous, the mental health respondents would tend to be satisfied and therefore be eager to have greater utilization of mental health personnel outside of direct mental health programs; on the other hand, the public health officials would be less satisfied and would be less likely to want an expansion of mental health personnel into public health and other-related programs.[5] An alternative hypothesis is also consistent with the results of the analysis presented thus far. If the organizational arrangements are the ones associated with greater integration between mental health and public health personnel, one might expect that the respondents would tend to want a greater increase in the utilization of mental health personnel than would be the case for respondents in other settings.

The evidence gives some support to each hypothesis--under varying conditions. The data presented in Table 85 A supports the first hypothesis. State public health respondents are most likely to prefer increased utilization of mental health personnel in public health programs where mental health programs are a division of public health, while State mental health

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[5]If one considers the absolute amount of utilization of mental health personnel in public health programs, the relationship should be different. Thus, mental health personnel tend to participate in public health programs more if the mental health programs are not separate and autonomous; respondents tend to prefer more absolute utilization where there is already relatively high utilization; therefore, in States or localities in which the mental health programs are not separate and autonomous, respondents are likely to mention a greater number of public health programs in which mental health personnel should be involved. This does seem to be the case. We also find that using the reported interaction of the respondents as a measure of the degree of current personnel integration, officials who report interacting with persons in the other professions are more likely than those who do not to mention wanting mental health personnel to be utilized in a large number of the public health programs.

officials are most likely to prefer such increased utilization of members of the mental health professions when the mental health programs are organized separately and autonomously. Among the local respondents, there is a similar relationship between the organization of mental health programs and the preferences of the respondents. The patterns are the same when preferences for the increased participation of mental health personnel in other-related programs are considered (see Table 86).

TABLE 85

PROPORTION OF RESPONDENTS PREFERRING MUCH OR SOMEWHAT GREATER UTILIZATION OF MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS BY ORGANIZATION OF MENTAL HEALTH PROGRAMS AND BY TYPE OF RESPONDENT

A. State Respondents

Type of Respondent	Organization of State Mental Health Programs		
	Separate and Autonomous	Division of Public Health	Somewhat Dispersed
Public health	27 (63)	34 (70)	26 (23)
Mental health	40 (137)	27 (89)	32 (40)

B. Local Respondents

Type of Respondent	Organization of Local Mental Health Programs	
	Separate and Autonomous	Not Separate and Autonomous
Public health	35 (61)	49 (45)
Mental health	49 (75)	44 (36)

When the location of the mental health authority is similarly analyzed, the same finding among State respondents occurs for preferences about the increased utilization of mental health personnel in public

health programs; public health officials are most likely to favor increased participation if the authority is located in a public health department; while mental health respondents are most likely to favor increased participation if the authority is located in a mental health department.[6]

TABLE 86

PROPORTION OF RESPONDENTS PREFERRING MUCH OR SOMEWHAT GREATER UTILIZATION OF MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS BY ORGANIZATION OF MENTAL HEALTH PROGRAMS AND BY TYPE OF RESPONDENT

A. State Respondents

Type of Respondent	Organization of State Mental Health Programs		
	Separate and Autonomous	Division of Public Health	Somewhat Dispersed
Public health	32 (61)	39 (69)	35 (23)
Mental health	54 (137)	44 (89)	50 (40)

B. Local Respondents

Type of Respondent	Organization of Local Mental Health Programs	
	Separate and Autonomous	Not Separate and Autonomous
Public health	38 (61)	42 (45)
Mental health	57 (75)	50 (36)

[6]There is no relationship among local mental health respondents; local public health respondents appear to be affected like State public health respondents in regard to this State level organizational arrangement. In the case of utilization of mental health personnel in other-related programs, there is no relationship among local respondents and both public health and mental health State respondents tend to favor increased utilization if the authority is not located in a mental health department.

There is no relationship between the respondents' preferences about the degree of close relations between the mental institutions and the public health departments and their preferences for the increased utilization of mental health personnel.

In connection with the joint or separate administration of the institutional and community mental health programs, the pattern is different. In States in which the two mental health programs are unified, respondents tend to favor increased utilization of mental health personnel outside of direct mental health programs. (This is true for each type of official except local mental health respondents--among whom there is no relationship.) This finding is consistent with the findings of Chapter II: there is widespread support among all respondents for the joint administration of the two mental health programs.

The two alternative hypotheses about the effect of current organizational arrangements upon preferences about the use of mental health personnel outside of mental health programs can now be reconciled. Apparently, where feelings about the appropriate organizational arrangements are strongly felt, persons in settings in which their preferences are satisfied, compared to those in settings in which they are not, tend to favor increased use of mental health personnel outside of direct mental health programs. When the feelings are less strongly felt or there is a high level of agreement, respondents in settings which are conducive to the use of mental health personnel outside of direct mental health programs, are more likely to want increased utilization than are respondents in other settings.[7]

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[7]This may account for the tendency for local respondents' preferences to be slightly less successfully explained by the first hypothesis than is the case for State respondents. As reported in Chapter II, positions about organizational arrangements are more strongly taken and more profoundly related to official role among State than among local respondents.

Before turning to a consideration of the respondents' preferences about organizational arrangements as they are related to preferences about utilization of mental health personnel, we will consider the relevance of certain population characteristics of the States and localities for the respondents' preferences about personnel integration.

As suggested at the outset of this chapter, closer integration of mental health and public health personnel may be viewed as a way of spreading the contributions of such personnel. If this is so, we would expect that in States in which such personnel are particularly scarce, the officials would be particularly likely to want closer integration of personnel.

Actually, there is no relationship between the density of population and preferences for increased utilization of mental health personnel outside of direct mental health programs or giving high rank to indirect services. This may reflect the interaction of two tendencies: a greater demand for mental health personnel as well as a greater supply in more urban centers. This interpretation will be argued in more detail when the manpower shortage as a barrier to the more effective use of mental health personnel in non-direct mental health programs is considered in Chapter VII.

There is a tendency for respondents in small population States or States with low per capita incomes to want greater integration of mental health personnel--compared to respondents in States with large populations or high per capita incomes. For example, respondents in low per capita income States are more likely than those in high per capita income States to favor much or somewhat greater utilization of mental health personnel in public health programs. The same tendency, if less marked, is true for the preferences concerning increased utilization of mental health

personnel in other-related programs. It also tends to be true for giving high rank to indirect service functions of mental health personnel. Low per capita income States have fewer psychiatrists per 100,000 persons in the population and presumably in general there is greater difficulty in such States in staffing mental health agencies.

In the case of population size, the pattern is the same (see Tables 87, 88, and 89). Increased utilization of mental health personnel tends to be preferred particularly in small population States. But there is no relationship between population size and ranking of indirect service functions.

TABLE 87

PROPORTION OF RESPONDENTS PREFERRING MUCH OR SOMEWHAT GREATER UTILIZATION OF MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS BY STATE POPULATION SIZE AND BY TYPE OF RESPONDENT

Type of Respondent	Population Size	
	Small	Large
State, public health	38 (76)	27 (85)
Local, public health	56 (45)	33 (69)
State, mental health	45 (121)	32 (161)
Local, mental health	55 (40)	45 (76)

TABLE 88

PROPORTION OF RESPONDENTS PREFERRING MUCH OR SOMEWHAT GREATER UTILIZATION OF MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS BY STATE POPULATION SIZE AND BY TYPE OF RESPONDENT

Type of Respondent	Population Size	
	Small	Large
State, public health	39 (76)	37 (82)
Local, public health	49 (45)	38 (69)
State, mental health	55 (121)	50 (161)
Local, mental health	65 (40)	51 (76)

TABLE 89

PROPORTION OF RESPONDENTS GIVING HIGH RANK TO INDIRECT SERVICE FUNCTIONS OF MENTAL HEALTH PERSONNEL BY STATE POPULATION SIZE AND BY TYPE OF RESPONDENT

Type of Respondent	Population Size	
	Small	Large
State, public health	44 (74)	39 (85)
Local, public health	29 (45)	29 (69)
State, mental health	26 (121)	28 (160)
Local, mental health	26 (42)	21 (76)

The pattern of associations at the local level is quite different. There is no relationship between preferences for increased utilization of mental health personnel in non-direct mental health programs and the type of community in which the respondent works. There is a tendency for indirect services of mental health personnel to be ranked high most frequently by respondents in metropolitan communities and least frequently by respondents in smaller communities. This seems contrary to the previous interpretation that where mental health personnel are less likely to be available in agencies, closer integration would tend to be preferred. Perhaps this indicates the other side of the picture: where the demand for mental health services is high a shortage of personnel is likely to be felt and therefore closer integration urged. These points will be discussed in detail in Chapter VII when the manpower shortage is discussed directly.

Respondent Characteristics

The relationship between the respondents' preferences concerning organizational arrangements and the utilization of mental health personnel

is an intriguing one. The data presented in Chapter II indicated that organizational preferences are profoundly affected by the respondents' official role, particularly among State level respondents. We now ask whether or not organizational preferences are influenced by preferences about the utilization of mental health personnel and whether or not preferences about organizational arrangements affect preferences about personnel integration.

First of all, it is clear that respondents who rank indirect services of mental health personnel high also tend to prefer that mental health programs be separately and autonomously organized. Since mental health respondents, compared to those with public health responsibilities, are much more likely to prefer an autonomous mental health organization and slightly less likely to rank indirect services high, this might be spurious; but, the relationship is found among each type of respondent--see Table 90A. Regardless of ranking indirect services high, however, respondents with mental health program responsibilities are still much more likely than those with public health program responsibilities to favor a separate organization of mental health programs.

If we look at the same information, percentaged in the other direction--as is done in Table 90 B--we can see that respondents who favor a separate organization of mental health programs are not likely to also give high ranking to indirect mental health services. Regardless of favoring a separate mental health organization, State public health respondents are still slightly more likely to rank indirect services high than are State mental health respondents; but holding preferences for a separate mental health organization constant, there is no consistent tendency for local public health officials to rank indirect services high compared to local mental health respondents.

TABLE 90

RELATIONSHIP BETWEEN PREFERENCES CONCERNING A SEPARATE AND AUTONOMOUS MENTAL HEALTH ORGANIZATION AND RANKING OF INDIRECT SERVICE FUNCTIONS OF MENTAL HEALTH PERSONNEL

A. Proportion of Respondents Very or Somewhat Favorable to a Separate and Autonomous Mental Health Organization by Ranking of Indirect Service Functions and by Type of Respondent

Type of Respondent	Ranking of Indirect Service Functions		
	High	Middle	Low
State, public health . . .	12 (66)	21 (62)	31 (32)
Local, public health . . .	6 (33)	13 (47)	24 (34)
State, mental health . . .	41 (77)	61 (126)	74 (81)
Local, mental health . . .	52 (27)	52 (57)	71 (34)

B. Proportion of Respondents Giving High Ranking to Indirect Service Functions of Mental Health Personnel by Preferences for a Separate and Autonomous Mental Health Organization and by Type of Respondent

Type of Respondent	Preferences for a Separate and Autonomous Mental Health Organization		
	Very or Somewhat Favorable	Slightly Favorable	Not Favorable
State, public health . . .	26 (31)	45 (56)	45 (73)
Local, public health . . .	12 (16)	29 (35)	33 (63)
State, mental health . . .	19 (167)	39 (80)	41 (37)
Local, mental health . . .	21 (68)	22 (36)	36 (14)

These results certainly indicate that the two preferences are highly related among the respondents; but, we cannot say that one preference influences the other.[8]

[8]Considering the other measures of organizational preferences, the same general pattern holds. Respondents ranking indirect services high tend to prefer the mental health authority to be located in a public health department; they tend to want the institutional and community mental health programs in separate departments (except local public

The relationships between preferences concerning increased utilization of mental health personnel outside of direct mental health programs and preferences concerning organizational arrangements are different than the ones we have just analyzed.

In the case of preferring increased utilization of mental health personnel in public health programs, we find an association only among the local respondents. If they want increased utilization, they tend not to favor a separate and autonomous mental health organization; and if they favor an autonomous organization, they tend not to want increased utilization (see Table 91 A and B). Among the State level respondents, there is no consistent association between the two preferences;[9] but note the slight tendency for State public health officials who are not favorable to an autonomous organization to be least likely to want increased utilization.

Regardless of preferences for increased utilization of mental health personnel, respondents with mental health program responsibilities are still much more likely than public health officials to favor an autonomous mental health organization (see Table 91 A). Similarly, at least among local respondents, regardless of preferences concerning an autonomous mental health organization, mental health respondents are more likely

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health respondents, among whom there is no relationship); and they tend to want local mental health needs served by local health centers including mental health centers, rather than separate mental health centers or clinics. There is no consistent relationship between ranking indirect services high and desiring close relations between mental institutions and the public health department generally.

[9]The pattern is the same when the percentage scores for the preferred extent of utilization of mental health personnel in public health programs is analyzed.

than public health ones to favor increased utilization (see Table 91 B).

TABLE 91

RELATIONSHIP BETWEEN PREFERENCES CONCERNING A SEPARATE AND AUTONOMOUS MENTAL HEALTH ORGANIZATION AND CONCERNING UTILIZATION OF MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS

A. Proportion of Respondents Very or Somewhat Favorable to a Separate and Autonomous Mental Health Organization by Preferences for Increased Utilization of Mental Health Personnel in Public Health Programs and by Type of Respondent

Type of Respondent	Net Preference Scores for Use of Mental Health Personnel in Public Health Programs	
	Much or Somewhat Greater	Same or Less
State, public health . . .	23 (52)	19 (108)
Local, public health . . .	6 (48)	18 (66)
State, mental health . . .	59 (103)	59 (174)
Local, mental health . . .	50 (56)	65 (60)

B. Proportion of Respondents Preferring Much or Somewhat Greater Utilization of Mental Health Personnel in Public Health Programs by Preferences for a Separate and Autonomous Mental Health Organization and by Type of Respondent

Type of Respondent	Preferences for a Separate and Autonomous Mental Health Organization		
	Very or Somewhat Favorable	Slightly Favorable	Not Favorable
State, public health . . .	37 (32)	38 (55)	26 (73)
Local, public health . . .	20 (15)	37 (38)	51 (61)
State, mental health . . .	38 (164)	38 (79)	36 (34)
Local, mental health . . .	42 (67)	58 (35)	57 (14)

Interestingly, too, State mental health officials who prefer the mental health authority to be located in a mental health department are most likely to want an increased utilization of mental health personnel, while among the State public health respondents, those preferring the authority to be located in a public health department are least likely to want increased utilization, and those preferring it to be located in an "other" department or agency are most likely to want increased utilization.[10]

These findings, as well as some of the others considered thus far, suggest that the respondents' organizational role commitments and loyalty to their professions as interest groups may influence the respondents' preferences about the use of mental health personnel. If this is so, however, it contributes only a little to a full explanation of these preferences.[11]

In the case of preferences concerning the increased utilization of mental health personnel in other-related programs, there is even less relationship with preferences concerning organizational arrangements than

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[10]The proportions of State mental health respondents wanting much or somewhat greater utilization of mental health personnel by preferred location of mental health authority are: mental health department, forty-one per cent; public health department, thirty-five per cent; other department or agency, thirty-one per cent. Among the public health respondents, the comparable percentages are: thirty-six, thirty, and fifty-three. Only State respondents were asked for their preferences concerning the location of the mental health authority.

[11]There is no relationship between preferences concerning increased utilization of mental health personnel in public health programs and preferences about (1) the joint or separate administration of the community and institutional mental health programs, (2) the degree of close relations between the mental institutions and the public health departments, or (3) the organization of local services for the provision of mental health needs.

in the case of preferences about increased utilization of mental health personnel in public health programs. Only among the local mental health respondents is there a clear association between preferences about an autonomous mental health organization and preferences about increased utilization of mental health personnel in other-related programs (see Table 92 A and B).

TABLE 92

RELATIONSHIP BETWEEN PREFERENCES CONCERNING A SEPARATE AND AUTONOMOUS MENTAL HEALTH ORGANIZATION AND CONCERNING UTILIZATION OF MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS

A. Proportion of Respondents Very or Somewhat Favorable to a Separate and Autonomous Mental Health Organization by Preferences for Increased Utilization of Mental Health Personnel in Other-Related Programs and by Type of Respondent

Type of Respondent	Net Preference Scores for Use of Mental Health Personnel in Other-Related Programs	
	Much or Somewhat Greater	Same or Less
State, public health	20 (60)	21 (97)
Local, public health	15 (48)	12 (66)
State, mental health	61 (144)	57 (133)
Local, mental health	51 (65)	67 (51)

B. Proportion of Respondents Preferring Much or Somewhat Greater Utilization of Mental Health Personnel in Other-Related Programs by Preferences for a Separate and Autonomous Mental Health Organization and by Type of Respondent

Type of Respondent	Preferences for a Separate and Autonomous Mental Health Organization		
	Very or Somewhat Favorable	Slightly Favorable	Not Favorable
State, public health	38 (32)	48 (52)	32 (73)
Local, public health	46 (15)	42 (38)	41 (61)
State, mental health	54 (164)	54 (79)	42 (34)
Local, mental health	49 (67)	60 (35)	79 (14)

State mental health respondents who prefer the mental health authority to be located in a mental health department are again most likely to want increased utilization of mental health personnel in other-related programs, while State public health officials are most likely to favor increased utilization if they prefer the authority to be located in an "other" department or agency; but there is no difference among State public health officials who prefer the authority to be located in a mental health rather than in a public health department.[12]

In short, preferences about the relative importance of various functions of mental health personnel are highly related to organizational preferences: officials favoring close organizational arrangements between mental health and public health programs also tend to give high rank to indirect service functions. There is a tendency only among local respondents for those who favor an autonomous organization of mental health programs to also favor increased utilization of mental health personnel. Apparently such role-related preferences are more relevant for ranking the functions of mental health personnel than they are for preferring increased utilization of such personnel.

In analyzing the respondents' preferences concerning organizational arrangements, three questions indicating general orientation toward some of the issues in this study were examined: (1) question 27 asked about the amount of training needed to help persons with emotional problems;

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[12]There are no relationships between respondents with different preferences about increased utilization of mental health personnel in other-related programs and preferences about: (1) the joint or separate administration of community and institutional mental health programs; (2) the degree of close relations between the mental institutions and the public health departments; and (3) the organizational form for providing local mental health services.

(2) question 28A asked about the extent to which public health departments should provide direct treatment services to patients; and (3) question 28B asked about the responsibility of public health and mental health agencies for treating the non-institutionalized mentally ill.[13]

Conceptions of the responsibility of agencies for treating the mentally ill are not related to preferences about increasing the use of mental health personnel in public health programs while those who believe agencies should provide extensive treatment services are somewhat less likely to prefer increased use of mental health personnel in other-related mental health programs.[14] Attitudes about the responsibility of agencies for treating the mentally ill are not related to ranking of indirect service functions of mental health personnel.

Local respondents who feel that the public health departments should greatly increase their treatment activities tend to think that there should be an increase in the use of mental health personnel in

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[13]It was found that respondents who differ about the responsibility of agencies for treating the mentally ill do not differ in organizational preferences. Local respondents who believe the public health department's mission should be primarily preventive tend to think that the local mental health programs should be separate and autonomous. Respondents who believe that considerable expertness is required to help persons with emotional problems tend to prefer a separate organization of mental health programs and services.

[14]Using the measure of the number of public health programs in which the respondents believe any mental health personnel should participate, we do find that public health respondents who believe the agencies should provide extensive therapeutic services tend to think there should be more extensive use of mental health personnel in non-direct mental health programs. Apparently, taking into account the actual utilization of mental health personnel (as is done in the measure of the preferences for increased utilization) reverses the relationship.

public health programs.[15] There is no relationship with preferences for the increased use of mental health personnel in other-related programs. Among local public health respondents only do we find that those who think treatment services should be increased greatly tend to rank indirect services high.

In the case of beliefs about the amount of training needed to help persons with emotional problems, we do find a marked and consistent tendency for respondents who think even a little training can make it possible to help people with emotional problems to rank indirect service functions of mental health personnel high (see Table 93). Such a belief, of course, must underlie valuing highly the consultation and in-service training functions of mental health personnel. Note, however, that such beliefs do not explain the differences between respondents with mental health and with public health program responsibilities. There is no relationship between beliefs about the amount of training needed and preferences for the increased use of mental health personnel in non-direct mental health programs.[16]

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[15]Using the measure of the number of programs in which the respondents believe mental health personnel should be used, there is some indication that, even among State respondents, believing the treatment activities should be greatly increased is related to wanting extensive use of mental health personnel. The same is true for public health respondents as concerns the number of other-related programs in which mental health personnel should participate.

[16]We do find that respondents who believe that even a little training is helpful tend to think mental health personnel should be used in more public health programs than do persons who think only specially trained persons can give help which will not do more harm than good. There is no relationship between such beliefs and the number of other-related programs in which the respondents believe that mental health personnel should participate in some way.

TABLE 93

PROPORTION OF RESPONDENTS GIVING HIGH RANKING TO INDIRECT SERVICE FUNCTIONS OF MENTAL HEALTH PERSONNEL BY BELIEFS ABOUT THE LENGTH OF TRAINING TO HELP PERSONS WITH EMOTIONAL PROBLEMS AND BY TYPE OF RESPONDENTS

Type of Respondent	Beliefs	
	Lengthy Training	Little Training
State, public health	26 (40)	46 (121)
Local, public health	15 (27)	33 (84)
State, mental health	18 (56)	29 (223)
Local, mental health	15 (33)	26 (84)

On the whole, beliefs about the amount of treatment agencies should provide do not seem to affect preferences about the increased use of mental health personnel. Beliefs about the amount of training needed to help emotionally disturbed persons does affect ranking of indirect service functions of mental health personnel: officials who believe that only persons with specialized lengthy training can give help to emotionally disturbed persons without doing more harm than good tend to rank indirect service functions of mental health personnel low. This belief does not seem to affect preferences for increased use of mental health personnel outside of mental health programs.

Another pair of measures of general orientations is provided by the respondents' ranking of the other functions of mental health personnel. The ranking of direct functions (individual therapy and counseling) is not related to preferences about the increased use of mental health personnel outside of direct mental health programs, but it is, of course, strongly inversely related to the ranking of indirect functions. The ranking of preventive functions is not related to ranking of indirect functions.

Public health respondents, particularly those at the local level, who give a high ranking to preventive functions tend to want increased utilization of mental health personnel in public health programs (see Table 94). In the case of increased utilization of mental health personnel in other-related programs, local respondents (particularly those with public health responsibilities) who rank preventive functions high tend to want increased utilization (see Table 95).

TABLE 94

PROPORTION OF RESPONDENTS PREFERRING MUCH OR SOMEWHAT GREATER UTILIZATION OF MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS BY RANKING OF PREVENTIVE MENTAL HEALTH FUNCTIONS AND BY TYPE OF RESPONDENT

Type of Respondent	Ranking of Preventive Functions		
	High	Middle	Low
State, public health	31 (73)	32 (40)	20 (36)
Local, public health	56 (34)	45 (40)	27 (34)
State, mental health	36 (109)	41 (98)	33 (70)
Local, mental health	52 (29)	44 (34)	47 (49)

TABLE 95

PROPORTION OF RESPONDENTS PREFERRING MUCH OR SOMEWHAT GREATER UTILIZATION OF MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS BY RANKING OF PREVENTIVE FUNCTIONS AND BY TYPE OF RESPONDENT

Type of Respondent	Ranking of Preventive Functions		
	High	Middle	Low
State, public health	37 (72)	31 (38)	36 (36)
Local, public health	65 (34)	47 (40)	12 (34)
State, mental health	50 (109)	54 (98)	53 (70)
Local, mental health	62 (29)	53 (34)	51 (49)

Finally, we turn to a consideration of certain background characteristics of the respondents. Respondents with different professional identifications do not markedly differ in their likelihood to prefer an increased utilization of mental health personnel in non-direct mental health programs. But, in the case of ranking of indirect service functions, we do find that public health nurses are more likely than those who identify themselves as public health professionals generally, to give high rank to indirect service functions (sixty-one per cent compared to thirty-four per cent). Psychiatrists are least likely to rank indirect service functions high, among the mental health professions.

Younger respondents do not consistently differ from older respondents in their preferences for the increased utilization of mental health personnel in non-direct mental health programs, holding type of respondent constant. Public health officials under fifty-five years of age tend to rank indirect service functions high, compared to those fifty-five or older. There is no clear relationship between age and ranking among mental health respondents (see Table 96).

TABLE 96

PROPORTION OF RESPONDENTS GIVING HIGH RANKING TO INDIRECT SERVICE FUNCTIONS BY AGE OF RESPONDENT AND TYPE OF RESPONDENT

Type of Respondent	Age		
	Under 45	45 - 54	55 or Older
State, public health	42 (31)	49 (64)	32 (65)
Local, public health	31 (29)	43 (42)	14 (42)
State, mental health	29 (140)	23 (94)	23 (53)
Local, mental health	20 (78)	26 (23)	29 (17)

It is noteworthy, finally, that State mental health officials who have been in their present job longer are more likely than those who have been in their job for fewer years to prefer increased utilization of mental health personnel in non-direct mental health programs.[17] There is no relationship among other types of respondents. There is no relationship between years in the job and ranking of indirect service functions.

In summary, ranking mental health personnel functions in terms of their importance is particularly associated with professional and role identifications. Preferences about increased utilization seem to be somewhat more affected by considerations of the situation within which the respondent works. Population characteristics of the States, current organizational arrangements, and other situational considerations particularly affect the respondents' judgments about the increased utilization of mental health personnel in non-direct mental health programs.

The respondents' program responsibilities play some role in affecting their preferences about the extent and form of mental health personnel utilization. Mental health officials may want increased utilization of their services, but they tend to want it so that they can perform functions which they think are important--ones which are central to their professional training. They also want (as we saw in Chapter II) to have mental health programs autonomously organized. There may be a dilemma here since the evidence of Chapter III indicates that greater personnel integration occurs when mental health programs are not autonomous. Public health officials

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[17] Thus, the percentage of State mental health respondents preferring much or somewhat greater utilization of mental health personnel in public health programs, by years in present job, is: less than two years, thirty per cent; two to four years, thirty-three per cent; five to nine years, forty-three per cent; and ten years or more, forty-seven per cent. The comparable percentages wanting increased utilization in other-related programs are: thirty-eight, fifty-six, fifty-five, and sixty-two, respectively.

may also want increased utilization of mental health personnel, although they are slightly less likely to want it, but they want it in a form which will help them and they do not want the mental health programs to be autonomous. Here are some bases for conflict over control and purpose of collaboration; the respondents' explicit view on these matters are discussed in the next chapter.

PART III.

PROBLEMS AND BARRIERS

CHAPTER VI

PROBLEMS IN INTEGRATING MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH AND OTHER-RELATED PROGRAMS

The difficulties and disadvantages of mental health personnel participating in public health and other-related programs, mentioned previously only in passing, is the subject of this chapter. Among the possible disadvantages is that efforts will be dissipated as many people try to do too many things at once. In a period of increasing knowledge, specialization may be necessary to achieve mastery and provide effective services and make significant advances. Differences in orientation may be disruptive to the smooth functioning of programs. Programs may lose their direction and coherence and thus lose their support. Many other possible risks could be mentioned and have been by the key officials interviewed for this study.

The respondents were asked several questions related to these issues. One question was: "Each profession and group of professions have their particular way of looking at matters related to their work. From your own experience and from what you have heard, what differences are there in approach between public health and mental health personnel that sometimes pose problems for cooperation between them?" The answers were categorized into several groupings and the results, by respondents with different program responsibilities, are presented in Table B-15. Few persons deny that there are problem-posing differences in approach between these two groups of professionals.

The most frequently mentioned specific difference in approach is that public health personnel are community or group-oriented while mental health persons are individual oriented. This is particularly reported by

heads of State public health programs; as one of them said:

> I would say public health personnel think in terms of groups of people for prevention and treatment. Mental health personnel, they think of health problems as they relate to an individual person and are unable to make use of public health's time-tested techniques; they are oriented toward treatment of disease.

This response was also coded in the other relatively frequently mentioned specific difference in orientation: that public health personnel are preventively oriented while mental health personnel are therapeutically oriented. Here is how the head of social services in a State mental health program expresses this idea:

> Public health personnel are health oriented and mental health personnel are "illness" oriented. A public health person is relatively more interested in prevention; mental health person is more interested in the clinical aspect. The basic difference is that between pathology and health. We tend to think in terms of direct services for their pathological conditions and they think of turning off the faucet. We live in different worlds. I've made it deliberately strong to highlight the differences.

It is noteworthy that public health and mental health respondents tend to agree in their perceptions of the differences in approach between them.

In addition to such specific differences in orientation, references to the idea that persons of one or both professions do not understand or appreciate each other's problems or the nature of their work are also very frequently made. The head of public health nursing services in one State answered this question at length--the interviewer recorded four typewritten pages--and discussed this idea as well as others with a concreteness which deserves extended quotation. Here are some excerpts:

> The mental health people do not know enough about how the other disciplines work. They don't know enough about how the sanitarian has to work or what he's responsible for. They don't know enough about the dentist--how he works. And they don't know enough about the social workers. They do know something about nursing. They do not know administration. And above all, they do not know how to explain

> what they can do for somebody else because they don't know where they can fit in.
>
> Now public health people on the other hand still call the mental health people headshrinkers. They still think this is a witch doctor that's going to come in and look at them and know what they're thinking.
>
> Another concept some public health people have is that they say "mental health doesn't concern me at all because I'm not dealing with people, I'm dealing with statistics or sewage tanks or newspapers. I'm not dealing with people; I don't have anything to do with the mentally sick--those people are over there; they're off their rocker; they don't have a physical ailment."
>
> The public health people themselves don't have an understanding of how to use the mental health people. They do have an overall approach and they can't understand why this mental health person doesn't have an overall approach. "Why he's in the field of public health--he's working in the same agency--what did they hire him for at that fantastic salary if he doesn't know ALL like I know ALL." It takes a tremendous amount of give and take from both of them.
>
> * * * *
>
> Another important area is a resistance between the physician and another person who is not a physician....This natural resistance isn't limited only to someone else being the top man to administer a program.....He's not going to cooperate with this mental health person and make things easier for him because if he does, and the mental health person gets too much power and starts too many programs and is in charge of too many areas, he will usurp the doctor as being the top man.

Clearly, the key officials who were interviewed are aware of many differences in approach between public health and mental health persons that sometimes cause problems in cooperation between them.

Although the differences may pose problems for cooperation, some persons may believe that such differences, nevertheless, are advantageous. Therefore the respondents were asked, "With respect to the effectiveness of health or health related programs, do you think such problems are an advantage or a disadvantage?" Most persons believe that they are disadvantages (see Table B-16). Nevertheless, about one out of five mental

health respondents say they are advantageous; as one of them said, "Having to give a reason for using one or the other approach gives stimulation to thought."

The key officials interviewed were also asked, "Aside from differences in orientation, what disadvantages are there in having mental health personnel working in health or health related programs?" Slightly more than half of the respondents say there are no other disadvantages. The heads of State public health and other State public health respondents are slightly more likely than mental health respondents to say there are none (see Table B-18). The most frequently cited disadvantages concerned (1) difficulties in dividing responsibilities and sharing the work and (2) difficulties in coordinating the programs and administering them properly. Two examples of such comments are given below:

> (A psychiatric nursing consultant in a State hospital-based mental health program:) They do not work together very well when it comes to direct programs....Public health feels that mental health is trying to "muscle in" and the disadvantage lies in the friction developed--each one wants to be at the upper command level.

> (A clinical psychologist in a State community based mental health program:) When the mental health program was part of the health program it was expected to do mental health education through the health education people. They were reluctant to do it. Treatment was not included. As a result the mental health program gets short shrift.

A wide range of other disadvantages is mentioned by the respondents. Several persons comment that mental health programs would be hampered in development; as one respondent said, "Public health services are often limited by cumbersome regulations and restrictions which have no particular relation to mental health activities." Another disadvantage is that the mental health personnel would be professionally isolated; one person reported, "They lack in professional contact--they are in a vacuum."

Another person said, "It impairs professional mobility--it obscures your public and professional image which is needed for proper identification."

Extent of Personnel Integration and Organizational Arrangements as Factors Affecting Perception of Problems

It seems reasonable to suppose that persons who work in settings in which there is more integration between mental health and public health personnel would be more aware of problems than would those in settings with less integration; but perhaps they come to ignore the problems or, indeed, the problems become less important where integration is greater. It also seems reasonable to suppose that persons working in settings in which the mental health programs are not separately organized would be particularly likely to find problems arising on a day-to-day basis; but ways of handling the problems may be more likely to develop so that the problems are less likely to be noticed. The data presented in Chapter III indicate that there is a tendency for greater integration between mental health and public health personnel to be found in States and localities in which the mental health programs are not autonomous. It is, therefore, necessary to analyze the extent of integration and the organizational arrangements simultaneously if we are to assess the role of each as a possible factor influencing perceptions of difficulties in the use of mental health personnel outside of direct mental health programs.

The way in which organizational arrangements and the extent of personnel integration affect perceptions of difficulties in the participation of mental health personnel outside of direct mental health programs is complex. As can be seen in Table 97, there is no relationship between organizational arrangements and awareness of differences in orientation between mental health and public health personnel. There is a tendency,

however, for respondents in States or localities in which there is relatively more utilization of mental health personnel in public health programs to be more aware of differences in orientation. If the extent of utilization of personnel from public health departments in mental health programs is examined, there is still no relationship between organizational arrangements and perception of problem-posing differences in orientation; perception of difficulties is more likely only in localities in which there is greater utilization--there is no relationship at the State level. If the use of mental health personnel in other-related programs is examined, no relationships are found.

TABLE 97

PROPORTION OF RESPONDENTS MENTIONING PROBLEM-POSING DIFFERENCES IN ORIENTATION BETWEEN MENTAL HEALTH AND PUBLIC HEALTH PERSONNEL BY ORGANIZATION OF MENTAL HEALTH PROGRAMS AND BY EXTENT OF UTILIZATION OF MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS

A. State Respondents

Level of Utilization of Mental Health Personnel	Organization of Mental Health Programs		
	Separate and Autonomous	Division of Public Health	Somewhat Dispersed
High	89 (92)	87 (119)	90 (22)
Low	79 (127)	86 (49)	73 (48)

B. Local Respondents

Level of Utilization of Mental Health Personnel	Organization of Mental Health Programs	
	Separate and Autonomous	Not Separate and Autonomous
High	86 (147)	81 (53)
Low	80 (75)	80 (30)

Apparently, then, awareness of differences in orientation between mental health and public health personnel does tend to be greater where there is more integration between them.

In the case of considering such differences in orientation a disadvantage, the results are different. It now appears that it is not the extent of personnel integration but whether or not the mental health programs are separately organized. If the mental health programs are not separately organized, persons who perceive differences in orientation are more likely to consider such differences disadvantageous, holding constant the extent to which public health personnel participate in mental health programs (see Table 98). If the participation of mental health personnel in public health programs is held constant, at the State level, respondents in States in which the mental health programs are a division of public health are most likely to consider differences in orientation disadvantageous. There are no relationships when the use of mental health personnel in other-related programs is held constant.

TABLE 98

PROPORTION OF RESPONDENTS CONSIDERING PERCEIVED DIFFERENCES IN ORIENTATION AS DISADVANTAGES BY ORGANIZATION OF MENTAL HEALTH PROGRAMS AND BY EXTENT OF UTILIZATION OF PUBLIC HEALTH PERSONNEL IN MENTAL HEALTH PROGRAMS

A. State Respondents

Level of Utilization of Public Health Personnel	Organization of Mental Health Programs		
	Separate and Autonomous	Division of Public Health	Somewhat Dispersed
High	72 (64)	77 (88)	73 (44)
Low	68 (115)	81 (57)	80 (10)

B. Local Respondents

Level of Utilization of Public Health Personnel	Organization of Mental Health Programs	
	Separate and Autonomous	Not Separate and Autonomous
High	72 (60)	76 (37)
Low	74 (54)	82 (28)

The respondents' perceptions of other disadvantages to the participation of mental health personnel outside of direct mental health programs are also affected by the settings in which they work. If the utilization of mental health personnel in public health programs is held constant, State respondents in States in which the mental health programs are not autonomous tend to report other disadvantages (see Table 99). Holding participation of public health personnel in mental health programs constant, there is no relationship with organizational arrangements but the respondents in States or localities with higher levels of utilization tend to report disadvantages. Holding constant the participation of mental health personnel in other-related programs gives similar results as when their participation in public health programs is held constant, as shown in Table 99.

TABLE 99

PROPORTION OF RESPONDENTS MENTIONING OTHER DISADVANTAGES IN THE PARTICIPATION OF MENTAL HEALTH PERSONNEL OUTSIDE OF DIRECT MENTAL HEALTH PROGRAMS BY ORGANIZATION OF MENTAL HEALTH PROGRAMS AND BY EXTENT OF UTILIZATION OF MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS

A. State Respondents

Level of Utilization of Mental Health Personnel	Organization of Mental Health Programs		
	Separate and Autonomous	Division of Public Health	Somewhat Dispersed
High	38 (93)	37 (119)	52 (21)
Low	32 (123)	49 (53)	39 (43)

B. Local Respondents

Level of Utilization of Mental Health Personnel	Organization of Mental Health Programs	
	Separate and Autonomous	Not Separate and Autonomous
High	44 (66)	40 (52)
Low	36 (73)	37 (27)

There is another kind of data which can be used to test the inferences being drawn. Public health respondents were asked whether or not they interacted professionally with mental health personnel and mental health respondents were asked the same question about their interaction with persons in the public health departments. Respondents reporting such interaction are more likely to mention problem-posing differences in orientation than are respondents who do not report such interaction (see Table 100). Respondents who report such interaction are also more likely to think such differences are disadvantageous, compared to those who do not report such interaction (seventy-four per cent compared to sixty-one per cent). Finally, respondents reporting interacting with members of the other profession tend to mention other disadvantages of mental health personnel participating in non-direct mental health programs (see Table 101).

TABLE 100

PROPORTION OF RESPONDENTS MENTIONING PROBLEM-POSING DIFFERENCES IN ORIENTATION BETWEEN MENTAL HEALTH AND PUBLIC HEALTH PERSONNEL BY TYPE OF RESPONDENT AND WHETHER OR NOT THEY INTERACT WITH EACH OTHER

Type of Respondent	Reported Interaction with Other Profession	
	Do Interact	Do Not Interact
State, public health	84 (186)	68 (13)
Local, public health	79 (101)	75 (16)
State, mental health	87 (243)	74 (35)
Local, mental health	89 (104)	54 (15)

TABLE 101

PROPORTION OF RESPONDENTS MENTIONING OTHER DISADVANTAGES IN THE PARTICIPATION OF MENTAL HEALTH PERSONNEL OUTSIDE OF DIRECT MENTAL HEALTH PROGRAMS BY TYPE OF RESPONDENT AND WHETHER OR NOT THEY INTERACT WITH EACH OTHER

Type of Respondent	Reported Interaction with Other Profession	
	Do Interact	Do Not Interact
State, public health	25 (182)	27 (11)
Local, public health	32 (98)	26 (16)
State, mental health	47 (245)	32 (34)
Local, mental health	50 (102)	29 (14)

These relationships, although they are not large, suggest that the awareness of difficulties in the participation of mental health personnel is affected by the respondents' settings. Closer relations between public health and mental health personnel, on the whole, do not at present seem to decrease awareness of difficulties; apparently there is greater awareness of the problems and disadvantages of members of the mental health professions participating in non-direct mental health programs.

The Effect of Perceived Problems upon Preferences Concerning Organizational Arrangements and Preferences Concerning the Participation of Mental Health Personnel in Non-Direct Mental Health Programs

Respondents in settings in which there is closer integration between mental health and public health personnel tend to be disproportionally aware of difficulties and disadvantages of the participation of mental health personnel outside of direct mental health programs. Does awareness of problems lead persons to prefer less close relations? There is one analytical point which must be noted. We have already seen, in Chapter II, that respondents tend to prefer the existing arrangements and this may counteract any such influence.

There is no relationship between awareness of differences of orientation or of considering those differences disadvantageous and preferences about organizational arrangements, even holding present organizational arrangements constant.

The results are different when we consider whether or not the respondents mention other disadvantages of the participation of mental health personnel outside of direct mental health programs. As can be seen in Table 102, respondents who mention other disadvantages of the participation

of mental health personnel, compared to those who do not, are more likely to be very or somewhat favorable to a separate mental health organization. Only among State mental health respondents does this relationship not hold.

TABLE 102

PROPORTION OF RESPONDENTS VERY OR SOMEWHAT FAVORABLE TO A SEPARATE AND AUTONOMOUS MENTAL HEALTH PROGRAM BY WHETHER OR NOT THEY MENTION OTHER DISADVANTAGES OF THE PARTICIPATION OF MENTAL HEALTH PERSONNEL OUTSIDE OF DIRECT MENTAL HEALTH PROGRAMS AND BY TYPE OF RESPONDENT

Type of Respondent	Other Disadvantages[a]	
	Mentions Some	Denies Any
State, public health	31 (39)	14 (112)
Local, public health	18 (33)	9 (72)
State, mental health	55 (128)	68 (142)
Local, mental health	66 (56)	51 (55)

[a]Respondents who said they did not know are excluded as are those who failed to answer the question.

In short, there is only a suggestion that officials who perceive difficulties and disadvantages in the participation of mental health personnel in non-direct mental health programs tend to want a separate mental health organization.

In the case of awareness of problems influencing preferences about personnel integration, we need not be very troubled by the actual settings in which the respondents work: the ranking of indirect service functions of mental health personnel is not related to the current level of utilization of such personnel in public health and other-related programs, nor is it related systematically to the actual organizational arrangements of mental health programs (see Chapter V); the measures of preference for

increased utilization of mental health personnel already take into account the actual level of utilization (see Chapter IV), but the measures are related in a complex way to actual organizational arrangements (see Chapter V).

Perceiving difficulties in the participation of mental health personnel in non-direct mental health programs does not seem to influence the respondents to rank indirect services of mental health personnel low. In fact, officials who report differences in orientation between mental health and public health personnel are somewhat more likely than those who do not, to rank indirect service functions high (thirty-one per cent compared to twenty-one per cent). This is true for each type of respondent also, except that there is no relationship among local mental health respondents. In the case of considering those differences disadvantageous, State public health respondents who do consider them disadvantageous do tend to rank indirect services low, but there is no relationship among the other types of respondents, or, as among the local mental health respondents, they are more likely to rank indirect services high if they consider the differences in orientation disadvantageous.

Similarly, State public health respondents who mention other disadvantages of mental health personnel participation in non-direct mental health programs tend to rank indirect services low, but this is not true for the other types of respondents (see Table 103).

On the whole, awareness of difficulties and disadvantages of mental health personnel participating in non-direct mental health programs does not tend to make the officials less desirous of having mental health personnel provide indirect service functions.

TABLE 103

PROPORTION OF RESPONDENTS RANKING INDIRECT SERVICE FUNCTIONS OF MENTAL HEALTH PERSONNEL HIGH BY WHETHER OR NOT THEY MENTION OTHER DISADVANTAGES OF THE PARTICIPATION OF MENTAL HEALTH PERSONNEL OUTSIDE OF DIRECT MENTAL HEALTH PROGRAMS AND BY TYPE OF RESPONDENT

Type of Respondent	Other Disadvantages[a]	
	Mentions Some	Denies Any
State, public health . . .	25 (40)	50 (106)
Local, public health . . .	29 (31)	33 (69)
State, mental health . . .	29 (130)	24 (140)
Local, mental health . . .	27 (56)	20 (54)

[a]Respondents who said they did not know are excluded as are those who failed to answer the question.

Awareness of difficulties and disadvantages, however, does seem to be related to not wanting an increase in the utilization of mental health personnel outside of direct mental health programs.

In the case of preferring an increase in the use of mental health personnel in public health programs, respondents who mention problem-posing differences in orientation are somewhat less likely to want an increase in utilization, compared to those who do not mention such differences. (This is most marked among local, public health and State mental health respondents; the relationship is slightly inverse among local mental health respondents.) Considering such differences disadvantageous is not related consistently with wanting an increased utilization of mental health personnel in public health programs. The findings for the relationship between reporting other disadvantages of mental health personnel participating in non-direct mental health programs and preferences for increased utilization of such personnel in public health programs are shown in Table 104.

Respondents who mention other disadvantages, compared to those who deny that there are any, tend to be less likely to want increased utilization of mental health personnel in public health programs.

TABLE 104

PROPORTION OF RESPONDENTS PREFERRING MUCH OR SOMEWHAT GREATER UTILIZATION OF MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS BY WHETHER OR NOT THEY MENTION OTHER DISADVANTAGES OF THE PARTICIPATION OF MENTAL HEALTH PERSONNEL OUTSIDE OF DIRECT MENTAL HEALTH PROGRAMS AND BY TYPE OF RESPONDENT

Type of Respondent	Other Disadvantages[a]	
	Mentions Some	Denies Any
State, public health . . .	29 (38)	33 (109)
Local, public health . . .	30 (33)	47 (71)
State, mental health . . .	35 (124)	39 (141)
Local, mental health . . .	40 (54)	57 (55)

[a]Respondents who said they did not know are excluded as are those who failed to answer the question.

In the case of preferring an increase in the utilization of mental health personnel on other-related programs, we find again that those who mention problem-posing differences in orientation are less likely to want an increase in such utilization. (This is the case for each type of respondent with the exception of local mental health respondents, among whom there is no relation.) We also find that respondents who consider such differences disadvantageous tend to be less likely to want increased utilization of mental health personnel in other-related programs. Finally, local public health respondents who mention other disadvantages of mental health personnel participation in non-direct mental health programs disproportionally tend to be less likely to prefer increased utilization of mental health

personnel in other-related programs; there is no relationship among the other types of respondents.

In conclusion, the findings presented in this chapter may be read to suggest the need for caution in rapid increases of mental health personnel participation in non-direct mental health programs. Closer organizational and personnel integration do not, at least immediately, do away with the difficulties and disadvantages of their participation. The officials are more likely to report disadvantages if they are in settings in which there is relatively close organizational and personnel integration. If respondents mention disadvantages other than differences in orientation, they are slightly more likely to prefer an autonomous mental health organization. If they mention problem-posing differences in orientation, consider them disadvantages, or mention other disadvantages, the officials tend not to favor increased utilization of mental health personnel. Interestingly, too, we find again that consideration of these factors related to the situation in which the respondents work affect their preferences for increased utilization of mental health personnel, but not their ranking of indirect service functions of such professions.

The associations reported, however, are not very strong. Therefore, we do not find that where mental health programs are not autonomous respondents do not want an increased utilization of mental health personnel (see Chapter V). Neither do we find that respondents generally want less intimate organizational connections between mental health and other programs (see Chapter II). On the whole, also, the officials do want members of the mental health professions to participate more in a wide range of non-direct mental health programs (see Chapter IV).

There is another meaning, therefore, to the findings reported in this chapter. The findings, in the context of the other analysis presented, indicate the strength of the desire for closer collaboration. After all, it would be amazing if awareness of difficulties and disadvantages did not make any difference for preferences about organizational arrangements and personnel integration. The weakness of the associations, then, are a testimony to the officials' belief in the advantages of such collaboration.

The point is that there are some risks in cooperation. Increased participation of mental health personnel does not automatically gratify all the members of the cooperating professions so that they want to increase it further. In the next chapter the respondents' reports of the barriers to the more effective use of mental health personnel shed some light on ways to bring about the generally desired increased participation without producing reactions against it.

CHAPTER VII

BARRIERS TO THE MORE EFFECTIVE USE OF MENTAL HEALTH PERSONNEL

Despite the difficulties and disadvantages of cooperation between members of the mental health professions and public health and other professions, collaborative work is necessary and undoubtedly will continue to grow. It is imperative, then, to consider the barriers to the more effective utilization of mental health personnel outside of direct mental health programs. The respondents were asked to assess the relative importance of several possible barriers. Their answers, an analysis of the State and local conditions related to varying assessments, and an analysis of the relationship between such assessments and preferences about organizational arrangements and personnel integration will suggest ways of reducing those barriers.

Each respondent was asked, "How important do you consider each of the following factors are as barriers to the more effective use of existing mental health personnel in your (STATE)(LOCAL) health and welfare programs?" The respondents were asked about nine factors:

1. Manpower shortage
2. Inadequate tax base, lack of resources
3. Differences in orientation and values between mental health and public health personnel
4. Unclear division of responsibility between agencies--"jurisdictional disputes"
5. Inappropriate use of personnel
6. Inadequate agency assessment of need
7. Resistance of tax appropriating bodies
8. Resistance of executive branch leadership
9. Lack of public support

The answers, by type of respondent, are presented in Tables B-19a through B-19i. Clearly, the factor most frequently mentioned as a very important barrier is the manpower shortage; about two-thirds or more of every major category of respondents consider this barrier very important. Since the question asked about the use of existing personnel, this insistence on the handicap imposed by the manpower shortage is even more striking. Respondents with mental health responsibilities are somewhat more likely to mention the manpower shortage as a very important barrier than are public health respondents (see Table B-19a). Inadequate tax base, lack of resources, is the second most frequently cited barrier. This is relatively frequently mentioned by heads of State alcoholism programs and local mental health respondents (see Table B-19b).

The third most frequently mentioned barrier is the resistance of tax appropriating bodies. Heads of alcoholism programs and State mental health respondents in community-based programs are particularly likely to consider this factor a very important barrier (see Table B-19g). Two other factors also involve outside support as a possible barrier. The resistance of executive branch leadership is rarely considered to be a very important barrier (see Table B-19h). The other, lack of public support, is regarded as a very important barrier by only about one-fourth of the respondents--but this is somewhat more than is true of most of the factors presented to the respondents. Heads of State alcoholism programs are particularly likely to consider this factor a very important barrier (see Table B19i);

In the previous chapter we had seen that the respondents are generally aware of important differences in orientation between mental health and public health personnel and generally regard such differences as a disadvantage of having mental health personnel working outside of direct

mental health programs. Nevertheless, among the list of factors about which they were asked, few respondents say they regard such differences as a very important barrier to the more effective use of mental health personnel (see Table B-19c).

Finally, three factors are related to organizational problems as possible barriers. All three are considered to be a very important barrier by only a few respondents. Unclear division of responsibility is mentioned about as infrequently by each group of respondents (see Table B-19d). Inappropriate use of personnel is considered a very important barrier only slightly more frequently by State mental health respondents than by State public health respondents (see Table B-19e). Inadequate agency assessment of need is somewhat more likely to be considered a very important barrier by heads of State alcoholism programs and State mental health respondents than by other respondents (see Table B-19f). There is an interesting tendency for heads of State public health programs to be least likely to consider each of these three organizational factors as a very important barrier.

Each of these possible barriers to the effective use of mental health personnel will be analyzed in detail.

Manpower Shortage

The shortage of trained personnel in the mental health professions is overwhelmingly considered a very important barrier to the more effective use of mental health personnel outside of direct mental health programs. The extent of the shortage is indicated by other information provided by the respondents. Each official was asked, "Is your (department)(clinic) currently recruiting or considering recruitment of any mental health personnel?" If the respondents answered "Yes," they were asked for what

position or positions they were being recruited. Since there are several respondents from each State, their answers to the questions must be analyzed separately for States and localities and for different programs.

In determining whether or not the public health department in a given State is currently recruiting mental health personnel, reports by the head of public health, or (in three cases) his deputy, are used. Of the fifty States and the District of Columbia, in twenty-six the public health departments are reported to be currently recruiting mental health personnel; in twenty they are not, and information is lacking for five States. In more than half of the States, then, public health departments are currently seeking mental health personnel. We can obtain a better view of what kinds of personnel are being sought for particular programs in public health by examining the reports given by heads of various public health programs.

In Table 105, the reports of the heads or deputies of various public health programs and of the alcoholism programs are summarized. From this table we can see, for example, that two-thirds of the respondents reporting about the Local Health Services say their departments are not recruiting mental health personnel and one-fifth say their departments are; furthermore, eleven per cent of them mention that they are recruiting psychiatrists (one or more full or part time), and fifteen per cent report that their departments are recruiting psychologists. Note that all these percentages are on the total base of persons reporting about each program. We could also look at the figures in terms of the percentage of local health service programs in which a given kind of mental health profession is being recruited among those recruiting any mental health personnel. Thus, of the twenty-two per cent reporting that they are recruiting mental health personnel, half of them are recruiting psychiatrists.

TABLE 105

RECRUITING OF MENTAL HEALTH PERSONNEL IN STATE PUBLIC HEALTH PROGRAMS AND IN ALCOHOLISM PROGRAMS

Recruiting, Kinds of Personnel	State Public Health Programs				Alcoholism Programs
	Local Health Services	Hospitals	Nursing	Other[a]	
Not recruiting	67	88	65	40	41
Don't know	11	9	-	-	-
Recruiting	22	3	35	60	59
Psychiatrists	11	-	2	33	26
Psychologists	15	-	4	33	18
Psychiatric social workers	4	-	-	20	41
Social workers	4	-	4	20	6
Psychiatric nurses	-	-	2	-	3
Nurses	7	-	20	7	3
Social scientists	-	-	-	-	12
Recreation, etc. therapists	-	-	-	-	3
Mental health worker	-	-	-	-	-
Administrator of mental health programs	-	-	4	-	9
Other mental health personnel	4	-	1	7	15
General, all kinds	-	3	6	7	-
Total per cent	100	100	100	100	100
Base for percentages	(27)	(33)	(51)	(15)[b]	(34)
No answer	(-)	(-)	(-)	(3)	(-)
Total number	(27)	(33)	(51)	(18)	(34)

[a] "Other" programs include heads or deputies of child services, deputies of the general public health programs and other State public health programs.

[b] Three respondents who are deputies of the heads of the health departments were used to provide information for the entire State as substitutes for the heads of public health in their States.

A few other explanations of the table should be noted. Psychiatric social workers are distinguished from social workers only because some respondents did not specify psychiatric social workers; in most cases that is what they actually meant. The same distinction is true for the psychiatric nurses and nurses categories. The "other" public health programs consist of heads or deputies of child services, deputies of the general public health programs and other State public health programs.

On the whole, Table 106 indicates that mental health workers are being recruited particularly in the alcoholism programs, to a lesser extent in the nursing programs, to an even lesser extent in the Local Health Services, and least in the hospital programs. Of the kinds of mental health workers being sought, psychiatrists, psychologists, and psychiatric social workers are most frequently mentioned. In the alcoholism programs, the recruitment of psychiatric social workers is particularly frequently mentioned.

In the case of State mental health programs, the extent of recruitment efforts is more overwhelming. Since, in many States, the mental health programs are divided between institutional and community programs, in many States there are reports for more than one head of mental health programs in a State. Combining such reports, of the fifty States and the District of Columbia, in only one State do the heads report that they are not currently recruiting any mental health personnel (information is lacking for three States). With mental health departments in nearly every State in the nation trying to recruit mental health personnel, the frequent references to a manpower shortage are quite understandable.

Now let us look in more detail at the particular mental health programs which are recruiting mental health personnel and the kinds of personnel being recruited (see Table 106). In nearly every mental health program

TABLE 106

RECRUITMENT OF MENTAL HEALTH PERSONNEL IN STATE MENTAL HEALTH PROGRAMS

Recruiting, Kinds of Personnel	Mental Health Programs								
	Hospital-Based				Community-Based				
	Psychological Services	Nursing Services	Social Work Services	Other Services[a]	Psychological Services	Nursing Services	Social Work Services	Local Community Services	Other Services[b]
Not recruiting .	9	-	19	15	-	46	15	25	25
Don't know . . .	-	-	-	-	6	8	-	-	4
Recruiting . . .	91	100	81	85	94	46	85	75	71
Psychiatrists .	18	7	12	52	22	17	40	25	43
Psychologists .	77	-	12	56	83	21	35	38	43
Psychiatric social workers.	9	-	42	15	22	13	45	31	27
Social workers.	9	-	42	30	17	-	10	6	16
Psychiatric nurses . . .	9	43	4	33	6	8	5	6	10
Nurses	-	50	4	19	17	21	20	6	16
Social scientists . . .	-	-	4	-	6	4	15	6	12
Recreation, etc. therapists .	-	-	4	26	-	-	-	-	6
Mental health workers . . .	-	-	-	-	-	-	5	-	-
Administrator of mental health programs	7	7	4	26	6	-	5	19	2
Other mental health personnel . . .	18	29	15	37	11	-	10	19	22
General, all kinds	9	21	12	-	6	4	5	13	4
Total percent . . .	100	100	100	100	100	100	100	100	100
Base for percentages .	(22)	(14)	(26)	(27)	(18)	(24)	(20)	(16)	(51)
No answer .	(-)	(-)	(-)	(1)[c]	(-)	(-)	(-)	(-)	(-)
Total number	(22)	(14)	(26)	(28)	(18)	(24)	(20)	(16)	(51)

[a] "Other" hospital-based services include superintendents of mental hospitals, head or deputy of psychiatric services, and other services.

[b] "Other" community-based services include head or deputy of mental health education, of psychiatric services, of planning, research, or evaluation, of other programs or the deputy administrator of community-based programs.

[c] One respondent who is the deputy of the head of the mental health department of one State was used to provide information for the entire State as a substitute for the head.

recruiting is reported by almost all respondents; only in the community-based nursing programs are less than half of the departments currently recruiting. On the whole, of course, each program is recruiting the kind of mental health professional that is most directly related to its activities. For example, in the psychological services programs, psychologists are most frequently reported as being recruited. In many programs, psychiatrists are less frequently mentioned than psychologists and in many programs psychiatric social workers and social workers are mentioned at least as frequently as either psychiatrists or psychologists. Recruitment of psychiatric nurses and nurses is not as common among the various programs as of the three previously mentioned professions, but they are relatively frequently mentioned among many of the community-based programs. Social scientists are infrequently mentioned as being recruited and when they are, it is among the community-based programs. Mental health workers are practically never mentioned among the mental health personnel being recruited.

Turning to the recruitment of mental health personnel in public health and mental health programs at the local level, we find that current recruitment efforts are not as widespread as at the State level, but they are, nevertheless, impressive. In the case of the localities, the reports of all the respondents are presented since in nearly all cases they are reporting about their entire department or clinic and nearly always it is the only one in the locality. Thirty-eight per cent of the local public health respondents and eighty-one per cent of the mental health respondents report that they are recruiting mental health personnel (see Table 107). Psychiatrists, psychologists, and psychiatric social workers and social workers are the most frequently mentioned as being sought; indeed, relatively few other mental health personnel are mentioned.

TABLE 107

RECRUITMENT OF MENTAL HEALTH PERSONNEL IN LOCAL PUBLIC HEALTH AND MENTAL HEALTH PROGRAMS

Recruiting, Kinds of Personnel	Local Programs	
	Public Health	Mental Health
Not recruiting	60	16
Don't know	2	3
Recruiting	38	81
Psychiatrists	20	49
Psychologists	19	48
Psychiatric social workers	15	44
Social workers	4	15
Psychiatric nurses	3	3
Nurses	6	3
Social scientists	-	4
Recreation, etc. therapists	1	6
Mental health workers	1	-
Administrator of mental health programs	2	9
Other mental health personnel	3	5
General, all kinds	2	-
Total per cent	100	100
Base for percentages	(119)	(120)
No answer	(1)	(-)
Total number	(120)	(120)

Not only is the manpower shortage currently severe, but it is likely to continue to be severe. There has been some increase in the number of persons in the mental health professions and a further increase can be expected, but the needs are likely to continue to rise at least concomitantly. The respondents were asked, "Do you think the needs for mental health

personnel in public agencies will increase greatly, increase somewhat, stay about the same, or decline in the next five years?" The overwhelming proportion of the officials believe that the needs will increase greatly; some say that they will increase somewhat; very few of the respondents think the needs will remain the same or decline (see Table B-27). The mental health respondents are even more likely than the public health officials to believe that the needs will increase greatly.

Factors Affecting Evaluation of Manpower Shortage as an Important Barrier to the Effective Use of Mental Health Personnel

In Chapter V, we suggested that some of the relationships between preferences about the utilization of mental health personnel and State population characteristics and types of communities might be attributable to differences in the supply and demand for mental health personnel. Now we will examine the effect of such population characteristics upon considering the manpower shortage a very important barrier. Later in this section the relationships between such considerations and preferences about organizational arrangements and personnel integration will be analyzed.

The demand and supply of mental health personnel are likely to vary together. For example, there may be more mental health personnel in high per capita income and high density States, but there is also likely to be greater demand for their services in such States. We would not, therefore, expect that respondents in States with low or high per capita income or in States with high or low density would differ in their estimates of the manpower shortage as a very important barrier. This is what we do find--there are no relationships. Nor do we find any relationship between such evaluations and the type of community or the population size of the respondents' States.

Of course, such population characteristics are relevant to many conditions in addition to the interrelated ones of supply and demand of

mental health personnel. Perhaps a more direct measure of the availability of mental health personnel would be more revealing. We do find a tendency for respondents in States with few psychiatrists per 100,000 population to be more likely to consider the manpower shortage a very important barrier (see Table 108). Their evaluations of this factor do reflect this aspect of the situation in which they work. Presumably, the number of psychiatrists per capita, although related in a general way to the total demand for psychiatrists, is not as precisely related to the demand for mental health personnel in agencies; where the number of psychiatrists per capita is low, the shortage of them for employment in agencies would be aggravated.

TABLE 108

PROPORTION OF RESPONDENTS CONSIDERING MANPOWER SHORTAGE A VERY IMPORTANT BARRIER BY NUMBER OF PSYCHIATRISTS PER 100,000 PERSONS IN THE STATE AND BY TYPE OF RESPONDENT

Type of Respondent	Psychiatrists per 100,000 Persons in State	
	Low	High
State, public health . .	77 (72)	65 (92)
Local, public health . .	65 (55)	63 (62)
State, mental health . .	80 (124)	72 (155)
Local, mental health . .	79 (52)	72 (68)

Evaluations of the manpower shortage as a very important barrier are not related to the political party designation of the Governor or political party composition of the State legislatures; they are not related to the organizational arrangements at the State or local level; they are not related to the extent of personnel integration at the State or local level.

The Effects of Considering the Manpower Shortage an Important Barrier upon Preferences Concerning Organizational Arrangements and Utilization of Mental Health Personnel

Aside from trying to directly reduce the shortage, two general policy alternatives may be followed if there is a severe manpower shortage: (1) have mental health personnel concentrate upon their core professional activities within their own organization, or (2) have mental health personnel widely utilized to spread their efforts--organized closely with other programs. Given the differences between mental health and public health persons, we might also expect that their inclinations would differ.

In the case of organizational preferences, we find that some respondents tend to choose the first policy alternative while others choose the second. The public health respondents generally choose the second: those who consider the manpower shortage a very important barrier tend to be less likely to favor a separate mental health organization and more likely to be not favorable. Among the mental health respondents, the results are more complex. Some of the mental health respondents also seem to follow the second alternative: there is a tendency for those respondents who think this factor is a very important barrier to be less likely to be very favorable to a separate and autonomous mental health organization. But there is also a tendency among the mental health respondents who think this factor is a very important barrier to be more likely to be somewhat favorable and less likely to be not favorable.

These findings suggest another possibility, in addition to the policy alternatives mentioned. Some persons, confronted by the manpower shortage as a very important barrier, tend to fall back upon the solution which is the typical position of their professional and organizational colleagues. It is as if, under pressure, their group position is reinforced.

The pattern is similar in the case of preferences concerning the location of the mental health authority. Both public health and mental health respondents who think the manpower shortage is a very important barrier tend to favor an "other" department or agency, compared to those who think the factor is not very important. But there is also a tendency for mental health respondents who think the factor is very important to be less likely to favor a public health department as the location of the authority and more likely to prefer a mental health department; while public health respondents who consider the factor a very important barrier tend to be less likely to favor a mental health department as the location of the authority. There is no relationship between evaluations of this factor as a very important barrier and preferences about the joint or separate administration of the institutional and community mental health programs or with preferences for close relations between mental institutions and public health departments.

In short, for organizational preferences which are highly related to the respondents' organizational and professional identification, considering the manpower shortage a very important barrier tends to increase the likelihood of officials preferring the typical position of their own professional group. There is also a tendency for respondents who consider this factor a very important barrier to be more likely to prefer closer organizational arrangements between mental health and other programs.

In the case of ranking indirect services, if the manpower shortage is considered very important, mental health respondents tend not to give high ranking to indirect service functions; but there is no relationship among public health respondents (see Table 109). Apparently, if mental health respondents perceive the manpower shortage as particularly severe,

they tend to favor concentrating on what they feel are the core functions of their profession.

TABLE 109

PROPORTION OF RESPONDENTS GIVING HIGH RANKING TO INDIRECT SERVICE FUNCTIONS OF MENTAL HEALTH PERSONNEL BY EVALUATIONS OF MANPOWER SHORTAGE AS A BARRIER AND BY TYPE OF RESPONDENT

Type of Respondent	Evaluations of Manpower Shortage	
	Very Important	Somewhat or Not at All Important
State, public health	42 (111)	41 (46)
Local, public health	29 (72)	28 (39)
State, mental health	20 (215)	46 (72)
Local, mental health	19 (89)	32 (28)

Respondents perceiving the manpower shortage as a very important barrier generally tend to want increased utilization of mental health personnel outside of direct mental health programs. In the case of preferring increased utilization of mental health personnel in public health programs, this is true only among local respondents (see Table 110). Apparently, if they perceive the shortage as a very important barrier, they are likely to consider increased utilization of mental health personnel in non-direct mental health programs as a possible solution to the shortage.

In the case of increased utilization of mental health personnel in other-related programs, State public health and local mental health respondents who consider the manpower shortage a very important barrier want a much or somewhat greater utilization of mental health personnel (see Table 111). Among the State mental health and local public health

respondents the pattern is not as contrary if we consider only the proportion wanting much greater utilization: (1) among the local public health respondents, of those who think the factor is a very important barrier, thirty per cent want much greater utilization; while of those who do not think it is very important, twenty-two per cent want much greater utilization; (2) among the State mental health respondents, the comparable percentages are twenty-four and twenty-three.

TABLE 110

PROPORTION OF RESPONDENTS PREFERRING MUCH OR SOMEWHAT GREATER UTILIZATION OF MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS BY EVALUATIONS OF MANPOWER SHORTAGE AS A BARRIER AND BY TYPE OF RESPONDENT

Type of Respondent	Evaluations of Manpower Shortage	
	Very Important	Somewhat or Not at All Important
State, public health	31 (111)	37 (46)
Local, public health	48 (73)	33 (37)
State, mental health	37 (211)	36 (69)
Local, mental health	52 (87)	39 (28)

TABLE 111

PROPORTION OF RESPONDENTS PREFERRING MUCH OR SOMEWHAT GREATER UTILIZATION OF MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS BY EVALUATIONS OF MANPOWER SHORTAGE AS A BARRIER AND BY TYPE OF RESPONDENT

Type of Respondent	Evaluations of Manpower Shortage	
	Very Important	Somewhat or Not at All Important
State, public health	42 (109)	31 (45)
Local, public health	41 (73)	46 (37)
State, mental health	50 (211)	56 (69)
Local, mental health	59 (87)	47 (28)

In summary, if the officials consider the manpower shortage to be a very important barrier to the more effective use of mental health personnel outside of direct mental health programs, two consequences seem to follow. In general, there is a tendency to be more favorable to organizational and personnel integration of mental health and other programs and personnel. There is an additional effect upon preferences which are highly related to the officials' professional and organizational identification--the preferences for an autonomous mental health organization and the ranking of indirect service functions of mental health personnel. In relationship to those preferences, the pressure implicit in the perceived severe manpower shortage tends to make some respondents even more likely than otherwise to choose the position taken generally by their organizational and professional colleagues.

Suggestions for Improving the Situation

For each factor which a respondent considered to be a very important barrier, he was asked, "We would appreciate your judgment as to what should be done to improve the situation; that is, what could be done to reduce these barriers?"

Among the respondents considering the manpower shortage a very important barrier, suggestions involving active recruitment of potential mental health personnel were most frequently made; thirty-seven per cent of them made such suggestions. Specifically, some of the suggestions in this category are:

> (Head, State Mental Health Community-Based Programs:) Try to recruit even at the high school level....I think this is where we have to begin.
>
> (Director of a local mental health center:) There has to be more effective recruiting to get them to go into training.... The social workers have hired a trained public relations person--this should help to let college students know more about this as a career. There should be a more organized effort--not just trusting to luck.

> (Head, city public health department:) Health officials should try to do more recruiting in college and medical schools to make people more aware of job opportunities in official health agencies....Mental health facilities are not emphasized in medical schools so if they were emphasized in all schools, all health officials could recruit more qualified people.

These suggestions emphasize making potential members of the mental health professions aware of the opportunities. The next most frequently mentioned kind of suggestions involve a way of making professional employment in mental health agencies more attractive.

Thirty-one per cent of the respondents suggested that salaries be increased in order to induce more persons to enter the mental health professions and take employment in agencies. Sometimes this is suggested as a way to compete for the available manpower. As one official said, "Increase salaries to compete for the few trained mental health personnel." Others consider this as a way of getting more persons into the field; for example, "This is basically a problem of inadequate pay to stimulate people to go into the profession; salaries should be in keeping with the qualifications for the positions." Other respondents mention specifically the salary limits imposed by civil service regulations. The head of a city mental health bureau presented his views as follows: "....Civil Service salaries are set by years of service--our people should work here for a while and leave, unless the city program grows at a very fast rate. So we should give salaries geared to their coming here for a short time only."

One-quarter of the respondents suggested increasing training facilities or programs or obtaining funds for training programs. The difficulties arising in one State because of the lack of training facilities was stated this way: "We have not had a school of social work in _____. People who have not been here just don't come here because there are not enough people

trained. The agencies have settled for a lesser trained person--and that is not good."

Closely related to suggestions for expanding training facilities are suggestions for more scholarships or other support for trainees (mentioned by fourteen per cent of the respondents) and suggestions for more in-service training (mentioned by ten per cent of the officials). Some of the officials mention ways in which their own agencies follow such suggestions: for example, they provide in-service training for their own staff. In other places, persons are sent for training to various schools and then return to work for the State. Others suggest the need for subsidies in the form of fellowships or tax deduction for training expenses.

Finally, there are less frequently mentioned specific suggestions such as training people, for example, teachers, to do some of the work of mental health personnel, improve working conditions, or improve organizational arrangements and allocation of personnel.

The respondents explicitly suggest, then, ways of directly increasing the supply of trained manpower. The analysis of the consequences of perceiving the manpower shortage as severe implied some ways of dealing with the manpower shortage, aside from directly increasing the manpower; but these ways are not salient for the respondents.

Inadequate Tax Base

Next to the manpower shortage, an inadequate tax base is most frequently considered to be a very important barrier to the more effective use of mental health personnel. An inadequate tax base is not necessarily viewed by the respondents as a fixed condition of the State or locality; it is often viewed as reflecting support for taxes and financial support.

Factors Affecting Evaluation of Inadequate Tax Base as an Important Barrier to the Effective Use of Mental Health Personnel

Respondents in low per capita income States are somewhat more likely than those in high per capita States to consider this barrier a very important barrier. This is true for the public health respondents, at the State and local level; but it is not the case among mental health respondents. Perhaps the mental health respondents are particularly likely to think of an inadequate tax base as affected by support for taxes.

State population size and density combine to affect evaluations of the importance of this barrier as follows: respondents in low-density and large-population States are most likely to consider inadequate tax base a very important barrier (sixty-one per cent so consider it); those in small-population States, regardless of density, are slightly less likely to consider it very important (fifty-two per cent do); while those in high-density and large-population States are least likely to consider this factor a very important barrier (forty-three per cent do).

The pertinence of per capita income is obvious. The tendency for inadequate tax base to be considered a very important barrier most frequently in low-density and large-population States may reflect the need for extensive programs and the lack of support for them because of the absence of urban centers. As we will see in a later section of this chapter, there is greater public support and legislative support in high-density States.[1]

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[1]There is no relationship between considering the tax base inadequate and the type of community in which the respondent works. Of course, the kinds of communities probably do not vary widely in the kind of characteristics relevant for the adequacy or inadequacy of the tax base.

The political party composition of the State legislature or the party designation of the Governor are not related to the respondents' consideration of an inadequate tax base as a very important barrier. The State or local organizational arrangements or the level of personnel integration do not appear to affect the respondents' consideration of this factor as a very important barrier.

The Effects of Considering Inadequate Tax Base an Important Barrier upon Preferences Concerning Organizational Arrangements or Concerning Utilization of Mental Health Personnel

There is a slight tendency for public health respondents who think an inadequate tax base is a very important barrier to be less likely to favor a separate and autonomous mental health organization; while among the mental health respondents, if they think this factor is a very important barrier, they tend to favor a separate and autonomous arrangement. Presumably, if respondents feel that there are special external difficulties, they are reinforced to support their organizational interests.

Ranking of indirect service functions of mental health personnel is not affected by beliefs that an inadequate tax base is a very important barrier. Such an evaluation of this barrier does not affect preferring increased utilization of mental health personnel in other-related programs. Presumably, these aspects of utilization of mental health personnel are not viewed as economizing of money.

There is a tendency among local respondents--particularly local mental health officials--to want increased utilization of mental health personnel in public health programs if they think this factor is a very important barrier. Thus, among the local mental health respondents, fifty-four per cent of those considering this factor very important want much or somewhat greater utilization compared to thirty-four per cent among those thinking the factor

is slightly or not at all important. This suggests that increased utilization of mental health personnel in public health programs is viewed by them as a way of economizing--it is not viewed as a way of getting support, as we shall see in the section on political and public support.

Suggestions for Improving the Situation

Respondents who considered inadequate tax base or lack of resources a very important barrier were asked what should be done to help reduce this barrier. The most frequent kind of suggestion, made by about one-third of these respondents, involves educating the public or obtaining public support for increased appropriations. This indicates that the respondents do not necessarily consider an inadequate tax base as a fixed condition of their State or locality--it is often viewed as reflecting the local tax structure as determined by legislation. Indeed, one out of five respondents suggested educating the legislature and pointing out the needs to the legislators. Fifteen per cent of these respondents suggest directly that taxes be increased and some of them even say that taxes should be raised specifically for mental health. Ten per cent of them suggest raising the limits on taxes or removing certain restrictions on tax sources--such as income taxes. Seven per cent of them urge that restrictions on the use of funds or a reallocation of the present use of funds be made.

A few of these respondents, three per cent, suggest that the mental health personnel and agencies take more initiative or demonstrate more progress in order to obtain support. As one person said, "program for economy and then howl for money."

Strikingly, only eight per cent of these respondents suggest that the Federal Government should increase appropriations and assume more financial responsibility for mental health activities. Only one per cent of them suggest raising money from voluntary contributions.

Inadequate Political and Public Support

Three factors related to external support for mental health and related programs as a possible barrier to the more effective utilization of mental health personnel are considered together: (1) resistance of tax appropriating bodies, (2) resistance of executive branch leadership, and (3) lack of public support. The first is relatively frequently considered a very important barrier, the second is rarely so considered, and the third is only occasionally evaluated as a very important barrier.

Factors Affecting Evaluation of Inadequate Political and Public Support as Important Barriers to the Effective Use of Mental Health Personnel

The population characteristics of the respondents' States seem to significantly affect their evaluations of resistance by tax appropriating bodies and lack of public support as very important barriers. These characteristics do not seem to affect considering resistance of executive branch leadership as a very important barrier.

There is a tendency for respondents in States with low per capita incomes to be more likely than those in high income States to think that lack of public support is very important. There is a tendency for respondents in small population States to be more likely to consider resistance of tax appropriating bodies and lack of public support to be a very important barrier.

It is population density which markedly affects such evaluations. Officials in low density States tend to consider the resistance of tax appropriating bodies a very important barrier more frequently than do respondents in high density States (see Table 112). The same is true for evaluations of public support; except in this case, the relationship holds only among the State level respondents. This should be expected since the

level of density in the State affects State public support but not necessarily the level of support in each local community. There is only a slight tendency for respondents in the smaller communities, compared to the large metropolitan and medical school communities to consider lack of public support a very important barrier. The range of communities in which interviews were conducted is not sufficiently large, apparently, to introduce such variance in this regard. As can be seen in Table B-20, local public health respondents are as likely as State public health officials to consider this factor a very important barrier. Local mental health respondents are about as equally likely to think it important as are public health respondents, but slightly less than are State mental health respondents.

TABLE 112

PROPORTION OF RESPONDENTS CONSIDERING RESISTANCE OF TAX APPROPRIATING BODIES A VERY IMPORTANT BARRIER BY STATE POPULATION DENSITY AND BY TYPE OF RESPONDENT

Type of Respondent	Population Density	
	Low	High
State, public health	42 (81	27 (89)
Local, public health	47 (60)	26 (57)
State, mental health	50 (131)	40 (149)
Local, mental health	47 (57)	37 (63)

Apparently, in high density States there is more public support for activities utilizing mental health personnel and this is reflected in the actions of the State legislature. There is evidence from surveys of national cross sections of the population that persons in more urban localities, compared to those in less urban localities, are more likely to

have used professionally trained mental health personnel and be more ready to consider their use.[2]

There is no relationship between considering political and public support a very important barrier and (1) the political party characteristics of the respondents' States, (2) the extent of personnel integration in the respondents' States or localities, or (3) the State organizational arrangements of mental health programs. At the local level, respondents in communities in which the mental health organization is separately organized are more likely than those in communities in which they are not autonomous to consider lack of public support a very important barrier.

The Effects of Considering Lack of Political and Public Support Important Barriers upon Preferences Concerning Organizational Arrangements and Utilization of Mental Health Personnel

Confronted with the challenge of lack of support, officials may feel that innovating change is the most appropriate response, or, under the pressure, conservative solutions would be favored.

On the whole, there is little significant association between any of the measures of support and preferences concerning forms of organizational arrangement. It is intriguing, however, that in the case of preferences about the location of the mental health authority, public health respondents who think public support is a very important barrier tend to favor a public health department as the location of the mental health authority; while mental health respondents who think this factor is a very important barrier tend not to favor a public health department as the location of the authority.[3] This suggests that the lack of public

[2]Gerald Gurin, Joseph Veroff, and Sheila Feld, Americans View Their Mental Health, (New York: Basic Books, 1960), pp. 255-343.

[3]Thus, among the State public health respondents who think lack of public support is a very important factor, eighty per cent favor a public health department designation for the authority, among those thinking the factor is somewhat important, seventy-six think a public health department

support tends to make each profession more likely to assume the more typical position of their profession--to be more likely to take the position of their organizational commitment.

A similar pattern is found in the case of the respondents' ranking of the indirect service functions of mental health personnel. Public health respondents who think lack of public support is a very important barrier are more likely than those who do not, to give high ranking to indirect service functions; while among mental health respondents, the opposite is true (see Table 113). Again, it appears that for issues which are highly associated with the respondents' professional identification and official program responsibilities, in the face of pressure of lack of public support, the professional and organizational role commitments are reinforced.

TABLE 113

PROPORTION OF RESPONDENTS GIVING HIGH RANKING TO INDIRECT SERVICE FUNCTIONS OF MENTAL HEALTH PERSONNEL BY EVALUATIONS OF LACK OF PUBLIC SUPPORT AS A BARRIER AND BY TYPE OF RESPONDENT

Type of Respondent	Evaluations of Lack of Public Support		
	Very Important	Somewhat Important	Not at All Important
State, public health	50 (34)	38 (66)	44 (52)
Local, public health	33 (24)	31 (52)	21 (28)
State, mental health	22 (95)	22 (116)	42 (66)
Local, mental health	21 (29)	20 (60)	36 (25)

should be designated and among those who think this factor is not at all important, only sixty per cent favor a public health department designation; on the other hand, among State mental health respondents, the comparable percentages are: nineteen, twenty-three, and thirty-two. There is a similar pattern among State public health respondents for evaluations of resistance of tax appropriating bodies as a very important barrier.

The pattern is not the same in the case of preferences concerning the increased utilization of mental health personnel outside of direct mental health programs. Evaluations of the importance of resistance of executive branch leadership as a very important barrier are not related to preferences about increased utilization of mental health personnel. There is a slight tendency, among the local respondents only, for those who consider resistance of tax appropriating bodies to be a very important barrier, to be more likely (than those who do not) to want much or somewhat greater utilization of mental health personnel in public health programs. In the case of lack of public support, we find that among the State respondents, those who consider this factor very important tend to be less likely to want increased utilization (see Table 114).

TABLE 114

PROPORTION OF RESPONDENTS PREFERRING MUCH OR SOMEWHAT GREATER UTILIZATION OF MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS, BY EVALUATIONS OF LACK OF PUBLIC SUPPORT AS A BARRIER AND BY TYPE OF RESPONDENT

Type of Respondent	Evaluations of Lack of Public Support		
	Very Important	Somewhat Important	Not at all Important
State, public health	30 (37)	26 (65)	45 (51)
Local, public health	42 (26)	41 (49)	37 (27)
State, mental health	34 (93)	37 (115)	43 (63)
Local, mental health	44 (27)	49 (61)	44 (25)

Preferences for increased utilization of mental health personnel in other-related programs are slightly less likely among respondents who think that resistance of tax appropriating bodies is a very important

barrier. This is true except among the local mental health respondents; for these respondents the relationship goes in the opposite direction. In the case of lack of public support, local public health respondents who consider this factor a very important barrier are less likely than other local public health respondents to prefer much or somewhat greater utilization of mental health personnel (see Table 115). Among local mental health respondents, the relationship appears to go in the other direction; but if we consider only the proportion who report wanting much greater utilization we find a pattern similar to that among the local public health respondents: of those who think this factor is a very important barrier, twenty-six per cent prefer much greater utilization; of those who think this factor is somewhat important, twenty-eight per cent want much greater utilization; and among those who think it is not at all important, thirty-two per cent prefer much greater utilization.

TABLE 115

PROPORTION OF RESPONDENTS PREFERRING MUCH OR SOMEWHAT GREATER UTILIZATION OF MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS, BY EVALUATIONS OF LACK OF PUBLIC SUPPORT AS A BARRIER AND BY TYPE OF RESPONDENT

Type of Respondent	Evaluations of Lack of Public Support		
	Very Important	Somewhat Important	Not at all Important
State, public health	41 (37)	34 (63)	42 (50)
Local, public health	31 (26)	41 (49)	45 (27)
State, mental health	47 (93)	48 (115)	52 (63)
Local, mental health	67 (27)	51 (61)	56 (25)

In summary, it does not appear that perceiving lack of political and public support encourages innovating solutions. Rather, the evidence suggests that lack of support is inhibiting. In the case of preferences which are highly related to the respondents' professional and organizational identification, lack of support makes them more likely to choose the typical preference of their professional group. This is indicated by the relationships between the evaluations and the preferences concerning the location of the mental health authority and the ranking of indirect service functions. In the case of preferences which are not as highly related to the respondents' official role, we find that perceiving lack of public support or resistance of tax appropriating bodies (1) does not affect other organizational preferences, or (2) does not affect preferences about increased utilization of mental health personnel, or if it does, tends to make the respondents less likely to want increased utilization.

Suggestions for Improving the Situation

Officials thinking each of the three kinds of support a very important barrier emphasized education as the means to reduce the barrier. Of those considering resistance of tax appropriating bodies a very important barrier, forty-three per cent suggest educating the legislators, explaining the needs and possible solutions; forty per cent suggest educating the public or explaining the needs and possible solutions to them. Among the respondents considering resistance of executive branch leadership a very important barrier, thirty-eight per cent suggest educating the executive, explaining the needs and possible solutions and twenty-two per cent suggest obtaining public support. Of the persons regarding lack of public support a very important barrier, fully eighty-four per cent suggest educating the public, explaining the needs and possible solutions.

There are also suggestions about how such education and influencing should be done. Fifteen to twenty per cent of the respondents considering each factor very important suggest more active agency lobbying, initiative, or demonstration of what can be done. For example, one person suggested the following to help reduce the barrier of resistance of tax appropriating bodies:

> I'd like to see a dramatic kind of attempt to do the same thing that vested interest pressure groups do to get what we need. After all, this is more important than bird and game and oil rights. There's nothing wrong in our shouting. The mental health of the country is at stake. ...I'd like to get a few well chosen and oriented statesmen and top notch people to be lobbying. We don't talk the legislators' language. Our legislators are used to operating in certain techniques. I'd like to see some mental health professionals in politics; it's hard to clinically orientate politicians, so maybe we should politically orientate clinicians.

The head of a county public health department suggested as a way to get public support:

> I think demonstration projects like the special childrens' clinic has shown the community what can be done for children. I think specific projects like that help win public support faster and more solidly than any amount of speeches that only talk at people. People are so enthusiastic about this project.... The mothers' group have been very active in spreading news about the activities and success of the clinic too.

There is another idea in this statement which some respondents also suggest as a way of reducing these barriers. That is, involve professional groups and civic organizations in the planning and operations of the programs; similarly, it is suggested that local people should be more involved and assume more responsibility for the programs.

Differences in Orientation

Fewer than one out of five of the respondents consider differences in orientation between mental health and public health personnel a very

important barrier for the more effective use of mental health personnel in health and other-related programs; nevertheless, almost one-half of them considered it somewhat important (see Table B-19c). Furthermore, as was discussed in Chapter VI, nearly all the respondents were aware of problem-posing differences in orientation. The respondents' reports about the nature of those differences help explain why they do or do not consider such differences a very important barrier to the more effective use of mental health personnel.

In the previous chapter the respondents' perceptions of the differences in orientation between mental health and public health personnel were discussed. The respondents' descriptions were categorized, however, not only in terms of their content, but also in terms of explicit evaluative statements. Although the respondents were not asked to make any judgmental statement about the differences in orientation, many did so. Each respondent's answer to the question was categorized in terms of explicit negative evaluations of public health or of mental health personnel or orientations (see Table B-17). It should be noted that many of the respondents could not be categorized as making any negative evaluations of either public health or mental health personnel or orientations. On the whole, there is a tendency for public health respondents to express negative evaluations of mental health personnel or orientations and for mental health respondents to do so of public health personnel or orientations. There is also a slight tendency for public health persons to express more negative evaluations of mental health personnel than vice versa. Finally, it appears that mental health respondents are somewhat less likely than public health respondents to express any negative evaluations at all.

The answers to this question, categorized in terms of descriptions and evaluations, can help make clear what it is about differences in orientation which makes some respondents consider such differences to be an important barrier to the more effective use of mental health personnel in health and other-related programs. Thus, respondents who say that differences in orientation is a very important barrier, compared to those who say it is not at all important as a barrier, are no more likely to say that public health personnel are community- or group-oriented, while mental health personnel are individual-oriented (thirty-two per cent compared to thirty-two per cent); however, they are more likely to say that members of one or both professions do not understand each other (thirty-nine per cent compared to eighteen per cent) and they are more likely to say that one or both professions do not accept the other as professional peers (twenty-four per cent compared to eight per cent).

It appears that it is not the awareness of differences in approach per se which accounts for the belief that differences of orientation are a barrier, but the feeling that there is lack of understanding or respect. We would, therefore, expect also that persons who express negative evaluations of either mental health or public health professionals or orientations would be more likely than those who do not, to believe that differences in orientation are an important barrier to the more effective use of mental health personnel. This does seem to be the case. Among respondents who express negative evaluations of public health personnel, seventy-one per cent consider the differences to be a very or somewhat important barrier; among those expressing negative evaluations of mental health personnel, eighty-two per cent consider the differences important; among those who express negative evaluations of both, the percentage is seventy-nine; while

among those who do not express any negative evaluations, sixty per cent consider such differences a very or somewhat important barrier.

Factors Affecting Evaluation of Differences in Orientation as an Important Barrier to the Effective Use of Mental Health Personnel

If awareness of non-evaluative differences in orientation is not related to considering such differences a very important barrier, we need not expect that organizational arrangements and personnel integration which seemed to affect awareness of differences would similarly affect considering the differences to be a very important barrier.

Analyzing organizational arrangements and personnel integration simultaneously in Chapter VI, we saw that organizational arrangements do not affect awareness of differences; but where personnel integration is high respondents are somewhat more likely to be aware of such differences. We also saw that if mental health programs are not separately organized, respondents tend to think such differences are disadvantageous; but the extent of personnel integration is not related to such perceptions. The pattern is somewhat different in the case of considering such differences in orientation to be a very important barrier to the more effective use of mental health personnel.

We can examine the effects of separately organized mental health programs and the level of utilization of mental health personnel in public health programs simultaneously in Table 116. There is no relationship at the State level; but at the local level, there is a slight tendency for respondents in localities in which the mental health organizations are autonomously organized to be more likely to consider differences in orientation a very important barrier. The same pattern of relationship is found

when we hold constant the level of utilization of public health personnel in mental health programs or of mental health personnel in other-related programs.[4]

TABLE 116

PROPORTION OF RESPONDENTS CONSIDERING DIFFERENCES IN ORIENTATION A VERY IMPORTANT BARRIER BY ORGANIZATION OF MENTAL HEALTH PROGRAMS AND BY EXTENT OF UTILIZATION OF MENTAL HEALTH PERSONNEL IN PUBLIC HEALTH PROGRAMS

A. State Respondents

Level of Utilization of Mental Health Personnel	Organization of Mental Health Programs		
	Separate and Autonomous	Division of Public Health	Somewhat Dispersed
High . . .	24 (93)	19 (121)	32 (22)
Low	16 (125)	23 (52)	8 (47)

B. Local Respondents

Level of Utilization of Mental Health Personnel	Organization of Mental Health Programs	
	Separate and Autonomous	Not Separate and Autonomous
High . . .	21 (67)	13 (53)
Low	15 (73)	10 (29)

These findings suggest that close personnel and organizational arrangements, while making respondents more aware of problem-posing differences in orientation and more likely to consider them disadvantageous,

[4] At the State level, organizational arrangements do not differently affect respondents with different program responsibilities. At the local level, mental health respondents in communities in which the mental health programs are not autonomous tend to think differences in orientation are a very important barrier; while public health officials in such communities are less likely to consider this factor a very important barrier.

do not influence the respondents to consider such differences so disadvantageous as to be a very important barrier.[5] Perhaps not being in settings in which the mental health programs are organizationally integrated with other programs leads participants to exaggerate the barrier caused by differences in orientation. Some further evidence supporting this interpretation is presented in the next section of this chapter.[6]

The Effects of Considering Differences in Orientation an Important Barrier upon Preferences Concerning Organizational Arrangements and Utilization of Mental Health Personnel

In Chapter VI we had seen no evidence indicating that respondents who are aware of problem-posing differences in orientation tend to be less favorable to closer organizational arrangements between mental health and other programs. In the light of the additional analysis presented, we would not expect that respondents who are unlike in their evaluations of the importance of differences in orientation as a barrier would be unlike in their organizational preferences. This expectation is fulfilled. There are no consistent relationships between evaluations of the importance of this factor and preferences concerning organizational arrangements, holding the respondents' program responsibilities constant.

There is no relationship, either, between evaluations of the importance of differences in orientation as a barrier to the more effective use of mental health personnel and the respondents' ranking of indirect service functions.

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[5] At the State level, other aspects of organizational arrangements were similarly analyzed; the results are consistent with these interpretations.

[6] Considering differences in orientation a very important barrier is not affected by the type of community, the per capita income, population size, density, or political party designation of the Governor or political party composition of the legislature of the State in which the respondents are employed.

In Chapter VI we saw that respondents who are aware of problem-posing differences in orientation or consider them disadvantageous tend to be less likely than other respondents to prefer increased utilization of mental health personnel. Now we find no relationship between evaluations of differences in orientation as a very important barrier and preferences concerning increased utilization of mental health personnel in other-related programs. There is a tendency for public health respondents who consider this factor to be a very important barrier to be less likely than other public health respondents to prefer increased utilization of mental health personnel in public health programs.

Suggestions for Improving the Situation

The basic suggestion made by the respondents to reduce the barrier caused by differences in orientation between mental health and public health personnel is to increase mutual understanding. Increasing mutual understanding can be attempted in the period of professional training and in the course of professional work.

One-third of the respondents suggest that the training of each profession should include more information about the other--for example:

> Including public health courses in the curriculum for people going into mental health work.
>
> There has to be better teaching in medical and nursing schools as to what is involved in mental health and public health programs.
>
> If people in public health could get a little more training in the concepts of mental health and vice versa, this would go a long way in dissolving these differences.

Twenty-nine per cent of the respondents suggest more seminars, joint institutes, or in-service training. One respondent said, "The Western Inter-State Commission of Health Education is reaching out and offering a ten week course in mental health. It's offered to public health people and an intensive

ten week program can do great things to educate each group to the orientations and values of the other group. I'd like to see more such programs."

The person (head of alcoholism program) who was quoted above as saying more training in the other professions' concepts would help dissolve the differences, also said: "These people with different orientations should work more closely together. By that I mean I think it's good to have them in the same agencies and the same program so that they become more familiar with the strengths and weakness of each of the disciplines." Such suggestions that there be closer day-to-day working relations are made by one out of five of the persons believing differences in orientation are a very important barrier.

Many persons express the general idea that there should be better mutual understanding and more and improved communication. The head of social service in a State mental health program said:

> I guess it's orientation on both sides. We've got to broaden our limited clinical orientation and consider the expansion of the indirect services as opposed to the direct--such as treatment. By indirect services I mean consultation, education, community organization. If we accept that changed emphasis, this means we are dealing with those other agencies in the community and then we are in the direction of positive mental health instead of just dealing with the end product of bad mental health. This is where we need the public health officer. On his part, there must be a greater awareness of the implications of the specialized field of mental health--particularly its extensiveness, its scope. In terms of numbers it's the single biggest problem there is; but to look at public health officers, you'd never know it. It's more than awareness; there's got to be training; there's got to be sensitivity.

This quotation, besides referring to the need for training discussed already, also suggests the need for closer organizational arrangements and coordination of activities. Such suggestions were made by about one out of ten other respondents. One person said, "Both programs should be combined into one operating unit to insure....teamwork." Another respondent

suggested that administrators of various agencies coordinate their programs and efforts in meeting the problems of families of mentally ill patients.

Organizational Problems

Three factors which may bear upon the effective use of mental health personnel outside of direct mental health programs are considered together as aspects of organizational problems. The respondents were asked how important a barrier each of the following factors is: (1) unclear division of responsibility between agencies, (2) inappropriate use of personnel, and (3) inadequate agency assessment of need. We have already seen that few respondents consider these factors to be very important barriers.

Factors Affecting Evaluation of Organizational Problems as Important Barriers to the Effective Use of Mental Health Personnel.

The respondents' estimates of the importance of unclear division of responsibilities as a barrier seem to be affected by the population size and density of their States. Thus, among officials in States with low density, twenty per cent consider unclear division of responsibility a very important barrier and thirty per cent of them consider it to be not at all important. On the other hand, among persons in States with high density, nine per cent consider this factor to be a very important barrier and forty-six per cent consider it to be not at all important. If population size and density are examined simultaneously, density continues to affect the evaluations, but population size does not.

Perhaps unclear division of responsibility between agencies is more likely to be perceived as a very important barrier to the use of mental health personnel in low density States because of the organizational arrangements in those States. We know that low density States tend to have their mental health programs divided and the community mental health programs

administratively integrated with the public health departments. Furthermore, we do find that in States in which the mental health authority is located in a department of public health, or in which the institutional and community mental health programs are in different departments, or in which the mental health programs are not characterized as autonomous, the respondents tend to report unclear division of responsibility to be a very important barrier.[7] Thus, in States in which the institutional and community programs are in the same department, ten per cent of the respondents consider this factor to be a very important barrier and forty-four per cent consider it to be not at all important; on the other hand, in States in which they are in separate departments, nineteen per cent consider it to be a very important barrier and thirty-two per cent consider it to be not at all important.

Interestingly, however, if we simultaneously examine the effects of joint or separate administration of institutional and community mental health programs and population density upon estimates of the importance of unclear division of responsibilities as a barrier, it appears that population density is the relevant determinant. Regardless of the administration of the two mental health programs, respondents in low density States are more likely to think this factor is a very important barrier than are persons in high density States (see Table 117). The same pattern occurs if population density and location of the mental health authority is examined simultaneously. Perhaps in low density States the lack of public support affects the respondents views of this factor also.

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[7]Very significantly, these patterns are the same even if we consider them only among State mental health or among State public health officials; the respondents with different program responsibilities agree in these evaluations, holding actual organizational arrangements constant.

TABLE 117

PROPORTION OF RESPONDENTS CONSIDERING UNCLEAR DIVISION OF RESPONSIBILITIES A VERY IMPORTANT BARRIER BY JOINT OR SEPARATE ADMINISTRATION OF INSTITUTIONAL AND COMMUNITY MENTAL HEALTH PROGRAMS AND BY STATE POPULATION DENSITY

State Population Density	Administration of the Institutional and Community Mental Health Programs	
	Same Department	Separate Departments
Low	13 (77)	22 (266)
High	9 (319)	7 (56)

Evaluations of inappropriate use of personnel or of inadequate agency assessment of need are not affected by State organizational arrangements or by the size or density of State population.[8] The per capita income of the State, party designation of the Governor, or the party composition of the State legislature do not affect the evaluations of any of the three aspects of organizational problems.

At the local level, we also find that unclear division of responsibility is more likely to be considered a very important barrier in one type of community--medical school communities. But this is the case largely because these communities tend not to have separately organized mental health programs and, among medical school communities, unclear division of responsibilities is more likely to be considered a very important barrier if the mental health programs <u>are</u> separately organized. We also find that at the

[8] In the case of evaluations of inadequate agency assessments of needs, we find a tendency for State mental health respondents to think this is a very important barrier if they are in States in which the mental health authority is <u>not</u> in a mental health department or the mental health programs are not autonomously organized; while State public health officials are more likely to think it is a very important barrier if they are in States in which the authority is not in a public health department or in which the mental health programs are autonomous.

local level respondents in communities with autonomously organized mental health programs tend to consider inappropriate use of personnel and inadequate agency assessment of need a very important barrier.[9]

On the whole, these findings support the interpretation made in the preceding section of this chapter. Respondents in States or localities in which the mental health programs are not autonomous are no more likely than respondents in other communities to consider these organizational problems as very important barriers. Indeed, at the local level, there is a tendency to consider them very important barriers if the respondents work in communities in which the mental health programs are separate and autonomous. In Chapter VI we had seen that respondents in States in which the mental health programs are autonomous are slightly less likely to be aware of "other" disadvantages of mental health personnel participating in non-direct mental health programs than are respondents in settings in which the mental health programs are not autonomous.

Apparently, there may be more awareness of organizational and professional difficulties if the mental health programs are not autonomous, but at least the aspects of organizational problems analyzed in this chapter are not more likely to be considered very important barriers for the effective use of mental health personnel in non-direct mental health programs by respondents in settings in which the mental health programs are autonomous. Perhaps closer working relations make the officials more aware of the problems, but also make them less likely to think they are a very great handicap.[10]

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[9]Mental health and public health respondents are not differently affected in their estimates by the organizational arrangements in their localities.

[10]This interpretation is supported by additional evidence. Respondents who report interacting with members of the profession other than their own are slightly less likely to consider these factors very important barriers.

The Effects of Considering Organizational Problems Important Barriers upon Preferences Concerning Organizational Arrangements and Utilization of Mental Health Personnel

Since various organizational arrangements are somewhat related to evaluating organizational problems as important barriers and since respondents tend to prefer existing arrangements, it is necessary to hold current arrangements constant in order to analyze the effects of considering these factors important barriers. The results indicate that one common effect is that respondents who consider such factors very important barriers, compared to those who do not, tend to prefer organizational arrangements which are different than the current ones in their State or locality. This tendency is particularly marked among public health respondents. There is also a tendency to prefer closer relations between mental health and other programs; this is found among mental health respondents under certain conditions.

For example, in Table 118 we can see the relationship between current organization of mental health programs, type of respondent, preferences for a separate and autonomous organization of mental health programs, and evaluation of unclear division of responsibility as an important barrier. Among the State public health respondents in States in which the mental health programs are autonomous, those who think this factor is not an important barrier tend to prefer the programs to be autonomous; while those in States in which the programs are dispersed tend to think the programs should be autonomous if they think this factor is important.

Such analyses of various actual arrangements, organizational preferences and aspects of organizational problems are quite complex. But it is certainly apparent that there is no tendency for the officials to prefer a separate organization of mental health programs if they think such factors are very important barriers. There are,rather, tendendies to prefer (1)

a different organizational arrangement than the existing one, whatever it is, and (2) closer organizational arrangements between mental health and other programs.

TABLE 118

PROPORTION OF RESPONDENTS VERY OR SOMEWHAT FAVORABLE TO A SEPARATE AND AUTONOMOUS MENTAL HEALTH ORGANIZATION BY CURRENT MENTAL HEALTH ORGANIZATION BY EVALUATION OF UNCLEAR DIVISION OF RESPONSIBILITIES AS AN IMPORTANT BARRIER, AND BY TYPE OF RESPONDENT

A. State Respondents

Type of Respondent and Evaluation of Importance of Unclear Division of Responsibilities	Organization of Mental Health Programs		
	Separate and Autonomous	Division of Public Health	Somewhat Dispersed
Public health			
Very or Somewhat important	19 (38)	8 (37)	31 (13)
Not at all important or Do not know	34 (27)	22 (32)	8 (12)
Mental health			
Very or Somewhat important	69 (62)	49 (61)	45 (20)
Not at all important or Do not know	67 (72)	55 (29)	63 (16)

B. Local Respondents

Type of Respondent and Evaluation of Importance of Unclear Division of Responsibilities	Organization of Mental Health Programs	
	Separate and Autonomous	Not Separate and Autonomous
Public health		
Very or Somewhat important	12 (34)	10 (20)
Not at all important or Do not know	22 (31)	12 (25)
Mental health		
Very or Somewhat important	56 (34)	39 (18)
Not at all important or Do not know	74 (42)	47 (19)

In the case of the respondents' ranking of indirect service functions of mental health personnel, officials who think inappropriate use of personnel or inadequate agency assessment of need is a very important barrier tend to give high ranking to indirect service functions. For example, for the factor of inadequate agency assessment of need, this is true for each type of respondent except State public health officials (see Table 119). For the factor of inappropriate use of personnel, this is true for State level respondents. Evaluations of unclear division of responsibilities as a very important barrier do not affect rankings of indirect service functions.

TABLE 119

PROPORTION OF RESPONDENTS GIVING HIGH RANKING TO INDIRECT SERVICE FUNCTIONS OF MENTAL HEALTH PERSONNEL, BY EVALUATIONS OF INADEQUATE AGENCY ASSESSMENT OF NEED AS A BARRIER AND BY TYPE OF RESPONDENT

Type of Respondent	Evaluations of Inadequate Agency Assessment		
	Very Important	Somewhat Important	Not at All Important
State, public health . .	50 (18)	40 (67)	48 (50)
Local, public health . .	39 (18)	31 (36)	24 (41)
State, mental health . .	35 (52)	27 (116)	23 (86)
Local, mental health . .	40 (15)	19 (41)	21 (38)

State public health officials who believe that unclear division of responsibilities are a very important barrier are less likely, than those who think it is not important, to prefer increased utilization of mental health personnel in public health or other-related programs. There is no such effect among other types of respondents.

Considering the other organizational problems to be very important barriers does not make the respondents less likely to want increased utilization of mental health personnel outside of direct mental health programs.

There is even a tendency for respondents who think inappropriate use of personnel or inadequate agency assessment of need is a very important barrier to be more likely to prefer increased utilization of mental health personnel in other-related programs. The findings for evaluations of inadequate agency assessment of need are presented in Table 120.

TABLE 120

PROPORTION OF RESPONDENTS PREFERRING MUCH OR SOMEWHAT GREATER UTILIZATION OF MENTAL HEALTH PERSONNEL IN OTHER-RELATED PROGRAMS BY EVALUATIONS OF INADEQUATE AGENCY ASSESSMENT OF NEED AS A BARRIER AND BY TYPE OF RESPONDENT

Type of Respondent	Evaluations of Inadequate Agency Assessment of Need		
	Very Important	Somewhat Important	Not at All Important
State, public health	50 (16)	40 (64)	35 (54)
Local, public health	42 (19)	46 (35)	33 (40)
State, mental health	58 (52)	48 (114)	53 (83)
Local, mental health	53 (15)	54 (41)	54 (37)

Presumably, closer personnel integration is not viewed as a way of solving the problem of unclear division of responsibilities; but it may be seen as relevant to having more appropriate use of personnel and more adequate agency assessment of needs, at least in other-related programs.

Suggestions for Improving the Situation

As in the case of the other factors we have examined, the respondents who considered each of the factors relating to organizational problems to be a very important barrier were asked what they thought could be done to improve the situation. Among the persons who thought unclear division of responsibility is a very important barrier, three kinds of suggestions are mentioned

particularly: (1) clearer definition of functions; (2) clearer organizational relationship, closer coordination of activities; and (3) better mutual understanding, more improved communication. As a State director of Local Health Services said:

> One agency should be assigned specific responsibility by the Executive. More definitive assignment. Legally, responsibility is in the Department of _____, but there is no responsibility delegated for community mental health. As it is set up now, each community or district sets up a hybrid mental health clinic autonomously. No one is ready to grab the responsibility for State-wide mental health clinics.

Among the persons who consider the inappropriate use of personnel to be a very important barrier, forty per cent of them suggest that better personnel selection and assignment for specific tasks would help improve the situation. For example, one respondent said:

> To take into account the professional training, personal capabilities, work experience and the current agency needs in assigning individuals to the duties and responsibilities in mental health--without becoming embroiled in the pushing for members of any particular guild being more important than any other members of the mental health task force.

Another kind of suggestion is made by about one-fifth of the persons considering inappropriate use of personnel to be a very important barrier: better planning of programs and long-range consideration of the use of personnel.

Finally, among the respondents who report that inadequate agency assessment of need is a very important barrier, two kinds of suggestions are made relatively frequently: (1) better utilization of information, more receptiveness to innovation, and (2) better trained personnel, better mutual understanding of what the other profession can do. To give one example of the latter kind of suggestion, one respondent said, "Better training for agency personnel in recognition of mental health needs of clients and on the agency's roles and responsibility in meeting these needs."

Clearly, these suggestions for improving the situation do not indicate that the respondents want to solve the problems by running away from them. Apparently, the need for collaboration is so strongly felt that the officials believe the difficulties are to be overcome by trying to solve them rather than abandoning the collaboration.

Conclusions Concerning the Barriers and the Role of the Federal Government

There is widespread agreement among the key officials interviewed for this study that the manpower shortage is a very important barrier to the more effective use of mental health personnel outside of direct mental health programs. An inadequate tax base is also generally considered a very important barrier. Lack of political or public support, differences in orientation between mental health and public health professionals, and organizational problems are relatively infrequently considered to be very important barriers.

The State and local characteristics associated with the respondents' evaluations of these various factors as barriers indicate that their evaluations are affected by the objective conditions in their States or localities.

The analysis reveals that the various factors have differing effects upon the respondents' preferences concerning organizational arrangements and the use of mental health personnel in non-direct mental health programs. Such effects implicitly suggest ways of reducing the barriers in addition to the explicit suggestions of the respondents.

In the case of preferences concerning organizational arrangements, we have seen that there is a tendency for persons who think certain factors are very important barriers to be particularly likely to express preferences which are typical of their profession and organizational group. This was noted for

The respondents were asked specifically about the possible assistance the Federal Government might be. The question was, "In what ways do you think the Public Health Service of the Federal Government can be of more help in bringing about more appropriate use of mental health personnel in your (STATE)(LOCAL) health and health related programs?"

There is general agreement among the officials with different program responsibilities about the role the Public Health Service should have (see Table B-20). Almost none of the respondents say that the Public Health Service should do less than it is presently doing or do nothing at all. Only a few more respondents suggest that the Public Health Service should simply continue as it is at present.

Among the positive suggestions, giving more advice and consultation is most frequently mentioned. There are also many respondents who suggest increased funds: for community and State services, formula grants, and demonstration projects. There are also many suggestions about the way in which the Public Health Service can help provide more personnel: by providing directly or providing funds for: in-service training, fellowships, or even loaning personnel for short periods of time. There are also suggestions of support for institutes and workshops and for research. There are suggestions, too, that the Public Health Service disseminate information about programs and assess them, perhaps even set standards. There are suggestions by some respondents about how the Public Health Service should provide its services--working more closely with local programs is particularly mentioned among these ideas.

Now let us look at these suggestions more closely. About one out of four respondents suggest that the Public Health Service give more advice and consultation; this is most frequently mentioned by nearly every category of

official. Some sample comments follow:

> More frequent consultation on local basis to provide know how.
>
> Increase use of consultation services by Public Health personnel to State department heads.
>
> I think that the few people.... in the regional offices do their level best to be helpful. But they are greatly understaffed. I'd like to be able to look to them for consultative leadership and /have/ opportunities to discuss many of our problems in relation to activities going on in the nation at large..... They do not have the personnel to do the job. They are good people, but not enough of them. I have learned a lot from watching them operate; however, if you want to consult with them you have to make a date months in advance.

About one out of five respondents suggest more funds for community and State services; this is particularly mentioned by local public health officials. The flavor of the suggestions can be gathered from these quotations:

> About the only way the Federal Public Health Service could be more effective would be to be directly financially involved. They have already offered consultation and leadership and any additional move would /have/ to be financial aid.
>
> Create a special category of funds under Hill-Burton[11] to construct....mental health facilities, centers, psychiatric units.
>
> I feel it is a State mental health problem--ideally. Practically, a State will use and is looking for assistance from the Federal Government as far as funds are concerned....I do not feel they can help in any other way; they already have advisory agents.

Public Health Service support for demonstration projects is mentioned, particularly by heads of alcoholism programs. They also suggest funds for workshops, institutes, and conferences. Heads of alcoholism programs also relatively frequently mention research support, as do local mental health officials and State mental health officials in hospital-based programs. The head of alcoholism programs in one State, speaking of the need for research

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[11] Popularly referred to as the Hill-Burton Act, the Hospital Survey and Construction Act, enacted in 1946, provides for Federal leadership and financial encouragement for the establishment of hospital and medical facilities.

said: "Im sure we do need to make better use of our mental health people. We need better coordination between departments and better cooperation. And I think this would come if we knew exactly what kinds of problems we have. This kind of research I think is the responsibility of government .....To find out the extent of the seriousness of the mental health problem in the State of _____."

Among the suggestions about how the Public Health Service should provide its assistance, working more closely with local programs is often mentioned--particularly by local mental health respondents. The administrator of a local clinic--a psychologist--expressed himself this way:

> By getting out more and talking and getting to know people who are actually working at mental health. They need to get out and meet people in the field.
>
> They tend to make plans and attack problems through one agency, and if the head of that agency cannot communicate very well the whole program flounders. Or, if it's a new program that's being planned, it may fall through simply because the Federal Government spent too much time talking to the wrong person and not enough time investigating conditions in the community and talking to the people who are actually working in mental health.
>
> They're very apt to work very rigidly through official channels.

He went on to make another suggestion, also made by some other local mental health respondents:

> They need to help us communicate with the local community people. Now, they /the local people/ don't understand us, or what we're trying to do. I think this might be one area in which they could be very helpful.

Finally, an example of the suggestion that the Public Health Service disseminate information about programs throughout the nation is worth noting. In this case, the respondent also suggests something about how it should be done:

I think they can help us by giving us the benefit of their knowledge and experiences and by telling us what programs are working effectively in other States and what are not--so we don't have to make the same mistakes. They will usually tell you about programs, but they don't tell you how they're working... They are hesitant to apply judgment or give assessments.

PART IV.

NEW DEVELOPMENTS

CHAPTER VIII

NEW DEVELOPMENTS IN THE USE OF MENTAL HEALTH PERSONNEL

Thus far the discussion has been concerned largely with current and desired collaboration between mental health and other professionals. In this chapter recent changes in the extent and character of the utilization of mental health personnel in public health, welfare, and other-related programs will be examined. Each respondent was asked about new developments in his State or locality; the question was, "In the past three years, have there been any changes or new developments in the use of mental health personnel in health or health-related programs, aside from 'direct' mental health programs?" Note, the question asked only about changes or developments in the last three years. Furthermore, the officials were not asked about the participation of non-mental health personnel in direct mental health programs. Some respondents mentioned such developments, for example, in after care programs; if they also explicitly mentioned that this resulted in closer relations with, or in-service training by, mental health personnel, the response was categorized as a "new development"; otherwise, it was not so categorized.

In this chapter the extent of such new developments in the States and in the localities will be examined first and then the programs in which new developments are reported will be reviewed. In the next chapter the background of the new developments will be discussed.

Extent of New Developments

The reports of all State respondents from each State were combined to characterize the new developments in each State. If any respondent

reported a new development in his State, it was categorized as having one. A similar procedure was followed for the 123 localities selected for this study.

In every State there is a report of at least one new development and in sixty-five per cent of the localities there is a report of a new development in the use of mental health personnel outside of direct mental health programs. Of course, part of this diffference between the State and local levels is due to the fact that we have reports from only one or two persons from each locality and many more from each State; the more people reporting, the more likely it is for someone to report something as a new development; also, the State respondents are reporting about developments in their whole State. It is, nevertheless, likely that in many localities there are simply no new developments to report. It should be remembered, moreover, that the sample of localities is drawn from among localities in which there is a mental health agency functioning. Obviously, in other localities one could expect very few new developments as defined here.

Respondents who said there were any new developments in their State or locality were asked to describe the development briefly. Many persons mentioned the program in which the new development occurred and often what the mental health personnel were contributing to the program. The responses were categorized largely in terms of the programs in which the new developments occurred. If, however, the respondent mentioned new developments with public health departments generally and did not specify a program, the developments were coded in terms of what services the mental health personnel provided. Thus, each development could be placed in a single category. This made it possible to aggregate the responses of different respondents from the same State or locality and, as will be discussed later, to identify the development chosen as most important.

As was mentioned, the new developments reported by all the respondents from the same State or locality were added together for that State or locality. The same development reported by several persons from the same State or locality, and coded the same way, could be counted only once. The results of these summarizations by States and localities are presented in Table 121. It is clear that at both levels increased relationships between mental health personnel and the public health departments generally is most frequently mentioned as a new development. At the local level, this most frequently entails in-service training and consultation; at the State level having added a mental health person to the public health departments is reported for forty per cent of the States and in-service training in thirty-eight per cent.

As an example of a new development involving in-service training, one respondent reported:

> Employment of people in the mental health field to provide in-service training to other staff people, to educate other staff on the use of mental health factors in all public health and community health problems, to improve all disciplines in working with people to the best advantage.

Another respondent said:

> The creation of a new position--psychiatric nurse. Shift in program emphasis...more professional in-service education and more community mental health planning. (This answer was also coded in the categories concerning adding a mental health person and use of mental health personnel in community planning or development.)

One local public health respondent mentioned the following new development, which was coded as adding a mental health person to the public health staff:

> Introduction of mental health worker in the county who serves as a coordinator for mental services and also as an advisor for the development of new programs.

TABLE 121

REPORTS OF NEW DEVELOPMENTS AND PROGRAMS IN WHICH NEW DEVELOPMENTS OCCURRED, BY STATES AND LOCALITIES, IN PERCENTAGES

Report of New Developments and Program in Which They Occurred	States	Localities
No new development	-	32
No information	-	3
New development reported	100[a]	65[a]
Closer coordination of activities of mental health and public health personnel	32	4
Program or case consultation in public health programs	34	10
In-service training of public health personnel	38	12
Mental health person(s) added to public health staff	40	6
Public health nursing	48	17
Maternal and child health, pediatric clinics	30	6
Hospitals, nursing homes	34	4
Aging	16	1
Chronic diseases	14	3
Community planning, development	40	5
Alcoholism	36	6
School	46	20
Handicapped, crippled children, rehabilitation	34	5
Mental retardation	28	6
Foster homes, day care centers	10	1
Correctional, penal	34	11
Welfare	26	6
Research	28	2
Other public health programs	16	2
Other programs	26	11
Total per cent	100	100
Base for percentages	(50)	(123)
No answer	(-)	(-)
Total number of cases	(50)	(123)

[a]Percentages of programs in which developments occurred total to more than percentage of States or localities in which new developments are reported to have occurred because more than one new development is reported from many States and localities.

Among the specific programs in which new developments are mentioned, public health nursing and school programs are most frequently mentioned: for forty-eight and forty-six per cent of the States and for seventeen and twenty per cent of the localities, respectively. A new development in the nursing program, as reported by one official, is:

> Consultation of psychiatrists, psychologists, and mental health social workers to nurses in after care.

Here are some examples of new developments in the school programs:

> Increased interest in school psychologists program, new venture....Psychologists spending time in schools for mental health education purposes.

> The development of providing county mental health teams in schools. This comes under the State department of education, but we provide consultation...see children on referral from principal.

> Our school mental health program. We have our people working with the school personnel to train them in mental health principles.

The developments in school programs are particularly mentioned by respondents from the localities.

Developments in one other program should be noted: the use of mental health personnel in community planning and development. There are reports of new developments in this program from forty per cent of the States and five per cent of the localities. The head of the mental health program in a large city reported:

> We have helped communities to take a total mental health program, emphasizing positive approach toward mental health in the community. We put emphasis upon community and implied contract. We go into the community and talk with public and private agencies, diagnose needs. We offer mental health services on contract if they do certain things. For example--schools--we'll take a disturbed child for treatment if they do not just drop the child from school, but take the child back and keep him, and help us get the mother to come in. They have to set up seminars for the teachers so that we can teach them how to recognize disturbed children. Sometimes the quiet ones

> the teachers like need care. We'll provide the staff. (This response was also coded as a new development in the school programs.)

The new developments are reported in nearly every program of the State and local health and health-related programs. If persons in the welfare programs had also been interviewed, there probably would be more reports of new developments in those programs. As it is, although persons from the education systems were not interviewed, there are numerous reports of new developments in the school programs.

In general, certainly at the State level, there appears to be considerable experimentation in the use of mental health personnel in various public health, educational, welfare, correctional, and other programs. The mental health personnel provide in-service training, case consultation, consultation for program development, and educational and therapeutic services as part of the major activities of a wide range of programs.

The respondents were also asked to select the one new development which they considered most important, if they mentioned more than one. These answers, with those given by respondents who mentioned only one new development, indicate the programs in which the new developments are considered particularly important by the respondents. The results are presented in Table 122.

Increased relations with public health departments generally are most likely to be mentioned as most important. Among the specific programs, new developments in public health nursing are evaluated as particularly important. Developments in school programs are considered particularly important by local respondents. Among State respondents, too, the utilization of mental health personnel in community planning and development, in alcoholism, and in handicapped, crippled children, and rehabilitation programs are considered particularly important.

TABLE 122

PROGRAMS IN WHICH NEW DEVELOPMENTS ARE MOST IMPORTANT AS REPORTED BY STATE AND LOCAL RESPONDENTS, IN PERCENTAGES

Program	Respondent	
	State	Local
Closer coordination of activities of mental health and public health personnel	8	5
Program or case consultation in public health programs	5	9
In-service training of public health personnel	5	10
Mental health person(s) added to public health staff	6	7
Public health nursing	16	13
Maternal and child health, pediatric clinics	5	6
Hospitals, nursing homes	5	3
Aging	1	-
Chronic diseases	1	3
Community planning, development	10	5
Alcoholism	6	5
School	8	17
Handicapped, crippled children, rehabilitation	6	-
Mental retardation	2	5
Foster homes, day care centers	2	*
Correctional, penal	3	3
Welfare	1	*
Research	4	2
Other public health programs	2	*
Other programs	4	7
Total per cent	100	100
Base for percentages	(240)	(105)
Inapplicable	(260)	(135)
Total number of cases	(500)	(240)

*Less than 0.05 per cent.

It is interesting to compare the programs in which new developments are reported and considered to be most important with those which currently have high utilization of mental health personnel and with those which are considered to most need increased services of such personnel, as discussed in Chapters III and IV. The respondents report certain programs to have relatively high utilization, to be most in need of increased services, and to be the location of the most important new developments. This seems to be the case for the nursing, school health, maternal and child health, alcoholism, and hospital programs.

Two programs, not among those which the respondents were asked to report current and preferred utilization, appear as ones in which there are new developments which are considered important: community development and mental retardation.

It is interesting, too, that although there is reported to be moderate utilization of mental health personnel in aging programs and they are considered to be among the programs most in need of increased services of such personnel, few important new developments are reported in the aging programs. On the other hand, important new developments are reported in research programs even though the utilization of mental health personnel is reported to be low and it does not rank high among the programs most in need of increased services. This is probably due to the fact that research was bracketed with vital statistics in the list of programs presented to the respondents.

Background of New Developments

How did these new developments originate? How were they funded and what effect have they had upon other programs? Each respondent was asked such questions about the only new development he mentioned or the one he

singled out as most important. First, the answers will be reviewed to see to what extent the background of new developments differs between the State and local level; then, differences among the programs in which new developments are reported will be examined.

The respondents were first asked, "Please tell me what persons or organizations were involved in the origin of the (most important) new development." The answers for State and local respondents are set forth in Table 123. Clearly, the government agencies are most frequently credited with originating the new development. References to public health and to mental health agencies are about equal. On the whole, State respondents refer to persons from the State level of government, while local respondents refer to local officials; there is only a slight tendency for local people to mention State officials more often than State respondents mention local officials. Officials from other government agencies such as the welfare department, the board of education, or the correctional institutions are the next most frequently mentioned. There are no marked differences between State and local respondents in referring to this source of the new development or to the other reported originators of the new development. In general, the respondents attribute the origin of the new development to the officials within the public health and mental health departments rather than to outside agencies or groups.

The answers to the next question asked of the respondents support the interpretation just made. The respondents were asked, "Were there special pressures from the public or from a special group in your (State) (community)?" Only one-third of the State and one-third of the local respondents reported some such pressure (see Table 124). Although most of the new developments seemed to have originated within the public health and mental

health agencies with no outside public pressure, a sizable percentage of the respondents reported such pressure. The group most frequently mentioned, by both State and local respondents, is the Mental Health Association. Civic, service, and community organizations are also relatively frequently mentioned, indicating the possible role of an active, concerned citizenry in promoting new developments.

TABLE 123

ORIGINATION OF NEW DEVELOPMENTS AS REPORTED BY STATE AND LOCAL RESPONDENTS, IN PERCENTAGES

Persons or Organizations Involved in Origin	Respondents	
	State	Local
State, public health agency	38	15
Local, public health agency	10	32
State, mental health agency	45	11
Local, mental health agency	5	38
State or local, other government agency	26	27
Governor, mayor, legislature	10	5
Voluntary organizations	14	19
Federal government	6	4
University, professional associations	12	8
Other	4	7
Don't know	4	1
Total per cent	174	167
Base for percentages	(224)	(103)
No answer	(16)	(2)
Inapplicable	(260)	(135)
Total number of cases	(500)	(240)

TABLE 124

PRESENCE OF SPECIAL PUBLIC PRESSURE AND SOURCE OF PRESSURE FOR NEW DEVELOPMENTS AS REPORTED BY STATE AND LOCAL RESPONDENTS, IN PERCENTAGES

Presence of Special Pressure and Source of Pressure	Respondents	
	State	Local
No pressure	65	65
Don't know	1	1
Yes, pressure	34[a]	34[a]
Mental health association	15	13
Other citizen organizations concerned with mental health	10	6
Service clubs, churches, and other voluntary community organizations	9	7
Teachers' associations	1	5
Psychologists', psychiatrists' associations	2	1
Medical associations	3	1
Other professional associations	2	2
Welfare council, council of social work agencies	3	-
The public	5	2
Other specific sources	4	4
Vague, don't know	1	1
Total per cent	100	100
Base for percentages	(222)	(102)
No answer	(18)	(3)
Inapplicable	(260)	(135)
Total number of cases	(500)	(240)

[a]The percentages for the sources of pressure total more than the percentage reporting any pressure because more than one source of pressure was reported by some respondents.

Consistent with the reports that most new developments originated within the public and mental health agencies themselves and without outside public pressure, the respondents frequently reported that the new development was supported out of the regular department budget (see Table 125). The respondents were asked, "How was the new development funded?" In addition to the regular department budget, funds from the State, the locality, and the Federal Government were frequently mentioned. It is noteworthy that Federal Government funds are as frequently mentioned as they are; perhaps this indicates that they are particularly likely to be used in new developments. There is no marked difference between State and local respondents in their reports of the funding of the new developments. There is a tendency for local respondents to mention regular departmental funds and city funds more than the State respondents do and to mention State and Federal funds somewhat less frequently than State respondents do.

Finally, the respondents were asked, "Were other programs dropped or curtailed as a result of this new development?" Only eight per cent of the State respondents and fourteen per cent of the local respondents answered "Yes." These are small percentages, but perhaps in some cases the respondents were disinclined to admit that other programs were dropped or curtailed. Given the general level of reflection and frankness in the interviews and given the very low percentage of respondents asserting that other programs have not been reduced, however, it seems safe to conclude that in the vast majority of cases the new developments are additions to and not substitutions for old programs.

Now we will consider the same background characteristics for the more frequently mentioned most important new developments, disregarding

whether or not they are reported by State or local respondents. In Table 126, we can see that public health departments are especially likely to be mentioned as involved in the origination of the new development in public health departments generally and in the two other special public health programs about which the number of cases is sufficient to report, nursing and maternal and child health.[1] In the case of new developments in community development, officials from the State department of mental health are mentioned particularly frequently as involved in the origin of the new development. In the case of new developments in the school programs, officials from the departments of mental health and from "other" government departments (presumably schools) are most frequently mentioned.[2] Finally, it is worth noting that in alcoholism programs, voluntary community organizations are relatively frequently mentioned as involved in the origination of the new development.

TABLE 125

SOURCE OF FUNDS FOR NEW DEVELOPMENTS AS REPORTED BY STATE AND LOCAL RESPONDENTS, IN PERCENTAGES

Source of Funds	Respondents	
	State	Local
Regular department budget, no additional funds	32	42
State funds (unspecified)	37	25
State grant-in-aid	5	5
City or county funds	17	27
Federal funds, grants (unspecified)	19	16
Federal research, mental health project, training grants	10	4
University funds	*	2
Funds from patients' fees	-	2
Voluntary contributions, through voluntary organizations	7	10
Other specific sources	2	-
Vague, don't know	2	2
Total per cent	131	135
Base for percentages	(216)	(96)
No answer	(24)	(9)
Inapplicable	(260)	(135)
Total number of cases	(500)	(240)

*Less than 0.5 per cent.

[1]There are too few cases to compare reports about each program for local and State respondents; this was done only for the programs with the largest number of cases: public health departments generally, nursing, and school programs. The pattern observed in the text appears to be true at the State and local levels.

[2]This holds at the State and local levels.

TABLE 126

ORIGINATION OF NEW DEVELOPMENTS BY PROGRAM IN WHICH DEVELOPMENTS ARE REPORTED, IN PERCENTAGES

Persons or Organizations Involved in Origin	Programs								
	Public Health Departments				Nursing	Maternal and Child Health	Community Development	Alcoholism	School
	Closer Coordination	Consultation	In-service Training	Person Added					
State, public health agency .	40	37	30	25	58	40	18	15	12
Local, public health agency .	20	37	30	30	22	7	11	25	12
State, mental health agency .	48	21	15	25	42	27	75	20	35
Local, mental health agency .	8	5	25	25	14	20	14	10	32
State or local, other government agency . .	32	11	25	5	24	7	7	20	62
Governor, mayor, legislature . ,	24	-	10	5	-	7	14	10	3
Voluntary organizations . . .	20	16	10	15	2	20	18	35	12
Federal government	-	16	-	5	2	7	4	10	9
University, professional associations. .	16	5	10	5	6	13	4	-	18
Other	-	11	-	-	8	7	7	5	-
Don't know . . .	-	11	-	5	2	7	-	10	3
Total per cent . . .	208	170	155	145	180	162	172	160	198
Base for percentages	(25)	(19)	(20)	(20)	(50)	(15)	(28)	(20)	(34)
No answer . .	(-)	(3)	(3)	(1)	(3)	(2)	(-)	(-)	(2)
Total number of cases .	(25)	(22)	(23)	(21)	(53)	(17)	(28)	(20)	(36)

When we turn to reports of any special pressures for the new developments, as can be seen in Table 127, reports of outside pressures are relatively infrequently mentioned for developments in the use of mental health personnel in the public health departments generally and they are relatively more frequently mentioned for school programs. In the school programs, teachers' associations and teachers are particularly mentioned; in the other programs, particularly for community development, the Mental Health Association is relatively frequently mentioned.

Funding of the new developments in the nursing and school programs is relatively frequently mentioned as coming from regular departmental budgets (see Table 128). Federal funds are somewhat more frequently mentioned in reference to developments in maternal and child health and in alcoholism programs. Consistent with the findings reported thus far, there are few reports of any other activities being dropped or curtailed as a result of the new developments. In the case of two programs, however, about a quarter of the persons reporting about new developments mentioned that other activities were dropped or curtailed, twenty-five per cent of those reporting that a mental health person was added to the health department and twenty-two per cent of those mentioning a new development in community development. It should also be pointed out that the dropping or curtailment of other activities is not always unfortunate. Some respondents mentioned that inadequate old programs were dropped and replaced by better ones.

In addition to the respondents' reports of the background of the new developments, it is possible to see if certain new developments are more or less frequent in different kinds of States and localities. Thus, States in which the mental health authority is located in a public health department, compared to the other States, are somewhat more likely to be

PRESENCE OF SPECIAL PUBLIC PRESSURE AND SOURCE OF PRESSURE BY PROGRAMS IN WHICH DEVELOPMENTS ARE REPORTED, IN PERCENTAGES

Presence of Special Pressure and Source of Pressure	Programs								
	Public Health Departments				Nursing	Maternal and Child Health	Community Development	Alcoholism	School
	Closer Coordination	Consultation	In-service Training	Person Added					
No pressure . . .	68	74	80	69	68	60	64	65	47
Don't know . . .	-	5	-	5	-	7	-	-	-
Yes, pressure[a] .	32	21	20	26	32	33	36	35	53
Mental health association .	16	21	15	11	8	7	25	15	6
Other citizen organizations concerned with mental health	8	5	-	5	6	7	7	5	12
Service clubs, churches, and other voluntary organizations . . .	8	5	5	11	2	7	18	15	6
Teachers' associations.	-	-	-	-	2	-	-	-	15
Psychologists', psychiatrists' associations.	8	-	-	-	-	7	-	-	3
Medical associations . . .	-	11	5	-	2	-	4	-	6
Other professional associations.	-	-	5	5	4	-	-	-	3
Welfare council, council of social work agencies . .	-	-	-	-	-	7	-	10	6
The public . .	4	-	-	-	-	-	4	5	3
Other specific.	4	-	-	-	-	14	-	10	3
Vague, don't know	-	-	-	5	-	-	-	-	3
Total per cent . .	100	100	100	100	100	100	100	100	100
Base for percentages . .	(25)	(19)	(20)	(19)	(50)	(15)	(28)	(20)	(24)
No answer .	(-)	(3)	(3)	(2)	(3)	(2)	(-)	(-)	(2)
Total number of cases.	(25)	(22)	(23)	(21)	(53)	(17)	(28)	(20)	(36)

[a]The percentages for the sources of pressure total more than the percentage reporting any pressure because more than one source of pressure was reported by some respondents.

TABLE 128

SOURCE OF FUNDS FOR NEW DEVELOPMENTS BY PROGRAMS IN WHICH DEVELOPMENTS ARE REPORTED, IN PERCENTAGES

Source of Funds	Programs								
	Public Health Departments				Nursing	Maternal and Child Health	Community Development	Alcoholism	School
	Closer Coordination	Consultation	In-service Training	Person Added					
Regular department budget, no additional funds	20	42	65	21	52	25	14	10	52
State funds (unspecified)	40	36	15	37	23	33	46	40	36
State grant-in-aid	8	-	10	11	-	-	4	10	3
City or county funds	28	36	15	32	12	25	25	25	21
Federal funds, grants (unspecified)	20	26	15	26	10	42	18	25	15
Federal research, mental health project, training grants	16	5	5	11	8	-	-	15	-
University funds	-	-	-	-	-	-	-	-	-
Funds from patients' fees	-	-	5	-	-	8	-	-	-
Voluntary contributions, through voluntary organizations	4	5	5	5	4	-	14	20	6
Other specific	4	-	-	-	-	-	4	-	-
Vague, don't know	4	5	-	-	4	-	4	5	-
Total per cent	144	155	135	143	113	133	129	150	133
Base for percentages	(25)	(19)	(20)	(19)	(48)	(12)	(26)	(20)	(33)
No answer	(-)	(3)	(3)	(2)	(5)	(5)	(2)	(-)	(3)
Total number of cases	(25)	(22)	(23)	(21)	(53)	(17)	(28)	(20)	(36)

reported to have new developments in the use of mental health personnel in public health departments generally. Such States are also relatively frequently reported to have new developments in the maternal and child health programs.[3] States in which the authority is located in a public health department also tend to have more reports of new developments in research.[4]

In the case of the nursing program, however, States in which the mental health authority is located in a mental health department are most likely to be reported to have new developments in the use of mental health personnel.[5] On the other hand, innovations in the penal and correctional programs are least likely to be reported in States in which the authority is located in a mental health department.[6] Finally, new developments in the welfare programs are most likely to be reported in States in which the authority is not located in either a mental health or public health department.[7]

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[3]New developments are reported in twelve of the twenty-five States with the authority in a public health department compared to three of the twelve with the authority in a mental health department and none of the thirteen States with the authority located elsewhere.

[4]New developments in research are reported in ten of the twenty-five States with the authority in a public health department, compared to two of the twelve with the authority in a mental health department and two of the thirteen States in which the authority is located in another department or agency.

[5]New developments are reported in nine of the twelve States with the authority in a mental health department compared to ten of the twenty-five with the authority in a public health department and five of the thirteen with the authority located elsewhere.

[6]New developments are reported in one of the twelve States with the authority in a mental health department compared to ten of the twenty-five States with the authority in a public health department and six of the thirteen in which the authority is located elsewhere.

[7]New developments are reported in two of the twelve States in which the authority is located in a mental health department and four of the twenty-five States in which the authority is located in a public health department compared to seven of the thirteen States in which the authority is located elsewhere.

At the local level, we find that the same proportion of localities in which the mental health programs are separately organized as those in which they are not are reported to have new developments; but more new developments are reported in localities which do not have separately organized mental health programs. For example, fourteen per cent of the localities in which the mental health programs are separately organized are reported to have new developments in the use of mental health personnel in the public health nursing programs, compared to twenty-three per cent of the localities in which the programs are not separately organized. Similarly, four per cent of the localities which have separately organized mental health programs are reported to have innovations in the penal and correctional programs, compared to eighteen per cent among the other localities.

Finally, the type of community also appears to be somewhat related to the extent to which new developments are reported: seventy-two per cent of the medical school communities for which we have information are reported to have had at least one new development, sixty-eight per cent of the large metropolitan communities have, and sixty-three per cent of the smaller communities have had such developments. The medical school communities are reported to have disproportionally more new developments in the use of mental health personnel in the public health programs generally; they also are reported to have innovations in the alcoholism programs more than have other types of communities (eleven per cent, compared to two and four per cent in the large and smaller metropolitan communities, respectively).

In summary, the evidence presented in this chapter indicates extensive innovations at the State and local levels in the use of mental health personnel outside of direct mental health programs. The new ways

in which members of the mental health professions participate are varied and are in a wide range of programs. The new developments considered most important by the respondents are usually in programs which the respondents often consider most in need of increased services of mental health personnel. This is the case for the following programs: nursing, school, maternal and child health, alcoholism, and hospitals. In addition, new developments in community development, mental retardation, and in research programs are relatively often mentioned as ones in which new developments are particularly important.

New developments in the use of mental health personnel generally are reported to have originated from within the government agencies most directly involved. Outside pressures are infrequently mentioned; of the outside groups mentioned, the Mental Health Association is most often cited. Consistent with these reports, many of the new developments are supported by regular departmental budgets. Nevertheless, the new developments are rarely reported to result in the curtailment of other programs. When mental health programs are organized together with non-mental health programs there seems to be some tendency for more innovations in the use of mental health personnel in those other programs.

PART V.

RESPONSIBILITIES OF GOVERNMENT

CHAPTER IX

GOVERNMENT RESPONSIBILITY FOR DIRECT MENTAL HEALTH SERVICES

What is the obligation of public agencies for the provision of direct services for the mentally ill and for the promotion of mental health? The discussion thus far has been concerned with how public agencies do and should provide mental health services. In this chapter the respondents' judgments concerning whether or not tax funds and public agencies should provide therapeutic and preventive services will be examined. In the next chapter the officials' views concerning the relative responsibility of State and local governments for the provision of psychotherapy in different settings and their views of the amount of leadership which the Federal government should exercise will be analyzed.

Historically, in this country, public health departments have provided only limited direct medical services in conjunction with their major work in disease prevention; particularly infectious diseases. Partly because of the success of these efforts, persons live to an older age; the diseases that older persons are subject to are more likely to be chronic and primary prevention is limited because the causes of many of these diseases are not known. As a result of these developments, public health departments have become more involved in the provision of care for individual patients. Furthermore, medical care for the indigent has long been a governmental responsibility. Of course, most medical care has been provided by private practitioners on a fee for service basis, modified in recent years by the development of various health insurance plans.

The provision of care for the mentally ill has been quite different. Since mental illness usually has been chronic and has required long-term care, the mentally ill have been treated in mental hospitals and ninety-eight

per cent of the psychiatric patients are under care in city, county, State or Federal hospitals.[1] Tax-supported clinics for the provision of treatment of the non-institutionalized mentally ill is more recent, but increasing. The provision of mental therapy by private practitioners on a fee for service basis has also been a relatively recent development. "It has been estimated that 1,070,000 Americans are hospitalized for mental illness in federal, state, and private institutions and in the psychiatric units of private hospitals. . . . Another 379,000 patients, at least, are treated in mental health clinics; between 365,000 and 451,000 are seen in the offices of psychiatrists."[2] Although these figures do not indicate the number of patients under care of tax supported services, it seems safe to conclude that even the non-institutionalized mentally ill do not receive treatment from private practitioners in the same proportion as do those who suffer from physical illness.

Recently there has been a growing belief in the advantages of treating the mentally ill outside of institutions--both as a preventive measure and as a more effective curative procedure. Such a change need not be viewed as ending governmental responsibility.

Past and present practices in the United States, then, can be cited to support arguments for many different ways of paying for the care of the non-institutionalized mentally ill.

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[1]Derived from United States Department of Health, Education, and Welfare, Health, Education, and Welfare Trends (Washington, D.C.: U.S. Government Printing Office, 1961 edition), p. 27.

[2]Richard J. Plunkett and John E. Gordon, Epidemiology and Mental Illness (New York: Basic Books, Inc., 1960), p. 41.

One question which gave respondents an opportunity to express their position about the role of public health and mental health agencies in providing direct mental therapy has been discussed earlier, on page 79. The question was whether agencies should:

> "(1) not try to provide actual therapy, but work on programs which will reduce the incidence of illness....or which will create a climate supportive for seeking therapy,
>
> (2) place major emphasis upon preventive programs, but provide some therapeutic services, [or]
>
> (3) maintain preventive programs, but provide extensive therapeutic services.

Now we want to consider the answers as indicating policy recommendations about the extent to which public agencies should be responsible for therapeutic services.

About one-fourth of the respondents express the judgment that public agencies should not provide direct therapeutic services; about one-half say some such services should be combined with preventive programs; and about one-fourth believe that extensive therapeutic services should be provided. The answers given by respondents with different program responsibilities are presented in Table B-35. Further analysis shows that among the local mental health respondents, those who are heads of government departments or bureaus, are very likely to favor extensive provision of therapeutic services (sixty-one per cent); university-associated respondents and heads of mental health centers or clinics are not likely to favor this alternative (eighteen per cent and twenty-four per cent, respectively).

There is a tendency for respondents in high density States to favor extensive therapeutic services. This alternative is also favored in the North East, compared to the South, holding population density constant (see Table 129). This regional finding suggests that political values may affect the preferences concerning the role of public agencies. Evidence presented

later will support this interpretation. Respondents in States with high or low per capita income or large or small populations do not differ in their preferences for agencies providing therapeutic services.

TABLE 129

PROPORTION OF RESPONDENTS WHO BELIEVE PUBLIC HEALTH AND MENTAL HEALTH AGENCIES SHOULD PROVIDE EXTENSIVE PSYCHO-THERAPEUTIC SERVICES BY REGION OF COUNTRY, AND BY STATE POPULATION DENSITY

Population Density	Region			
	North East	North Central	South	West
Low	28 (21)	26 (119)	7 (72)	24 (130)
High	34 (105)	28 (90)	22 (152)	29 (31)

On the whole, as we have already noted in Chapters II and V, there is no relationship between favoring different policy alternatives about the role of public agencies for treating the mentally ill and preferring various organizational arrangements, preferring increased utilization of mental health personnel, or ranking indirect service functions of mental health personnel.

There does seem to be a general attitude about the role of government agencies in the provision of therapy. The respondents were asked another question about the mission of public health departments: whether it should be primarily preventive, assume some responsibility for treatment of patients, or greatly increase treatment activities. The answers have been discussed on pages 77-78. We can see in Table 130 that respondents who believe that public health departments should be concerned primarily with preventive programs generally believe this is also true for public

agencies and the mentally ill; officials who feel that public health departments should greatly increase their treatment activities also are likely to think that public agencies should provide extensive therapeutic services for the mentally ill.

TABLE 130

PREFERENCES CONCERNING MISSION OF PUBLIC AGENCIES IN CARE OF MENTALLY ILL BY PREFERENCES CONCERNING MISSION OF PUBLIC HEALTH DEPARTMENT

Mission of Public Agencies in Care of Mentally Ill	Mission of Public Health Departments		
	Primarily Preventive	Assume More Responsibility for Treatment	Greatly Increase Treatment Activities
Only preventive programs . . .	42	12	9
Major emphasis upon prevention, some therapy	39	68	37
Maintain preventive programs, extensive therapeutic services	17	20	54
Don't know	1	*	-
Total per cent	99	100	100
Base for percentages .	(302)	(289)	(129)
No answer	(1)	(1)	(-)
Total number	(303)	(290)	(129)

*Less than 0.05 per cent.

Among the personal characteristics of the respondents, we find that there is a slight tendency for younger officials to be more likely to choose the alternative that public agencies provide extensive therapeutic services. Among officials under forty-five years of age, twenty-eight per cent choose this alternative; among those forty-five to fifty-four, twenty-six per cent do; and among respondents who are fifty-five or older, twenty per cent choose this policy alternative. This relationship holds for each type of respondent.

The respondents were asked another question which directly concerns the obligation of providing mental health services through tax funds. The question was, "Excluding care for the instituionalized mentally ill, should the 'direct' mental health agency programs of your (STATE)(LOCALITY) be financed primarily by tax supported agencies, primarily by privately supported agencies, or about equally by both?" This question refers to agency programs--both preventive and therapeutic.

Almost none of the respondents answer that the mental health programs should be primarily supported by private agencies (see Table B-28). About twenty-five to fifty per cent of each type of respondent answer that the programs should be supported equally by privately supported and by tax supported agencies. About fifty to seventy-five per cent of the respondents with each type of program responsibility reply that the direct mental health programs should be financed primarily by tax supported agencies. This last alternative is somewhat more likely to be chosen by public health than by mental health respondents. Among the local mental health respondents, those in government departments or bureaus and those in universities are more likely to choose this alternative than are directors of clinics (sixty-four per cent compared to forty-six per cent).

The answers to this question, as well as to the question concerning the provision of therapeutic services by public health and mental health agencies indicate that a majority of the respondents believe that tax support should be given for the provision of care for the non-institutionalized mentally ill and that such care is within the mission of public agencies. There is an indication that public health respondents are more likely than mental health respondents to believe that direct mental health needs should be supported by tax funds; but there is a slight tendency for public health

officials, compared to mental health respondents, to be less likely to favor public agencies providing extensive therapeutic services.

The respondents' positions regarding the use of tax funds are related to their positions concerning the desirability of public agencies providing direct treatment of the non-institutionalized mentally ill. Thus, among respondents believing that public agencies should restrict themselves to preventive programs, forty-nine per cent believe programs for the care of the mentally ill should be primarily tax supported; among those believing some therapeutic services should be provided, sixty per cent believe the programs should be primarily tax supported; and among those who believe extensive therapeutic services should be provided, sixty-six per cent feel the programs should be provided by tax-supported agencies.

This, too, indicates that there is an underlying socio-political attitude involved in these issues. Officials vary in the degree to which they feel government agencies have a responsibility for action in the area of mental illness; if they think this is a governmental responsibility they also tend to think the agencies should provide extensive therapeutic services for the non-institutionalized mentally ill.

In addition to general socio-political orientations of the respondents, apparently conditions in the settings in which the respondents are employed affect their preferences for tax versus privately supported agencies as the means to provide direct mental health programs. This is indicated by an analysis of the possible barriers to the more effective use of mental health personnel outside of direct mental health programs, as discussed in the preceding chapter. Respondents who consider these factors to be very important barriers tend to favor privately supported agencies. The relationship is clearest in the case of the inadequate tax base factor:

among officials who think this is a very important barrier, only fifty-six per cent think tax supported agencies should be primarily responsible for direct mental health programs; among officials who think it is somewhat important, fifty-eight per cent favor tax supported agencies; and among those who think this factor is not at all an important barrier, seventy-two per cent favor tax supported agencies.[3] Presumably, since the mental health agency programs generally are tax supported, if there are problems, the solution would suggest itself to alter the situation--in this case, have more utilization of privately supported agencies.[4]

In summary, there is almost complete agreement among the respondents that public agencies have some responsibility for maintain direct (non-institutional) mental health programs. This is considered a legitimate governmental function at the local as well as State level. There is less agreement about the extent to which public agencies should provide therapeutic services. About three out of four respondents think public agencies have some responsibility for such services and one out of four think that extensive therapeutic services should be provided.

There are no marked differences among respondents with different program responsibilities. It appears that preferences concerning this issue are largely affected by the respondents' general socio-political orientation about the role of government.

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[3]It may be recalled, however, that in the respondents' suggestions for reducing the barrier posed by an inadequate tax base, obtaining more voluntary contributions was mentioned rarely (see page 238).

[4]These preferences are not related to the age of the respondent except among local public health officials; older local public officials tend to favor tax-supported agencies.

CHAPTER X

THE LEVEL OF GOVERNMENT WHICH SHOULD HAVE RESPONSIBILITY

Assuming some government responsibility for providing care for the mentally ill, which level of government should have responsibility for various programs? The respondents were asked about the responsibility of State and local governments for the care of the mentally ill and a general question about the amount of leadership the Federal Government should have in the field of mental health.

State and Local Government Responsibility

There is a growing belief in the value of treating the mentally ill within their home community. In this way, the patient's family, friends, and work colleagues can contribute to the therapy and maintenance of his health; and in this way the professional personnel helping the patient can provide more continuous and coordinated treatment. Such beliefs are likely to be reflected in opinions about the level of government which should have responsibility for programming treatment of the mentally ill.

Each respondent was asked,

> "Apart from questions of financing in this State, should programming for treatment of fully institutionalized persons be exclusively a State government responsibility, primarily a State government responsibility, shared about equally between State and local governments, primarily a local government responsibility, or exclusively a local government responsibility?"

The same question was asked about treatment of the mentally ill in day hospitals, night hospitals, half-way homes, and foster homes and also about treatment of the mentally ill in clinics.

In regard to treating the fully institutionalized mentally ill, the largest proportion of each category of respondents recommend that the State

have primary responsibility for programming treatment (see Table B-29). Even in the case of the fully institutionalized, only about one-fourth of the respondents report that they think the State should have exclusive responsibility. There is general agreement among the different types of respondents--only the State, community-based mental health respondents and the local mental health respondents are slightly less likely to prefer primary or exclusive State responsibility than are the other respondents. Very few officials say that the localities should have primary responsibility and practically none say they should have exclusive responsibility.

With respect to treatment of the mentally ill in day hospitals, night hospitals, half-way homes, and foster homes, there is a significant shift. Now only somewhat more than one-fourth of the respondents believe that the State should have primary or exclusive responsibility for programming treatment (see Table B-30). State public health officials, particularly heads of State programs, are somewhat more likely to believe that the State should have exclusive or primary responsibility than are other respondents. There are still few respondents who believe the local government should have exclusive responsibility; but equal responsibility is very frequently preferred. At least one-half of every category of respondents believe the localities should have at least equal responsibility.

There is a further shift in the case of treatment of the mentally ill in clinics (see Table B-31). Very few persons think responsibility for such treatment should be exclusively the responsibility of the State. The majority of respondents think such treatment should be equally the responsibility of the State and local governments. Furthermore, about one-fourth of the respondents think it should be the primary or exclusive responsibility of local government. Local respondents, particularly local

public health officials, are most likely to think local government should have primary or exclusive responsibility for programming such treatment.

These preferences are not affected by the population or political characteristics of the respondents' States, nor by the community type or organizational arrangement in the respondents' locality, nor by the extent of personnel integration at the State or local level. The respondents' preferences about organizational arrangements or about increased utilization of mental health personnel outside of direct mental health programs do not affect their preferences about the level of government which should have responsibility for the treatment of the mentally ill in the settings considered.

There is a tendency for respondents in States in which the mental health authority is located in a mental health or public health department to be less likely to favor State responsibility than are those in States in which the authority is located in another department or agency. There is also a tendency for respondents in the North East region to be more likely to favor State responsibility than are other respondents.

It is revealing that respondents who are more favorable to government action in the field of mental care tend to favor State rather than local responsibility. As can be seen in Table 131, for example, respondents who think direct mental health programs should be financed primarily by tax supported agencies are more likely to favor State responsibility compared to those who think financing should be about equally by both or primarily by privately supported agencies.

These findings indicate that a socio-political orientation affects preferences concerning the level of government which should have responsibility for treating the mentally ill. Apparently, persons who favor more

active government action in the mental health field also tend to favor higher levels of government having responsibility for the action.

TABLE 131

PROPORTION OF RESPONDENTS FAVORING EQUAL OR MORE RESPONSIBILITY OF LOCAL GOVERNMENTS FOR PROGRAMMING TREATMENT OF THE MENTALLY ILL IN VARIOUS SETTINGS BY PREFERENCES FOR SUPPORT OF MENTAL HEALTH AGENCY PROGRAMS

Preferences for Support of Mental Health Agency Programs	Treatment Settings		
	Fully Institutionalized	Semi-Institutionalized	Clinics
Primarily tax support . . .	33 (427)	75 (427)	84 (427)
About equally by both . . .	41 (280)	81 (280)	93 (280)
Primarily private support .	47 (19)	90 (19)	100 (19)

Preferences about the level of government which should have responsibility for programming treatment are also probably affected by beliefs about the appropriate way of providing care. We lack items in the questionnaire to directly test this, but there is a tendency for persons who rank indirect service functions of mental health personnel high to also favor local responsibility for programming treatment of the mentally ill who are fully or semi-institutionalized.[1] Similarly, there is a tendency for respondents who believe even a little training would make it possible to help persons with emotional problems to favor local responsibility.[2]

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[1]Among respondents ranking indirect service functions high, forty-one per cent say the localities should be equally, primarily, or exclusively responsible for programming treatment of the fully-institutionalized mentally ill; among those giving a middle rank to indirect service functions, thirty-seven per cent give the same answer; among those giving a low rank to these functions, thirty per cent give the same answer; in the case of programming treatment of the mentally ill who are semi-institutionalized, the comparable percentages are: seventy-seven, seventy, seventy-one.

[2]Among respondents believing even a little training can be helpful, seventy-four per cent think the localities should have equal or more responsibility for programming the treatment of the semi-institutionalized mentally ill, compared to sixty-five per cent among those who think lengthy training is necessary; in the case of clinic treatment, the comparable percentages are eighty-nine and eighty-three.

Federal Government Leadership

Each respondent was asked:

> Considering the relationship among the Federal, State, and local government agencies as they are at present, do you think the Federal government should have more, less, or about the same amount of leadership it now has in the field of mental health?

Over all, thirty-nine per cent of the officials think the Federal government should have more leadership; forty-eight per cent say the same amount; only six per cent think the Federal government should have less; and seven per cent do not know. There are no marked differences among respondents with different program responsibilities (see Table B-32).

This question also evokes the socio-political values of the officials. Among the respondents who think direct mental health agency programs should be primarily tax supported, fifty per cent think the Federal government should have only as much leadership as at present or less; while among those who think such programs should be equally or primarily financed by privately supported agencies, sixty per cent think the Federal government should have the present amount of leadership or less. It appears again that officials who do not favor government action also tend to favor lower levels of government to have responsibility for the action.[3]

We also find that officials who believe the Federal government should have more leadership are more likely to favor State responsibility

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[3]Thus, too, respondents who think public agencies should restrict themselves to preventive programs for the mentally ill tend to think the Federal government should not have more leadership: among those who think public agencies should have only preventive programs, fifty-eight per cent think the Federal government should have the present amount of leadership or less; among those thinking public agencies should provide some therapeutic services, the percentage is fifty-five; and among those thinking the agencies should provide extensive therapeutic services, forty-nine per cent think the Federal government should have the present amount or less leadership.

for the treatment of the fully institutionalized mentally ill than are respondents who do not favor more Federal government leadership (see Table 132).

TABLE 132

PROPORTION OF RESPONDENTS FAVORING EQUAL OR MORE RESPONSIBILITY OF LOCAL GOVERNMENTS FOR PROGRAMMING TREATMENT OF THE MENTALLY ILL IN VARIOUS SETTINGS BY PREFERENCES FOR FEDERAL GOVERNMENT LEADERSHIP

Preferences for Federal Government Leadership	Treatment Settings		
	Fully Institutionalized	Semi-Institutionalized	Clinics
More leadership	32 (290)	70 (290)	85 (290)
Same amount	38 (352)	73 (352)	90 (352)
Less leadership	48 (46)	76 (46)	89 (46)

It is also interesting that perceiving certain factors as very important barriers to the more effective use of mental health personnel is related to preferring more Federal government leadership. Thus, officials who think inadequate tax base or lack of support are important barriers also tend to favor Federal government leadership. For example, among respondents who think that lack of public support is a very important barrier, forty-six per cent think the Federal government should have more leadership; among those who think this factor is somewhat important, forty-one per cent favor more Federal government leadership; and among those who think this factor is not at all important, thirty-four per cent favor more Federal leadership.[4]

[4]This is true despite the fact that lack of public support is more likely to be perceived to be an important barrier in low density States and there is a tendency for respondents in low density States to be less likely to favor more Federal government leadership.

Perceptions of the manpower shortage, differences in orientation, or organizational problems as very important barriers are not related to preferences concerning the amount of Federal government leadership.

In summary, there is general agreement among the respondents that responsibility for programming treatment of the mentally ill who are fully institutionalized should be the primary or exclusive responsibility of the State; in the case of the semi-institutionalized and particularly those treated in clinics, the respondents believe localities should have at least equal responsibility. These preferences are affected by the officials' socio-political values about the role of government in the mental health field: those who favor more government action tend to favor State responsibility. These preferences are probably also affected by beliefs about the appropriate ways of providing care.

The officials believe that the Federal government should have about the same amount of leadership as at present (forty-eight per cent), or more leadership (thirty-nine per cent); few believe it should have less. These preferences are also affected by the respondents' socio-political values about the role of government: those who think the government should assume more responsibility for mental health programs and particularly for therapy also tend to favor more Federal government leadership. Feeling that certain factors are important barriers also influences the respondents to prefer more Federal leadership.

PART VI.

SUMMARY AND CONCLUSIONS

CHAPTER XI

SUMMARY AND CONCLUSIONS

A summary chapter makes it possible to draw together many of the lines of reasoning which previously could be developed only one at a time. In doing so, however, interpretations must be simplified. The documentation of the findings--and the qualifications concerning some of them--will not be repeated.

Members of the mental health and public health professions are finding their activities increasingly interrelated. The key officials bearing responsibility for programs in these fields generally think increased cooperation is desirable, but they do not agree about the form it should take.

The Current Situation

Organizational Arrangements

Most States can be placed into two categories: (1) those in which the mental health programs are autonomous, the institutional and community mental health programs are unified (that is, in the same department), and the mental health authority is not located in a public health department (eighteen States), or (2) the mental health programs are not autonomous, the institutional and community programs are not unified, and the authority is located in a public health department (twenty-one States). The other States fall between these two types along the dimension of autonomous and unified organization of mental health programs.

As shown in Chapter I, urban States are very likely to have autonomous and unified mental health programs. This is slightly modified by the fact that urban States are likely to have longer established mental health

programs and in such States the mental health programs were not originally established with independent departmental status and were not quickly given such status. Organizational arrangements in the States seem to be affected also by the arrangements in neighboring States; thus a non-urban State among urban ones tends to have arrangements like urban States.

At the local level, mental health programs are more likely than at the State level to be separately organized: sixty-one per cent of the localities are characterized as having separate and autonomous mental health programs; thirty-one per cent of them have the programs organized as a division of public health; and eight per cent are characterized as having somewhat dispersed mental health programs.[1] A separate organization of mental health programs at the local level usually means that the mental health programs are provided by a mental health center or clinic whose director is most likely responsible to non-government officials or, somewhat less frequently, to a State official. In a few cases it entails a government agency with departmental status.

Localities in States in which the State mental health authority is located in a public health department tend to have their local mental health programs organized as a division of public health rather than autonomously.

Personnel Integration

Among the direct mental health programs, public health personnel are reported to participate in various programs as follows:

High Participation	Moderate Participation	Low Participation
Mental health education	Diagnosis	Direct therapeutic services
Supportive services for patients receiving therapy	Services for patients leaving or formerly in mental hospitals	Nursing homes, halfway houses, and similar institutions
Supportive services for families of patients		24 hour emergency service

[1]The proportion of States similarly categorized, of those which could be categorized is: forty-five per cent, forty per cent, and fifteen per cent.

Personnel from the public health nursing departments are most often reported to participate in mental health programs. These patterns are similar at the State and local level.

The public health programs in which there is relatively high utilization of mental health personnel are also similar at the State and local level. The programs with the most extensive participation are:

	State	Locality
High Participation:	Nursing Alcoholism Hospitals	Nursing School health
Moderate Participation:	Aging Maternal and child health School health Local health services Health education	Health education Hospitals Alcoholism Maternal and child health Aging

At both the State and local level, participation is particularly low in occupational and communicable disease programs and almost non-existent in the environmental sanitation and dental health programs. Occasional consultation is the most common form of utilization of mental health personnel.

In addition to reports about the participation of mental health personnel in public health programs, reports concerning their participation in other-related, but non-direct mental health, programs are discussed in Chapter III. Relatively high participation is reported for the following programs:

State	Locality
Mental health in education Correctional and penal Rehabilitation Juvenile delinquency	Juvenile delinquency Mental health in education Family service Rehabilitation

At both the State and local levels, utilization is not frequently reported in the accident prevention, health and welfare councils, or public assistance programs.

There is more personnel integration at the State level than at the local level. There is also considerable variation among the States and localities in the degree to which personnel integration exists. The organizational arrangements have some effect upon the extent of integration between public health amd mental health personnel, but not upon the extent of participation of mental health personnel in other-related programs.

Among the States and among the localities, integration between public health and mental health personnel and programs tends to be greater where the mental health programs are not separately organized. As discussed in Chapter III, this does not seem to be merely a function of whether or not the mental and public health programs are administered together. There is most likely to be extensive use of public health personnel in mental health programs in States in which the mental health authority is located in an "other" department or agency or in which the mental health programs are somewhat dispersed. On the other hand, in the case of mental health personnel in public health programs, utilization tends to be lowest in such States. Perhaps mental health programs are somewhat more open to non-mental health personnel when they are not independently organized; but too great dispersion of mental health programs makes it difficult for mental health personnel to enter into public health programs.

Among the localities where a separately organized government agency has existed for a longer time, integration between mental health and public health personnel tends to be higher than where the agency has been recently established. No such relationship is found among the States.

In addition to the organizational arrangements, the respondents' preferences about the utilization of mental health personnel seem to affect the level of integration. Thus, each measure of utilization is positively related to each other measure, among localities and States. This is true despite the fact that all three measures are not similarly related to any single organizational arrangement or other State or local characteristics--except that medical school communities more than metropolitan communities, and they more than smaller communities, tend to have high personnel integration according to all three measures. This gives further support to the idea that the respondents' preferences are an important factor in affecting the degree of personnel integration since medical school-associated mental health personnel disproportionally tend to want increased utilization of mental health personnel in non-direct mental health programs.

The considerations affecting the respondents' preferences about personnel integration, then, are relevant to explaining the actual extent of integration. The analysis of preferences concerning integration has been focused upon preferences for <u>increased</u> utilization of mental health personnel outside of mental health programs. These preferences are inversely related to the actual levels due to the way the net preference scores are constructed; but the factors associated with the net preference scores suggest considerations which may spur the officials to bring about a higher level of utilization of mental health personnel in non-direct mental health programs in their States or localities.

As shown in Chapter VII, increased utilization of mental health personnel tends to be favored among local respondents who think an inadequate

tax base is an important barrier to the more effective use of mental health personnel. Respondents who consider the manpower shortage to be severe also tend to favor increased utilization of mental health personnel in non-direct mental health programs. But respondents who think lack of legislative or public support is an important barrier are slightly less likely to prefer increased utilization of mental health personnel. It is intriguing that respondents in non-urban States tend to think such lack of support is an important barrier; but we have also shown in Chapter I, that non-urban States tend not to have autonomous mental health programs and in such States integration between mental health and public health personnel tends to be high.

Of course, organizational arrangements have other consequences which in turn affect the respondents' preferences about participation of mental health personnel outside of direct mental health programs. Thus, the analysis presented in Chapter VI indicates that where the mental health programs are not autonomous there tends to be more awareness of differences in orientation between mental health and public health personnel and more awareness of other disadvantages in mental health personnel working outside of mental health programs; furthermore, awareness of such problems tends to make the officials slightly less likely to prefer increased utilization of mental health personnel. But we have seen in Chapter VII that, at least at the local level, if the mental health programs are separate, officials are more likely to think that differences in orientation and organizational problems are important barriers to the effective use of mental health personnel; however, such evaluations do not affect preferences for increased utilization of mental health personnel.

The existing organizational arrangements differentially affect the preferences of respondents with different responsibilities. Thus, at the State level, mental health respondents are most likely to want increased utilization of mental health personnel where the mental health programs are separate and autonomous; but public health respondents are most likely to favor increased utilization where the programs are a division of public health; neither is especially likely to favor increased utilization where the programs are somewhat dispersed (see Table 85 in Chapter V). This helps explain the finding noted earlier that mental health personnel are least likely to be extensively involved in public health programs in States in which the mental health programs are dispersed or in which the authority is located in an "other" department or agency. This indicates, too, some of the difficulties arising from the desire of each set of professions to control the form of cooperation between them.

A brief summary of the findings in regard to new developments in the use of mental health personnel in non-direct mental health programs is in order. The officials consider the new developments in the following programs to be particularly important: public health nursing, schools, maternal and child health, community development, alcoholism, hospitals, mental retardation, and research programs. When mental health programs are organized together with non-mental health programs, there seems to be some tendency for more new developments to be reported in the use of mental health personnel in those other programs.

The Respondents' Preferences

Organizational Arrangements

Although it is not usually the actual arrangement, the officials generally prefer that there be close relations between the mental institutions

and the public health departments and also that the institutional and community mental health programs be in the same department. Mental health respondents, particularly those in hospital-based programs, are especially likely to favor the unification of the two mental health programs (see Chapter II).

The respondents' program responsibilities markedly affect their preferences for an autonomous organization of mental health programs and their preferences about the location of the mental health authority. Mental health respondents want the mental health programs autonomously organized; public health officials do not. Mental health respondents tend to want the authority located in a mental health department; public health officials tend to favor a public health department.

The differences among the respondents seem to be largely due to their organizational and official role commitments and loyalties. This is modified somewhat by preferring the existing organizational arrangements in their States or localities. Since preferences concerning the aspects of organizational arrangements related to the autonomy of mental health programs are so closely associated with the respondents' official roles, external difficulties seem to intensify the divergencies rather than induce a common solution. Thus, at both the State and local level, public health respondents who consider the manpower shortage or inadequate tax base to be an important barrier are somewhat less likely than other public health respondents to favor an autonomous mental health organization; while among mental health respondents, the relationships tend to go in the opposite direction (see Chapter VII).

Difficulties which are more directly connected with the relations between mental health and public health officials, significantly, do

not have the same kind of divisive effect. Thus, there is a slight tendency for respondents who think organizational problems are very important barriers to be less likely to favor an autonomous mental health organization, holding constant current organizational arrangements. But awareness of disadvantages other than differences in orientation seems to influence the respondents generally to favor an autonomous mental health organization.

The preferences concerning an autonomous mental health organization, then, are not simply determined by the officials' own organizational role. This is further indicated by the finding reported in Chapter II, that respondents who favor having the community and institutional mental health programs in the same department also favor an autonomous mental health organization. This is true even holding the respondents' program responsibilities constant. Similarly, as shown in Chapter V, respondents who give low ranking to indirect service functions of mental health personnel also tend to favor an autonomous mental health organization--again, even holding the respondents' program responsibilities constant.

The organizational lines, apparently, are not as clearly drawn at the local as at the State level; the preferences are less likely to appear as entrenched positions. This is indicated by the fact that local respondents' preferences seem to be affected by considerations in addition to those summarized above. Thus, local respondents disproportionally favor an autonomous local mental health organization if they (1) are employed in smaller communities rather than metropolitan or medical school communities, (2) believe that the public health departments' mission is primarily preventive, (3) believe that lengthy training is necessary to help persons with emotional problems (this is also true among State mental health officials), and

(4) do not favor increased utilization of mental health personnel in public health programs.

Personnel Integration

The officials generally want members of the mental health professions to be utilized more than is currently the case in public health and other-related programs (see Chapter III). On the whole, the respondents are more likely to want increased utilization in the other-related than in the public health programs. Local respondents are more likely to want increased utilization than are State officials. Mental health respondents are somewhat more likely than public health officials to favor increased utilization.

The specific programs which the officials consider most in need of increased services of mental health personnel are: juvenile delinquency, aging, and maternal and child health. Mental health in education, school health, alcoholism, nursing, correctional and penal system, hospitals and medical facilities, family service, rehabilitation, and local health services are also frequently mentioned, in the order given. Generally, respondents consider those programs which currently have relatively high utilization to be most in need of increased services; presumably they think the current relative allocation is the strategic one.

The respondents ranked nine functions of mental health personnel--direct as well as indirect ones. There is marked divergence between mental health and public health officials in the ranking of several of these functions. For example, mental health education for the public is ranked high by public health respondents and low by respondents with mental health program responsibilities. Two functions, in-service training for staffs of other agencies and consultation with other public health or health-related

agencies, were combined to yield a score on ranking of indirect service functions. Public health respondents tend to rank indirect services high compared to mental health respondents, particularly those in State, hospital-based mental health programs.

The analysis of the preferences concerning personnel integration was focused upon wanting increased utilization of mental health personnel in public health and in other-related programs and upon ranking indirect functions. The ranking of indirect functions is one indication of preferences about what mental health personnel should do in those non-direct mental health programs. The two kinds of preferences are not positively associated with each other. Among State public health respondents, those who favor increased utilization of mental health personnel also tend to rank indirect functions high; but among local mental health respondents, the opposite is true: those who favor increased utilization tend to give low ranking to indirect service functions; there are no clear relationships among the other types of respondents.

The ranking of indirect service functions appears to be more significantly tied to the respondents' organizational and professional identification than are the preferences concerning increased utilization of mental health personnel. Both kinds of measures are related to the respondents' organizational and professional role and also to the respondents' consideration of various circumstances in their States or localities. But considerations of external circumstances seem to affect preferences about increased utilization of mental health personnel more than ranking of indirect functions; and considerations related to organizational and professional role seem to affect ranking of indirect functions more than preferences about increased utilization.

For example, respondents who consider the manpower shortage a very important barrier to the more effective use of mental health personnel tend to favor increased utilization of mental health personnel. In the case of ranking indirect functions, we find a relationship only among mental health respondents and the direction is different: if they consider this factor a very important barrier, they are less likely to give high ranking to indirect functions. Another example: State respondents who consider lack of public support an important barrier tend to favor increased utilization; but the pattern is different for ranking indirect services--public health officials who consider this factor an important barrier are more likely to give high ranking to indirect functions while mental health respondents are less likely to do so.

Consistent with this argument, there is a slight tendency among local respondents for those who consider an inadequate tax base an important barrier to be more likely than other local respondents to favor increased utilization of mental health personnel in public health programs; there is no relationship with ranking of indirect service functions. Respondents who mention problem-posing differences in orientation between mental health and public health personnel or other disadvantages to mental health personnel working outside their own programs tend not to favor increased utilization of mental health personnel; but there is no relationship in the case of ranking indirect service functions.

Furthermore, in States in which the institutional and community mental health programs are in the same department, respondents tend to favor increased utilization of mental health personnel. It is true, however, that State public health respondents in States in which the mental health programs are a division of public health are most likely to prefer

increased utilization of mental health personnel while mental health respondents in States in which the mental health programs are autonomous are most likely to favor increased utilization. In the case of ranking indirect service functions, we find that only among local public health officials is there a relationship with organizational arrangements: those in localities in which the mental health programs are not autonomous disproportionally tend to give high ranking to indirect service functions. Finally, among State mental health respondents those who have been in their present job for many years are more likely than those who have been in their job only a few years to favor increased utilization.

On the whole, it appears that increased utilization of mental health personnel is viewed pragmatically--in terms of the special circumstances in the officials' external setting. But the ranking of indirect service functions evokes professional and organizational identifications and concerns. There are two reasons why this may be so.

Members of the mental health professions are likely to feel that direct therapeutic services are their core professional functions--that is what they were trained for. Indirect functions are not central. Among the mental health respondents, psychiatrists are less likely than non-psychiatrists to give high ranking to indirect functions. Among all the respondents, those who believe that lengthy training is necessary to help persons with emotional problems are less likely to give high ranking to indirect service functions.

There is a second major reason why ranking of indirect service functions is tied to professional and organizational identifications. One of the defining characteristics of a profession is that professional colleagues may, but laymen may not, exercise control over professional activities.

Providing in-service training and even consultation, to some extent, does not assure the mental health professionals' control over their activities, at least not control over the way patients are treated. Concern about control may be an important ingredient in the officials' consideration of how to rank indirect service functions. Even holding program responsibilities constant, respondents who favor an autonomous organization of mental health programs are much less likely to give high ranking to indirect service functions than are those who are not favorable.

Problems and Barriers

Nearly all the officials are aware of problem-posing differences in orientation between mental health and public health personnel. Two specific differences are most frequently mentioned by the respondents: (1) public health personnel are community or group-oriented while mental health personnel are individual-oriented and (2) public health personnel are preventively-oriented while mental health personnel are therapeutically-oriented. Respondents with different program responsibilities tend to agree that these differences exist. Slightly more than half of the officials say that there are no other disadvantages to having mental health personnel working in health or health related programs. The most frequently cited disadvantages involve: (1) difficulties in dividing responsibilities and sharing the work and (2) difficulties in coordinating the programs and administering them properly.

There is widespread agreement among the key officials that the manpower shortage is a very important barrier to the more effective use of mental health personnel outside of direct mental health programs. An inadequate tax base is also generally considered a very important barrier.

Lack of political or public support, differences in orientation between mental health and public health personnel, and organizational problems are infrequently considered to be very important barriers.

Responsibilities of Government

The officials agree that public agencies have some responsibility for maintaining direct mental health programs, aside from programs for the institutionalized mentally ill. There is less agreement about the extent to which public agencies should provide therapeutic services. About three out of four officials think public agencies have some responsibility for such services and one out of four thinks extensive therapeutic services should be provided. The respondents' socio-political values rather than their program responsibilities seem to affect these opinions.

The respondents generally agree that responsibility for programming treatment of the mentally ill who are fully institutionalized should be the primary or exclusive responsibility of the State; in the case of the semi-institutionalized and particularly those treated in clinics, the officials believe localities should have at least equal responsibility. Respondents who favor more government action tend to favor State rather than local responsibility. These preferences probably are also affected by beliefs about the appropriate way of providing care.

Few officials believe the Federal government should have less leadership in the mental health field than it currently has. Almost one-half of the respondents think it should have the same amount and thirty-nine per cent think it should have more.

Some Closing Observations

The analysis has revealed problems as well as opportunities resulting from the convergence of mental health and public health activities. The activities are converging because of changes in the nature of public health and mental health programs as discussed in the Introduction, and because of the expansion of mental health programs. This expansion undoubtedly affects both public health and mental health officials' preferences about organizational and personnel integration between them.

The convergence provides many opportunities. The members of relevant professions can broaden their approaches and increase the range of techniques they use. Patients can receive more comprehensive and coordinated treatment.

The major difficulties in this convergence, key officials believe, are external to the relations between these professions--they involve manpower and financial shortages. But in this report attention has been directed particularly at problems associated with the relations between the professions. This has been done because the information collected in this survey is most pertinent to those problems and because such difficulties are more manipulatable--they are more directly under the control of the officials themselves.

The basic difficulty in the relations between the professions appears to involve authority: should the mental health programs be autonomous? Should priority be given to indirect service functions by mental health personnel? For reasons already frequently discussed, mental health and public health officials do not agree about the answers to these questions.

This basic difficulty is complicated by another factor which has not been explicitly discussed in the report: the mental institutions.

We have noted that the hospital-based State mental health officials are particularly likely not to give high ranking to indirect service functions and to favor an autonomous mental health organization. Their interests are somewhat different than those of the community-based State mental health officials.[2] Such divergences increase the difficulty of finding arrangements which maximally satisfy the members of all the professions at the same time. The mental institutions present another kind of difficulty. There is general support for the joint administration of the institutional and community mental health programs, even among public health officials; and public health officials tend to favor close organizational connections between public health and mental health programs; but the mental institutions are large agencies which at least some public officials see as difficult to assimilate within the traditional public health departments. Perhaps, as mental institutions become smaller and more closely associated with the communities, some of the divergent interests and contradictory preferences among and between mental health and public health officials will decrease and arrangements can be made which will be satisfactory to larger segments of all the relevant professions.

The already existing consensus among all the officials should not be minimized. They generally agree upon the need and propriety of government action in direct mental health programs, aside from care of the institutionalized mentally ill. They desire coordinated services by members of all the relevant professions. They even agree about which programs are

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[2]Perhaps if State public health officials in programs which rarely utilize mental health personnel or concepts were interviewed as well as those who are responsible for programs somewhat related to mental health activities, we would find marked divisions among public health officials. We might also find a greater divergence between public health and mental health officials than our present data indicate.

particularly in need of such increased cooperation. There is some common understanding of the differences among the professions and the consequent possibility of mutual growth and improved services through cooperation.

Given the preferences of the public health and mental health officials, the size of their programs, the differences in the nature of the programs, the trends of growth and change in the programs, and the political support each can raise, it is unlikely that either set of programs will generally be taken within the other's organizational realm. It is also unlikely that a fully integrated organizational arrangement will be established. For the foreseeable future, then, it is most likely that variations of the current arrangements will continue. There is also likely to be closer administrative liaison and more inter-penetration of personnel and practices in the day-to-day activities of both sets of programs.

MENTAL HEALTH AND PUBLIC HEALTH PERSONNEL AND PROGRAMS:

THEIR RELATIONS IN THE FIFTY STATES

A Report of a Survey of Key Public Health
and Mental Health Officials

VOLUME II

APPENDICES

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APPENDICES

APPENDIX A: METHODS USED IN OBTAINING INTERVIEW

APPENDIX B: BASIC MARGINALS

APPENDIX C: INTERVIEW SCHEDULE

APPENDIX A

METHODS USED IN OBTAINING INTERVIEWS

Selection of Respondents

Respondents for this study are key officials in public health and mental health programs at the State and local levels, from all fifty States and the District of Columbia. Respondents were selected by the Professional Services Branch, National Institutes of Mental Health, whose chief, Dr. Richard H. Williams, served as staff coordinator for the sponsoring Ad Hoc Committee on Mental Health Activities. The Branch was assisted in the selection by the Community Services Branch and the staffs of the Regional Offices of the Public Health Service.

Respondents were selected from the following public health positions in each State in which the positions were filled:

1. Heads, state public health programs;
2. Such other officials in State public health programs as heads of the divisions of hospital services and facilities, of local health services, and of public health nursing;
3. Head, State alcoholism programs.

State mental health personnel included:

1. Four categories of heads, State mental health programs:
   a. Community-based or oriented;
   b. Hospital-based or oriented;
   c. Combined community and hospital;
   d. Head of any other department or agency which has been designated the "State mental health authority";
2. Others responsible for particular aspects of State mental health programs, such as psychiatric and psychological consultants, social workers, chiefs of community mental health services, clinical directors, mental health nurses, superintendents of State hospitals, mental health education workers, and social scientists.

For local information, communities were selected which have both public health and mental health programs. Where possible, three types of communities were chosen in each State:

1. Communities containing a medical school;
2. Metropolitan centers with population over 75,000;
3. Smaller municipalities with population between 25,000 and 75,000.

All three of these categories were represented in twenty-five of the fifty States. Twenty-one of the remaining number included a combination of two of the community types. There were no local programs represented in four States. Local respondents consisted of:

1. Heads of local public health programs;
2. Heads of local mental health programs.

Development of Questionnaire

The questionnaire used in interviewing was drafted jointly by Dr. Williams and the staff of the National Opinion Research Center. Several professionals in the health fields were also consulted during its preparation. Prior to printing, the questionnaire was pre-tested in February and March by Dr. Williams in California, Hawaii, and Nebraska; by Miss Mary Belle Roberts, of the Community Services Branch of the Public Health Service, in St. Louis, Missouri, and Philadelphia, Pennsylvania; and by the NORC staff in the Chicago area.

The interview schedule was designed to facilitate speedy processing of data; hence, much of it was pre-coded. Nevertheless, many of the questions were "open-ended," permitting extended expression of the respondent's opinions and preferences, or factual information about distinct features of his program.

Administering the Questionnaire

Most of the interviewing in this study was done by NORC interviewers located throughout the country. In three States, Dr. Williams conducted all the interviews and in several other States additional interviews were conducted by Dr. Williams and Miss Roberts. Interviewing extended from February to June, 1961.

Assignments to the NORC field staff were made on April 10 and interviewing continued through June, although the greater part of it had been completed by the middle of May.

Procedures used by NORC in managing its part of the interviewing can be briefly summarized. On April 7, 1961, personal letters were sent to all respondents, describing the purpose of the study and soliciting their cooperation. Among the other materials transmitted in this mailing to respondents were a copy of a letter from the Surgeon General endorsing this study and a copy of the questionnaire to be used. Respondents who were to be interviewed by telephone also received a card addressed to the field representative assigned to conduct the interview; this card enabled the respondent to notify the interviewer of his preferences for interviewing dates and times.

The decision to employ telephone interviewing techniques in this study was made in consideration of both economy and efficiency. NORC's trained corps of interviewers has been developed to service the sample points ordinarily used in nationwide surveys. Because this study was concerned with a coverage of all States, with heavy concentration in State capitals, rather than a random cross-section of the population, the location of sample points was in many cases irrelevant to these needs. Use of the long-distance telephone thus eliminated the necessity to recruit and

train new interviewers and to allow for long travel distances and special living arrangements for the duration of the study.

Of the 740 completed interviews, 247, or nearly thirty-four per cent of the cases, were face-to-face interviews. Four hundred ninety-one, or sixty-six per cent, were accomplished by long-distance telephone. Two questionnaires were self-administered.

The estimated average length of time for a telephone interview was one hour and fifteen minutes, whereas the average length of face-to-face interviews was about two hours. Each respondent was urged to review the thirty-three-page questionnaire in advance of the interview and to retain his copy for the interview. Ninety-seven per cent of the respondents did have copies before them during the interview.

Approximately 750 positions in the public health and mental health services were originally chosen to provide respondents for this study. As field work proceeded, it was found necessary to drop some from consideration, while others were added. For example, nineteen of the offices initially assigned to NORC interviewers proved to be vacant, or there was no program in operation. On the other hand, additions included certain deputies or assistants who reported for their absent chiefs.

From the final list of respondents, seventy-six interviews were completed by Dr. Williams and Miss Roberts. The remaining 696 respondents were assigned to the NORC staff, and 664, or 95.4 per cent, of these were completed. Fourteen would not consent to be interviewed, and eighteen were unavailable. The disposition of cases for which NORC had responsibility can be seen in Table A-1.

Five of the fourteen refusals were by respondents who had been instructed by their supervisors not to participate in the study. These included one mental health and four public health officials. Nine other

individuals declined to be interviewed: four of these were heads of State public health departments, one was the head of a State mental health program, one was administrator of hospitals, two were heads of local public health departments, and one was the head of a local mental health program. Various reasons were given for these refusals, such as inability to spare the time or doubts about the value of such studies. Two felt they had not been approached with the proper degree of "protocol."

TABLE A-1

COMPLETION RATE FOR RESPONDENTS ASSIGNED TO NORC STAFF

Result	Number	Per cent
Interviews completed . .	664	95.4
Refusals . . .	14	2.0
Unavailable . .	18	2.6
Total .	696	100.0

Although the interviewing continued for a span of several weeks, there were some respondents who were unavailable during the entire period. Illness and traveling were the commonest explanations. Four of the eighteen persons who were not available were heads of State public health departments, but substitute interviews were obtained from their assistants or deputies. Their responses are included in the tabulations.

The remaining fourteen officials who could not be reached for interviewing included one head of a community-based State mental health program, one head of a combined community and hospital-based State mental health program, two directors of hospital services, one director of local health

services, and one director of nursing. Also unavailable were a chief of the youth rehabilitation section in a community-based State mental health program, and one chief social worker, one superintendent of a State hospital, and one clinical psychologist, all working in hospital-based State mental health programs. Two of the local officials not available during the interviewing period were heads of public health departments, and two were heads of mental health programs at the community level.

On the whole, the respondents expressed great interest in the study and enthusiasm about the way it was conducted. Receiving a copy of the questionnaire in advance of the interview permitted the respondents to look through it and reflect on their answers. Eighty-seven per cent of the respondents reported that they did look through the questionnaire before the interview, and thirty-nine per cent of them discussed at least some of the questions with one or more colleagues. The interviewers were instructed to note any comments by the respondents about the questionnaire and to ask informally whether or not they felt there was an adequate coverage of the issues in the study and whether or not there was any bias in the way the questions were formulated. We have information about such reactions from two-thirds of the respondents. Among those reporting such reactions, eighty-five per cent said they thought the coverage was adequate and eighty-four per cent said they could not see any bias. The specific references to points not adequately covered were extremely varied, ranging from the need for more about the relationship between mental health and other programs aside from public health ones, to needing more about what public health personnel are doing in their own programs. Obviously, many of the points mentioned were omitted because they lacked direct pertinence or because of limitations of time. The references to bias were usually vague statements

such as, "They wouldn't put out a questionnaire like this if they didn't have something to prove." There was about an equal number of respondents (a dozen) who said they felt the questions were biased in favor of a separate department of public health as there was of those who said they felt it was biased in favor of an integrated public health and mental health department. Many comments expressed great satisfaction with the questionnaire and the study. For example, "This questionnaire made me think--I had to decide how I really felt about these matters," or "I am very pleased with this as the material is so vital and I feel something like this should have been done long ago."

APPENDIX B

BASIC MARGINALS

In this appendix we are presenting the distribution of answers to most of the questions in the interview schedule. Responses to some questions have not been included because they refer to different States or localities and cannot be added together since several persons are reporting about the same State or locality. The answers to these questions were combined to provide descriptions of each State and locality; these summaries are discussed in the text of the report. Other questions are not included because the answers depend upon answers to previous questions, and therefore the responses to such questions are presented in the text.

The distributions of the responses are presented for eight categories of respondents: State heads of public health programs, other State public health officials, heads of State alcoholism programs, local public health officials, heads of State mental health programs, other State mental health officials in community programs, other State mental health officials in hospital programs, and local mental health officials. We are not presenting the distribution of responses for all the respondents together because that would be misleading. It would be misleading because the respondents do not constitute a sample of any universe, nor are they a clearly definable universe of "key officials in public health and mental health." Rather, we have sought to obtain a census of persons in specific key positions. If other positions were included--for example, State heads of environmental sanitation programs, or if we included more localities or more kinds of

persons from local programs, the summary results might be different from the summary of results for the respondents whom we did interview in this study. It is important to remember that the results are for the persons who were interviewed. A detailed listing of the positions of all the respondents is presented in Table B-1.

The question upon which each table is based is indicated in the upper left hand corner of the page; the question number refers to the question in the interview schedule which is in Appendix C.

TABLE B-1

OFFICIAL POSITIONS OF RESPONDENTS

Title	Number		
Total number	740		
Public Health, State		173	
Head, State public health program			43
Other public health official			130
Head, or deputy, State local health or community health services			27
Head, or deputy, State hospitals programs, planning, services			34
Head, or deputy, State public health nursing			51
Head, or deputy, child services			2
Head, or deputy, other State public health program.			12
Deputy head of State public health program			4
Public Health, Local		120	
Head, city or county public health department			97
Head, public health district or region			13
Head, city or county public health and welfare programs			2
Other local public health official			8
Alcoholism, State		34	
Mental Health, State		293	
Head, State mental health program			74
Head, State mental health program, community-based or oriented			26
Head, State mental health program, hospital-based or oriented			21
Head, State mental health program, combined community and hospital			21
Head, other State department designated as "Mental Health Authority"			6
Other mental health official, community-based or oriented			129
Head, or deputy, local or community mental health services			16
Head, deputy, or consultant, psychiatrists, psychiatric services			5
Head, deputy, or consultant, psychologists, psychological services			18

TABLE B-1--Continued

Title	Number	
Head, deputy, or consultant, psychiatric social worker, social work services		20
Head, deputy, or consultant, psychiatric, mental health nurses or nursing services		24
Head, deputy, or consultant, planning, research, evaluation		3
Head, deputy, or consultant, mental health education		6
Head, deputy, or consultant, other mental health programs (e.g., youth rehabilitation, school mental health program)		8
Head, director of mental health clinic or center		4
Deputy administrator		11
Other State mental health official in community-based program		14
Other mental health official, hospital-based or combined hospital and community programs	90	
Head, deputy, or consultant, hospital social services, social workers		26
Head, deputy, or consultant, nurses, nursing services		14
Head, deputy, or consultant, psychologists, psychological services		22
Head, deputy, or consultant, psychiatrists, psychiatric services		5
Superintendent of mental hospital		10
Deputy of general mental health program--general administration		2
Other program responsibility in mental health, hospital-based programs		11
Mental Health, Local	120	
Head, community mental health department, bureau, or division		13
Head, community mental health, hygiene, guidance, or psychiatric center		30
Head, community mental health, hygiene, guidance, psychiatric, or out-patient clinic		24
Head, community adult or child guidance, psychiatric or mental health clinic		30
Head, university department of psychiatry		8
Head, university mental health, psychiatric clinic		6
Head, university child, adult psychiatric clinic		3
Other local mental health official		6

TABLE B-2

PROBLEMS IN PROVIDING SERVICES, BY TYPE OF RESPONDENT, IN PERCENTAGES

Problems	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
None, no problems	-	1	1	-	-	1	-	2
Salary scale inadequate; not competitive; maximum salaries too low[a]	28	13	22	21	27	14	31	15
Insufficient funds to hire needed staff[a] . .	14	11	13	12	11	5	14	18
Shortage of trained personnel to be recruited.	51	35	32	33	59	31	46	23
Other handicaps in recruiting needed staff .	7	8	9	9	8	6	18	11
Lack of adequate staff[b] .	26	34	36	24	24	39	24	42
Insufficient funds for necessary physical facilities	2	2	2	-	3	2	3	2
Lack of funds (general); lack of support from legislature	74	55	60	64	70	40	34	46
Inadequate physical facilities	19	9	18	18	14	4	8	23
Lack of understanding and support from public, non-governmental groups	40	14	29	61	23	25	14	23
Inadequate organization community groups, resources; inadequate community resources . . .	2	5	9	9	7	12	4	11
Public or organized group pressure for additional services	-	5	4	-	-	3	-	7
Inadequate coordination among agencies	7	13	9	3	8	10	4	6
Other agencies do not cooperate sufficiently; do not understand our work	5	5	4	15	6	8	1	7
Lack of cooperation, mutual understanding between professions . .	-	9	3	6	10	7	10	7

[a] Not coded with each other.

[b] Not coded with the preceding four codes.

TABLE B-2--Continued

Problems	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Superordinate officials administer poorly . . .	-	2	2	-	1	9	6	3
Other inter-personal difficulties among staff .	-	5	2	3	4	4	6	3
Difficulty in conducting certain professional activities within agency having given functions	-	1	-	-	4	3	3	3
Lines of authority are not clear; lack clear authority for activities	5	2	2	-	7	3	3	3
Other organizational difficulties	7	5	1	-	6	8	6	2
Gaps in service; absence of needed programs . .	7	5	8	12	8	8	8	6
Lack of information about availability of services	-	2	3	-	1	3	-	3
Difficulties during period of change in programs; lack of planning new programs	5	8	3	-	4	6	2	1
Legislative limitations concerning programs . .	5	3	2	-	3	2	1	4
Population and services distributed unequally; population too widely distributed	9	5	1	3	8	10	2	3
Problems with particular segments of the population	2	4	4	-	-	2	-	-
Personal inadequacies of training, experience .	-	1	-	-	-	2	6	-
Inherent difficulties of task	2	9	9	15	13	10	8	6
Other	2	3	8	6	1	5	7	2
Vague, indeterminate . .	-	1	-	-	-	-	-	-
Total per cent . . .	319	275	296	314	330	282	269	283
Base for percentages	(43)	(128)	(119)	(33)	(71)	(129)	(90)	(120)
No answer	(-)	(2)	(1)	(1)	(3)	(-)	(-)	(-)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-3

NUMBER OF PERSONS UNDER RESPONDENT'S DIRECTION, BY TYPE OF RESPONDENT, IN PERCENTAGES

Number of Persons	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Less than 30 . . .	2	67	32	70	33	73	54	82
30 - 59 . .	-	8	21	18	3	9	9	6
60 - 99 . .	2	7	17	9	3	5	1	4
100 - 199 . .	19	5	11	3	7	7	9	3
200 - 299 . .	12	3	4	-	1	2	4	1
300 - 499 . .	21	4	8	-	3	1	1	3
500 - 699 . .	7	1	2	-	3	-	4	-
700 - 899 . .	7	2	1	-	1	-	-	-
900 - 1,999	23	2	2	-	7	-	8	1
2,000 - 5,999	7	1	2	-	24	1	7	-
6,000 - 9,999	-	-	-	-	4	-	1	-
10,000 or more . .	-	-	-	-	11	2	1	-
Total per cent	100	100	100	100	100	100	99[a]	100
Base for percentages . .	(43)	(129)	(120)	(34)	(73)	(125)	(89)	(120)
No answer . .	(-)	(1)	(-)	(-)	(1)	(4)	(1)	(-)
Total number .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Does not equal 100 per cent due to rounding of figures.

TABLE B-4

TOTAL DEPARTMENTAL BUDGETS FOR CURRENT FISCAL YEAR, REPORTED BY HEADS, IN PERCENTAGES

Budget	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Less than $50,000 . . .	-		4		3			29
$ 50,000-$ 99,999	-		13		10			32
$ 100,000-$ 199,999	-		20		8			19
$ 200,000-$ 499,999	-		27		7			6
$ 500,000-$ 999,999	4		14		5			3
$ 1,000,000-$ 1,499,999	13		6		3			3
$ 1,500,000-$ 1,999,999	8		6		3			3
$ 2,000,000-$ 2,999,999	10		1		3			2
$ 3,000,000-$ 9,999,999	38		8		14			2
$10,000,000-$39,999,999	21		1		24			1
$40,000,000-$69,999,999	4		-		5			-
$70,000,000 or more . .	2		-		15			-
Total per cent	100		100		100			100
Base for percentages . .	(48)[a]		(113)		(72)[b]			(111)
No information	(-)		(7)		(4)			(9)
Total number .	(48)		(120)		(76)			(120)

[a] Includes five public health officials who are not Heads, but who reported for their departments in the absence of the Heads.

[b] Includes two mental health officials who are not Heads, but who reported for their departments in the absence of the Heads.

TABLE B-5

OFFICIALS TO WHOM RESPONDENTS ARE DIRECTLY RESPONSIBLE, BY TYPE OF RESPONDENT, IN PERCENTAGES

Officials to whom responsible	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Electorate	-	-	-	-	-	-	-	1
Governor	47	-	-	3	25	-	1	-
Special State Board or Commission	51	-	1	32	23	1	7	2
Head, State Department of Public Health	2	64	15	21	22	5	1	-
Head, State Department of Mental Health or Hygiene	-	-	-	6	3	35	29	5
Head, State Department of Institutions and Agencies	-	-	-	-	3	-	4	-
Head, State Department of Corrections and Institutions	-	-	-	-	-	-	1	-
Head, State Department of Welfare	-	-	-	3	5	1	-	1
Head, State Department of Health and Welfare	2	2	2	3	4	1	-	-
Head, State Local Health Services	-	11	9	-	1	1	-	3
Head, State Hospitals or Clinics.	-	-	-	3	1	4	17	-
Other State official	-	22	1	29	12	51	40	13
Mayor	-	-	9	-	-	-	-	-
City Manager	-	-	9	-	-	-	-	-
City or County legislative body	-	-	11	-	-	-	-	1
Special City or County Board or Commission	-	-	25	-	-	-	-	3
City or County Department of Public Health	-	-	16	-	-	2	-	5
City or County Department of Mental Health or Hygiene	-	-	-	-	-	1	-	2
City or County Department of Welfare	-	-	-	-	-	-	-	-
City or County Department of Health and Welfare	-	-	2	-	-	-	-	1
Other local official	-	1	13	-	-	1	-	18
Private Board of Directors	-	-	-	-	-	1	-	32
Dean of Medical School	-	-	-	-	1	-	-	9
Other non-governmental official	-	1	1	-	-	-	-	13
Total per cent (some report being directly responsible to more than one office)	102	101	114	100	100	104	100	109
Base for percentages	(43)	(130)	(119)	(34)	(73)	(129)	(90)	(116)
No answer	(-)	(-)	(1)	(-)	(1)	(-)	(-)	(4)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-6

REPORTS OF INTERACTION WITH MENTAL HEALTH PERSONNEL, BY TYPE OF PUBLIC HEALTH RESPONDENT, IN PERCENTAGES

Interact with Mental Health Personnel	Public Health			Alcoholism	Mental Health[a]			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Yes	98	91	86	100	100	100		
No.	2	9	14	-	-	-		
Total per cent. . . .	100	100	100	100	100	100		
Base for percentages .	(43)	(130)	(118)	(28)	(5)	(13)		
No answer . .	(-)	(-)	(2)	(6)	(1)	(-)		
Inapplicable	(-)	(-)	(-)	(-)	(68)	(116)	(90)	(120)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Inapplicable to mental health respondents, except that Heads of "Other departments designated as the mental health authority" were asked about their interaction with mental health personnel, and mental health nursing consultants were asked about their interaction with both public health and mental health personnel because of their dual function as public health and mental health people. See Table B-7 for responses of mental health officials.

TABLE B-7

REPORTS OF INTERACTION WITH PUBLIC HEALTH PERSONNEL, BY TYPE OF MENTAL HEALTH RESPONDENT, IN PERCENTAGES

Interact with Public Health Personnel	Public Health[a]			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Yes					94	90	80	87
No					6	10	20	13
Total per cent. . . .					100	100	100	100
Base for percentages. .					(67)	(127)	(90)	(119)
No answer . .					(1)	(2)	(-)	(1)
Inapplicable	(43)	(130)	(120)	(34)	(6)[b]	(-)	(-)	(-)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Inapplicable; question asked of mental health personnel only. See Table B-6 for responses of public health officials.

[b]Heads of "Other departments designated as the mental health authority" were asked about their interaction with mental health personnel (see Table B-6).

TABLE B-8

MENTAL HEALTH PERSONS WITH WHOM PUBLIC HEALTH RESPONDENTS INTERACT, BY TYPE OF RESPONDENT REPORTING ANY INTERACTION, IN PERCENTAGES

Mental Health Persons with Whom Respondents Interact	Public Health			Alcoholism	Mental Health[a]			
	State		Local	State	State			Local
	Head	Other			Head[a]	Other Commun.[a]	Other Hosp.	
Head, director, commissioner of mental health	43	35	16	21	20	33		
Head, director, superintendent of mental hospital(s)	14	13	9	7	20	11		
Director, head of psychiatric or child guidance clinic or center	14	11	24	11	20	-		
Other administrator of mental health agencies; boards	31	33	14	29	-	33		
Psychiatrists	24	23	48	36	40	33		
Psychologists, clinical psychologists	26	22	39	32	20	33		
Psychiatric social worker, social workers	17	24	40	61	20	55		
Mental health nurses, psychiatric nurses, nurses	14	32	16	7	20	44		
Mental health educators	-	2	6	21	-	-		
Social scientists	2	1	-	11	-	11		
Other mental health professional personnel	2	8	8	7	-	-		
Vague, indeterminate	12	6	5	7	40	11		
Total per cent (some mention more than one kind of person)	199	210	225	250	200	264		
Base for percentages	(42)	(116)	(102)	(28)	(5)	(9)		
Inapplicable and no information	(1)	(14)	(18)	(6)	(69)	(120)	(90)	(120)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]This question inapplicable to mental health respondents, except that Heads of "Other departments designated as the Mental Health Authority" were asked about their interaction with mental health personnel, and Mental Health Nursing Consultants were asked about their interaction with both public health and mental health personnel, because of their dual function as public health and mental health people. See Table B-9 for responses of mental health officials.

TABLE B-9

PUBLIC HEALTH PERSONS WITH WHOM MENTAL HEALTH RESPONDENTS INTERACT, BY TYPE OF RESPONDENT REPORTING ANY INTERACTION, IN PERCENTAGES

Public Health Persons with Whom Respondents Interact	Public Health[a]			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Head, deputy, of public health. .					62	32	19	42
Other health officer.					24	27	17	28
Head, deputy, public health nurse					13	24	15	8
Public health nurse					44	62	50	61
Health educators.					19	25	6	5
Bio-statisticians, Researchers. .					8	4	-	2
Sanitarians					14	6	1	22
Head, superintendent of hospitals					11	4	6	1
Public health, medical social workers					5	12	11	12
Heads, other public health programs					19	11	11	6
Other public health professionals					11	17	19	7
Communicable diseases					14	9	13	2
Chronic diseases, aging					3	3	1	2
Dental health					8	4	-	1
Maternal and child health, family service					17	15	4	15
Hospitals and medical facilities, nursing homes					19	6	11	7
Rehabilitation					3	6	-	7
Alcoholism					3	4	6	2
School health					5	6	1	6
Crippled children, handicapped children					6	10	4	6
Local health services, community programs					16	27	13	27
Other public health programs. . .					17	13	11	6
Vague, general, indeterminate . .					8	6	11	3
Total per cent (some mention more than one kind of person)					349	333	230	258
Base for percentages . . .					(63)	(113)	(72)	(101)
Inapplicable and no information	(43)	(130)	(120)	(34)	(11)	(16)	(18)	(19)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Inapplicable. See Table B-8 for responses of public health officials.

TABLE B-10

PURPOSE OF INTERACTION BETWEEN PUBLIC HEALTH AND MENTAL HEALTH PERSONNEL, BY TYPE OF PUBLIC HEALTH RESPONDENT REPORTING ANY INTERACTION, IN PERCENTAGES

Purpose	Public Health			Alcoholism	Mental Health[a]			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Consultation concerning program planning, development	40	40	24	29	40	22		
Coordination of programs, procedures	17	22	13	25	20	11		
Coordination of treatment or provision of services	17	16	25	29	-	22		
Case consultation	7	9	20	11	-	33		
Referral of cases	10	8	31	18	-	-		
Consultation about training programs, arranging joint institutes	5	11	4	4	-	-		
In-service training, educational guidance	5	21	19	36	-	66		
Planning, participation in research	-	3	3	18	-	-		
Discussion of budgetary matters	10	3	5	-	40	-		
Regular administrative liaison, reporting and supervision	43	20	23	14	40	-		
Other specific purposes of interaction	5	5	5	-	-	-		
Vague, general	14	3	7	4	-	11		
Total per cent (some give more than one purpose)	173	161	179	188	140	165		
Base for percentages	(42)	(116)	(102)	(28)	(5)	(9)		
Inapplicable and no answer	(1)	(14)	(18)	(6)	(69)	(120)	(90)	(120)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Inapplicable to mental health respondents, except that Heads of "Other departments designated as the Mental Health Authority" were asked about their interaction with mental health personnel, and Mental Health Nursing Consultants were asked about their interaction with both public health and mental health personnel, because of their dual function as public health and mental health people. See Table B-11 for responses of mental health officials.

TABLE B-11

PURPOSE OF INTERACTION BETWEEN MENTAL HEALTH AND PUBLIC HEALTH PERSONNEL, BY TYPE OF MENTAL HEALTH RESPONDENT REPORTING ANY INTERACTION, IN PERCENTAGES

Purpose	Public Health[a]			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Consultation concerning program planning, development					44	49	26	27
Coordination of programs, procedures					29	23	15	13
Coordination of treatment or provision of services, following patients					30	28	33	26
Case consultation					6	19	10	36
Referral of cases					8	5	10	31
Consultation about training programs, arranging joint institutes					10	15	7	3
In-service training, educational guidance					24	33	28	23
Planning, participation in research					6	5	10	2
Discussion of budgetary matters					13	4	6	7
Regular administrative liaison, reporting and supervision					17	9	10	12
Other specific purposes of interaction					6	4	8	3
Vague, general					8	3	11	7
Total per cent (some give more than one purpose).					201	197	174	190
Base for percentages					(63)	(113)	(72)	(101)
Inapplicable and no information	(43)	(130)	(120)	(34)	(11)[b]	(16)	(18)	(19)
Total number.	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Inapplicable; question asked of mental health personnel only. See Table B-10 for responses of public health officials.

[b]Six Heads of "Other departments designated as the Mental Health Authority" were asked about their interaction with mental health personnel (see Table B-10).

TABLE B-12

PREFERRED EXTENT TO WHICH MENTAL HEALTH PERSONNEL SHOULD BE USED IN NON-DIRECT MENTAL HEALTH PROGRAMS, BY TYPE OF RESPONDENT, IN PERCENTAGES

a. Communicable Diseases

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	16	7	9	6	12	5	10	5
Part-time person(s) employed . .	7	11	12	15	12	8	3	6
Frequent consultation (at least once a week)	12	5	19	12	19	18	13	9
Occasional consultation.	40	38	43	24	37	43	38	28
In-service training.	16	19	19	12	25	27	9	11
No utilization	26	20	27	18	19	21	15	40
Don't know	7	21	1	33	13	10	21	15
No program at respondent's level	-	-	-	-	-	-	-	-
Total per cent (some choose more than one category)	124	121	130	120	137	132	109	114
Base for percentages . . .	(43)	(122)	(113)	(33)	(68)	(124)	(87)	(113)
No answer	(-)	(8)	(7)	(1)	(6)	(5)	(3)	(7)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

b. Chronic Diseases

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	33	21	20	36	37	13	24	23
Part-time person(s) employed . .	21	21	17	12	20	14	8	15
Frequent consultation (at least once a week)	40	24	32	18	44	33	30	28
Occasional consultation.	24	29	31	12	21	45	29	27
In-service training.	38	29	21	15	35	36	17	13
No utilization	2	3	3	9	4	6	12	8
Don't know	-	7	2	24	6	2	6	9
No program at respondent's level	-	-	4	-	-	-	-	3
Total per cent (some choose more than one category).	158	134	130	126	167	149	126	126
Base for percentages . . .	(42)	(126)	(116)	(33)	(71)	(126)	(90)	(119)
No answer	(1)	(4)	(4)	(1)	(3)	(3)	(-)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

c. Aging

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	33	28	23	42	58	36	53	35
Part-time person(s) employed . .	24	21	20	18	28	21	11	21
Frequent consultation (at least once a week)	48	26	36	21	39	30	29	28
Occasional consultation.	10	24	27	15	13	27	13	21
In-service training	38	29	23	15	30	34	15	12
No utilization	5	1	3	3	-	1	1	5
Don't know	-	7	-	18	3	1	6	5
No program at respondent's level	-	-	5	-	-	-	-	3
Total per cent (some choose more than one category).	158	136	137	132	171	150	128	130
Base for percentages . . .	(42)	(127)	(116)	(33)	(71)	(128)	(89)	(120)
No answer	(1)	(3)	(4)	(1)	(3)	(1)	(1)	(-)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

d. Dental Health

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	8	2	3	-	17	3	9	2
Part-time person(s) employed . .	5	5	6	9	9	2	2	6
Frequent consultation (at least once a week)	-	2	3	6	9	3	1	1
Occasional consultation	42	21	30	16	38	44	34	17
In-service training	12	12	11	6	18	19	9	7
No utilization	35	31	41	25	24	29	24	45
Don't know	12	31	5	44	14	16	24	20
No program at respondent's level	-	-	8	-	-	-	-	10
Total per cent (some choose more than one category)	114	104	107	106	129	116	103	108
Base for percentages . . .	(40)	(121)	(115)	(32)	(66)	(117)	(82)	(116)
No answer.	(3)	(9)	(5)	(2)	(8)	(12)	(8)	(4)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

e. Maternal and Child Health

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	48	22	28	44	48	41	33	37
Part-time person(s) employed . .	29	22	17	9	32	16	13	23
Frequent consultation (at least once a week)	40	37	34	29	37	37	22	27
Occasional consultation	10	16	29	12	11	19	25	13
In-service training	29	22	28	9	30	32	13	23
No utilization	2	2	4	3	4	2	7	6
Don't know	-	12	3	18	6	3	6	4
No program at respondent's level	-	-	3	-	-	-	-	3
Total per cent (some choose more than one category)	158	133	146	124	168	150	119	136
Base for percentages . . .	(42)	(125)	(116)	(34)	(71)	(129)	(87)	(119)
No answer	(1)	(5)	(4)	(-)	(3)	(-)	(3)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

f. Nursing

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun	Other Hosp.	
Full-time person(s) employed . .	55	38	42	47	72	48	54	35
Part-time person(s) employed . .	14	17	16	6	19	11	12	18
Frequent consultation (at least once a week)	36	35	36	18	33	43	29	35
Occasional consultation	14	14	13	6	8	12	9	8
In-service training	33	31	33	15	44	36	21	25
No utilization	2	2	6	6	-	3	2	4
Don't know	-	8	3	21	1	-	3	5
No program at respondent's level	-	-	1	-	-	-	-	3
Total per cent (some choose more than one category)	154	145	150	119	177	153	130	133
Base for percentages . . .	(42)	(127)	(116)	(34)	(72)	(128)	(89)	(119)
No answer	(1)	(3)	(4)	(-)	(2)	(1)	(1)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

g. Environmental Sanitation

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	2	2	5	6	8	2	9	2
Part-time person(s) employed . .	7	7	11	6	5	7	3	4
Frequent consultation (at least once a week)	-	1	9	9	9	4	7	5
Occasional consultation.	29	22	29	9	32	36	27	22
In-service training	10	13	24	3	17	22	6	6
No utilization	44	28	37	26	24	26	19	45
Don't know	15	33	4	47	21	23	33	22
No program at respondent's level	-	-	-	-	-	-	-	-
Total per cent (some choose more than one category)	107	106	119	106	116	120	104	106
Base for percentages . . .	(41)	(120)	(110)	(34)	(66)	(123)	(86)	(106)
No answer	(2)	(10)	(10)	(-)	(8)	(6)	(4)	(14)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

h. Occupational Health

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	7	5	9	18	14	13	13	15
Part-time person(s) employed . .	12	11	12	15	10	15	11	11
Frequent consultation (at least (once a week)	12	9	14	18	24	19	19	15
Occasional consultation	38	30	34	15	35	39	28	29
In-service training	24	15	16	3	21	24	8	8
No utilization	21	9	20	12	8	10	10	18
Don't know	10	24	4	26	11	6	17	11
No program at respondent's level	2	9	12	3	7	4	4	9
Total per cent (some choose more than one category)	126	112	121	110	130	130	110	116
Base for percentages . . .	(42)	(127)	(115)	(34)	(72)	(127)	(90)	(117)
No answer	(1)	(3)	(5)	(-)	(2)	(2)	(-)	(3)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

i. Health Education

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	31	17	29	53	54	38	42	36
Part-time person(s) employed . .	17	13	19	12	19	17	15	22
Frequent consultation (at least once a week)	38	32	28	21	35	27	27	23
Occasional consultation	19	27	22	9	11	27	18	19
In-service training	26	17	30	6	22	23	10	15
No utilization	2	4	5	-	1	3	4	4
Don't know	-	11	2	18	3	2	4	7
No program at respondent's level	-	-	2	-	-	-	-	3
Total per cent (some choose more than one category)	133	121	137	119	145	137	120	129
Base for percentages . . .	(42)	(126)	(116)	(34)	(72)	(128)	(89)	(119)
No answer	(1)	(4)	(4)	(-)	(2)	(1)	(1)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

j. Hospitals and Medical Facilities

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	25	15	25	59	62	43	62	53
Part-time person(s) employed . .	25	23	15	6	18	11	4	12
Frequent consultation (at least once a week)	22	18	20	26	31	36	21	25
Occasional consultation	35	24	18	6	18	23	14	12
In-service training	18	14	16	6	25	30	13	15
No utilization	5	9	13	-	-	4	2	5
Don't know	2	14	6	18	4	2	6	7
No program at respondent's level	-	-	11	-	-	-	-	-
Total per cent (some choose more than one category)	132	117	124	121	158	149	122	129
Base for percentages . . .	(40)	(125)	(116)	(34)	(71)	(128)	(90)	(118)
No answer	(3)	(5)	(4)	(-)	(3)	(1)	(-)	(2)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

k. Vital Statistics and Research

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	18	11	13	44	41	33	38	31
Part-time person(s) employed . .	12	10	13	-	17	18	9	16
Frequent consultation (at least once a week)	15	7	14	18	21	14	12	15
Occasional consultation	48	23	25	12	27	30	20	16
In-service training	2	6	6	-	21	12	7	7
No utilization	15	18	33	15	1	6	10	17
Don't know	5	33	10	21	9	11	15	14
No program at respondent's level	-	-	-	-	-	-	-	-
Total per cent (some choose more than one category)	115	108	114	110	137	124	111	116
Base for percentages . . .	(40)	(125)	(104)	(34)	(70)	(125)	(89)	(119)
No answer.	(3)	(5)	(16)	(-)	(4)	(4)	(1)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

1. Rehabilitation

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	33	29	22	56	68	53	64	45
Part-time person(s) employed . .	17	18	27	21	21	18	15	13
Frequent consultation (at least once a week)	31	35	27	24	43	34	20	37
Occasional consultation	22	15	25	9	7	14	12	11
In-service training	25	21	15	6	29	30	10	15
No utilization	14	-	4	-	-	1	-	5
Don't know	3	8	4	15	3	-	2	4
No program at respondent's level	-	-	7	-	-	-	-	-
Total per cent (some choose more than one category)	145	126	131	131	171	150	123	130
Base for percentages . . .	(36)	(124)	(116)	(34)	(72)	(128)	(89)	(119)
No answer.	(7)	(6)	(4)	(-)	(2)	(1)	(1)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

m. Accident Prevention

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	19	7	7	26	21	13	14	7
Part-time person(s) employed . .	12	14	12	6	11	16	13	12
Frequent consultation (at least once a week)	21	21	24	18	21	19	18	8
Occasional consultation	38	31	32	18	35	45	28	32
In-service training	17	18	18	6	19	20	10	8
No utilization	12	3	12	15	8	8	8	18
Don't know	-	19	10	26	13	4	17	17
No program at respondent's level	5	4	6	-	4	2	2	9
Total per cent (some choose more than one category)	124	117	121	115	132	127	110	111
Base for percentages . . .	(42)	(127)	(114)	(34)	(72)	(128)	(90)	(119)
No answer	(1)	(3)	(6)	(-)	(2)	(1)	(-)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

n. Juvenile Delinquency

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	44	37	46	71	71	67	70	74
Part-time person(s) employed . .	12	17	21	9	19	9	7	13
Frequent consultation (at least once a week)	21	24	30	18	32	32	20	33
Occasional consultation	15	7	13	9	14	8	10	4
In-service training	12	13	18	6	25	24	8	21
No utilization	15	2	3	-	-	2	-	1
Don't know	6	14	2	15	1	1	4	2
No program at respondent's level	3	6	6	-	1	2	-	-
Total per cent (some choose more than one category)	128	120	139	128	163	145	119	148
Base for percentages . . .	(34)	(127)	(116)	(34)	(72)	(129)	(90)	(120)
No answer	(9)	(3)	(4)	(-)	(2)	(-)	(-)	(-)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

o. Drug Addiction

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	24	34	28	62	53	46	61	37
Part-time person(s) employed . .	11	16	16	9	24	17	7	13
Frequent consultation (at least once a week)	13	14	19	15	21	19	14	16
Occasional consultation.	18	12	20	6	26	18	17	22
In-service training	11	14	12	6	22	21	6	11
No utilization	18	2	9	3	4	5	2	11
Don't know	13	15	8	15	3	2	4	11
No program at respondent's level	11	9	14	3	6	5	1	8
Total per cent (some choose more than one category)	119	116	126	119	159	133	112	129
Base for percentages	(38)	(127)	(116)	(34)	(72)	(127)	(90)	(119)
No answer	(5)	(3)	(4)	(-)	(2)	(2)	(-)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

p. Alcoholism

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	52	46	40	85	78	65	74	55
Part-time person(s) employed . .	20	17	19	24	19	11	9	19
Frequent consultation (at least once a week)	22	24	31	26	33	26	15	20
Occasional consultation	12	9	14	15	17	11	10	10
In-service training.	15	16	16	26	25	23	7	13
No utilization	10	2	4	-	-	2	-	6
Don't know	-	8	3	3	1	2	3	7
No program at respondent's level	2	2	6	-	-	1	1	2
Total per cent (some choose more than one category).	133	124	133	179	173	141	119	132
Base for percentages . . .	(40)	(127)	(116)	(34)	(72)	(129)	(89)	(120)
No answer.	(3)	(3)	(4)	(-)	(2)	(-)	(1)	(-)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

q. School Health

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	29	21	45	50	51	47	41	53
Part-time person(s) employed . .	24	22	19	9	20	18	15	19
Frequent consultation (at least once a week)	41	33	29	18	38	31	31	27
Occasional consultation	20	19	19	12	10	16	12	10
In-service training	24	25	27	9	20	28	8	19
No utilization	5	1	3	-	3	2	8	5
Don't know	2	12	2	21	3	2	6	3
No program at respondent's level	-	-	1	-	-	-	-	1
Total per cent (some choose more than one category	145	133	145	119	145	144	121	137
Base for percentages . . .	(41)	(125)	(116)	(34)	(71)	(129)	(88)	(119)
No answer	(2)	(5)	(4)	(-)	(3)	(-)	(2)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

r. Family Service

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun	Other Hosp.	
Full-time person(s) employed . .	27	23	31	56	44	36	51	49
Part-time person(s) employed . .	8	16	19	21	23	17	13	12
Frequent consultation (at least once a week)	32	28	26	12	41	44	22	36
Occasional consultation	16	17	28	15	15	17	16	7
In-service training	27	16	18	12	22	26	7	13
No utilization	8	-	4	-	-	1	-	5
Don't know	5	16	5	18	7	2	4	3
No program at respondent's level	11	7	3	-	3	2	2	3
Total per cent (some choose more than one catetory)	134	123	134	134	155	145	115	128
Base for percentages . . .	(37)	(127)	(116)	(34)	(73)	(129)	(90)	(118)
No answer	(6)	(3)	(4)	(-)	(1)	(-)	(-)	(2)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

s. Mental Health in Education

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	33	38	32	62	64	57	56	47
Part-time person(s) employed . .	21	15	24	15	17	12	15	23
Frequent consultation (at least once a week)	36	26	29	21	35	34	15	26
Occasional consultation	10	15	15	9	14	9	11	14
In-service training	23	14	20	18	18	27	11	17
No utilization	8	1	7	3	-	2	-	2
Don't know	-	15	5	12	4	4	8	3
No program at respondent's level	-	-	4	-	-	-	-	-
Total per cent (some choose more than one category)	131	124	136	140	152	145	116	132
Base for percentages . . .	(39)	(117)	(116)	(34)	(72)	(127)	(89)	(120)
No answer	(4)	(13)	(4)	(-)	(2)	(2)	(1)	(-)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

t. Crippled Children

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	34	15	11	38	24	27	24	18
Part-time person(s) employed . .	17	15	19	18	25	20	11	19
Frequent consultation (at least once a week)	37	33	23	26	23	32	30	31
Occasional consultation	26	27	37	12	27	30	24	25
In-service training	26	22	14	15	17	22	9	10
No utilization	9	2	10	3	8	6	5	11
Don't know	-	13	3	18	10	2	9	8
No program at respondent's level	-	-	7	-	-	-	-	-
Total per cent (some choose more than one category)	149	127	124	130	134	139	112	122
Base for percentages . . .	(35)	(126)	(116)	(34)	(71)	(127)	(88)	(118)
No answer	(8)	(4)	(4)	(-)	(3)	(2)	(2)	(2)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

u. Health and Welfare Council

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	12	12	10	26	15	16	28	15
Part-time person(s) employed . .	12	11	14	21	18	11	9	16
Frequent consultation (at least once a week)	10	11	22	12	25	31	22	26
Occasional consultation	19	35	34	26	33	34	24	35
In-service training	14	9	16	9	13	11	2	6
No utilization	19	2	11	-	6	5	2	7
Don't know	5	23	9	26	10	8	15	6
No program at respondent's level	26	8	9	-	4	5	2	4
Total per cent (some choose more than one category)	117	111	125	120	124	121	104	115
Base for percentages . . .	(42)	(127)	(116)	(34)	(72)	(128)	(89)	(119)
No answer	(1)	(3)	(4)	(-)	(2)	(1)	(1)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

Q.12.A.v

TABLE B-12--Continued

v. Local Health Services

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local[a]	State	State			Local[a]
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed . .	38	26	-	29	34	28	32	-
Part-time person(s) employed . .	15	15	-	18	24	15	12	-
Frequent consultation (at least once a week)	25	28	-	24	36	40	21	-
Occasional consultation	25	27	-	29	27	25	30	-
In-service training	12	26	-	12	17	22	7	-
No utilization	5	1	-	3	3	3	2	-
Don't know	2	11	-	18	4	3	8	-
No program at respondent's level	-	-	100	-	-	-	-	100
Total per cent (some choose more than one category)	122	134	100	133	145	136	112	100
Base for percentages . . .	(40)	(124)	(120)	(34)	(70)	(126)	(90)	(120)
No answer	(3)	(6)	(-)	(-)	(4)	(3)	(-)	(-)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Not applicable; refers to State programs only.

Q.12.A.w

TABLE B-12--Continued

w. Public Assistance

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed	31	17	17	29	32	29	25	24
Part-time person(s) employed	3	13	14	18	15	14	9	13
Frequent consultation (at least once a week)	24	22	23	18	31	37	21	42
Occasional consultation.	24	17	28	21	24	27	30	25
In-service training . .	14	13	16	3	18	23	8	18
No utilization	17	7	10	6	4	6	3	8
Don't know	7	28	5	24	9	4	13	5
No program at respondent's level	-	-	12	-	-	-	-	2
Total per cent (some choose more than one category) . . .	120	117	125	119	133	140	109	137
Base for percentages . . .	(29)	(116)	(115)	(34)	(68)	(125)	(89)	(119)
No answer	(14)	(14)	(5)	(-)	(6)	(4)	(1)	(1)
Total number . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-12--Continued

x. Correctional and Penal System

Preferred Extent of Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Full-time person(s) employed .	56	50	39	68	82	65	70	59
Part-time person(s) employed .	12	12	21	6	17	11	8	15
Frequent consultation (at least once a week)	12	21	19	18	34	26	18	23
Occasional consultation . . .	9	6	17	9	4	11	11	15
In-service training	16	15	15	9	28	23	11	14
No utilization	12	4	7	-	1	5	1	4
Don't know	9	19	8	18	3	3	6	4
No program at respondent's level	-	-	-	-	-	-	-	-
Total per cent (some choose more than one category)	126	127	126	128	169	144	125	134
Base for percentages .	(32)	(113)	(100)	(34)	(71)	(123)	(90)	(118)
No answer	(11)	(17)	(20)	(-)	(3)	(6)	(-)	(2)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-13

PROGRAMS BELIEVED MOST NEEDING INCREASED SERVICES OF MENTAL HEALTH PERSONNEL, BY TYPE OF RESPONDENT, IN PERCENTAGES[a]

Program	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Communicable diseases	-	2	4	-	1	-	-	1
Chronic diseases	32	29	19	6	1	6	6	4
Aging	37	31	30	16	34	24	30	27
Dental health	-	1	-	-	-	-	-	-
Maternal and child health	37	41	23	3	30	36	13	28
Nursing	24	29	23	3	18	16	17	8
Environmental sanitation	-	-	3	-	1	2	-	-
Occupational health	-	-	2	-	1	-	1	2
Health education	7	6	16	6	4	7	8	9
Hospitals and medical facilities	7	9	6	28	30	9	29	25
Vital statistics and research	-	1	1	3	4	5	15	6
Rehabilitation	12	19	7	6	20	17	26	9
Accident prevention	5	5	3	3	-	2	-	2
Juvenile delinquency	17	21	36	31	30	29	31	50
Drug addiction	5	6	3	3	-	3	3	2
Alcoholism	22	19	20	69	13	17	21	19
School health	10	17	36	3	27	22	15	26
Family service	7	20	18	19	13	16	6	19
Mental health in education	17	9	17	34	25	35	17	28
Crippled children	5	-	1	-	1	2	-	1
Health and welfare council	-	-	1	3	-	2	3	2
Local health services	37	16	15	16	15	14	13	9
Public assistance	5	2	2	3	8	12	6	8
Correctional and penal system	14	10	11	28	21	21	35	14
All programs listed	-	-	-	-	-	2	-	-
Don't know	-	7	2	13	-	-	5	1
Total per cent[a]	300	300	299	296	297	299	300	300
Base for percentages	(41)	(126)	(115)	(32)	(71)	(129)	(89)	(116)
No answer	(2)	(4)	(5)	(2)	(3)	(-)	(1)	(4)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Respondents were asked to name three programs of those listed in Table B-12; some respondents named fewer than three.

TABLE B-14

CHOICES OF BEST POSSIBLE RELATIONSHIP BETWEEN MENTAL HEALTH AND OTHER HEALTH, HEALTH RELATED, AND WELFARE PROGRAMS, BY TYPE OF RESPONDENT, IN PERCENTAGES

a. First Choice

Choices of Best Possible Relationship Between Mental Health and Other Health, Health Related, and Welfare Programs	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Mental health activities are very distinctive and should be organized into separate programs.	-	-	3	3	9	3	6	3
Mental health activities should be separately and autonomously organized but have provision for consultation with other programs regarding special problems	2	1	3	3	4	8	16	10
Mental health activities should be separately and autonomously organized but should have provision for regular and frequent liaison with other programs . .	2	9	6	26	40	45	45	48
Mental health activities are part of public health and should be a division in the department of public health . . .	68	67	67	44	29	25	12	11
There should be a distinct mental health unit within one of the (State or local) agencies, with a small staff, and other mental health personnel should be assigned to other agencies for varying periods of time	5	4	5	3	3	3	3	6
Mental health relates to all programs of health and welfare and mental health personnel should be dispersed among these various programs, with the provision that they meet for periodic conferences, perhaps with a chairman	12	9	7	3	1	4	7	9
It really does not matter where the "Mental Health Authority" is provided there is an identifiable group and they are willing to work with other agencies as needs and time permit	10	9	9	18	11	12	10	13
No first choice	-	1	-	-	3	-	1	-
Total per cent	99[a]	100	100	100	100	100	100	100
Base for percentages . . .	(41)	(127)	(119)	(34)	(70)	(129)	(90)	(120)
No answer	(2)	(3)	(1)	(-)	(4)	(-)	(-)	(-)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Does not equal 100 per cent due to rounding.

TABLE B-14--Continued

b. Second Choice

Choices of Best Possible Relationship Between Mental Health and Other Health, Health Related, and Welfare Programs	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Mental health activities are very distinctive and should be organized into separate programs.	-	2	-	6	9	3	4	3
Mental health activities should be separately and autonomously organized but have provision for consultation with other programs regarding special problems	7	10	8	23	39	29	42	34
Mental health activities should be separately and autonomously organized but should have provision for regular and frequent liaison with other programs . .	29	19	19	15	11	26	17	22
Mental health activities are a part of public health and should be a division in the department of public health . .	10	7	14	9	11	12	8	12
There should be a distinct mental health unit within one of the (State or local) agencies, with a small staff, and other mental health personnel should be assigned to other agencies for varying periods of time	25	22	18	23	10	8	9	6
Mental health relates to all programs of health and welfare and mental health personnel should be dispersed among these various programs, with the provision that they meet for periodic conferences, perhaps with a chairman	5	18	24	18	10	9	10	10
It really does not matter where the "Mental Health Authority" is, provided there is an identifiable group and they are willing to work with other agencies as needs and time permit	17	17	14	6	4	12	9	12
No second choice	7	5	3	-	6	1	1	1
Total per cent	100	100	100	100	100	100	100	100
Base for percentages . . .	(41)	(124)	(119)	(34)	(70)	(128)	(90)	(119)
No answer	(2)	(6)	(1)	(-)	(4)	(1)	(-)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-14--Continued

c. Third Choice

Choices of Best Possible Relationship Between Mental Health and Other Health, Health Related, and Welfare Programs	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Mental health activities are very distinctive and should be organized into separate programs.	3	2	2	6	16	13	22	16
Mental health activities should be separately and autonomously organized but have provision for consultation with other programs regarding special problems	12	17	12	6	14	17	10	17
Mental health activities should be separately and autonomously organized but should have provision for regular and frequent liaison with other programs . .	17	18	9	29	24	11	20	10
Mental health activities are a part of public health and should be a division in the department of public health . . .	7	8	3	9	7	16	15	15
There should be a distinct mental health unit within one of the (State or local) agencies, with a small staff, and other mental health personnel should be assigned to other agencies for varying periods of time	10	12	29	9	9	13	11	10
Mental health relates to all programs of health and welfare and mental health personnel should be dispersed among these various programs, with the provision that they meet for periodic conferences, perhaps with a chairman	12	15	14	20	14	13	4	9
It really does not matter where the "Mental Health Authority" is, provided there is an identifiable group and they are willing to work with other agencies as needs and time permit	24	16	25	18	9	16	16	19
No third choice	15	12	6	3	7	1	2	4
Total per cent	100	100	100	100	100	100	100	100
Base for percentages . . .	(41)	(123)	(118)	(34)	(70)	(128)	(90)	(119)
No answer	(2)	(7)	(2)	(-)	(4)	(1)	(-)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-15

DIFFERENCES IN APPROACH BETWEEN PUBLIC HEALTH AND MENTAL HEALTH PERSONNEL BELIEVED TO POSE PROBLEMS FOR COOPERATION, BY TYPE OF RESPONDENT, IN PERCENTAGES

Differences	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
No differences	9	10	13	9	15	5	9	6
Public health personnel are community-, group-oriented; mental health persons are individual-oriented	47	21	29	18	31	33	26	29
Public health personnel are preventive-oriented; mental health personnel are therapy-oriented	23	17	16	9	25	25	27	21
Public health personnel are concerned with immediate cure, work with concrete matters and definitive procedures; mental health personnel concerned with long-time perspective, work with less tangible matters and less definitive procedures	5	9	6	12	8	13	8	11
Public health personnel deal with many matters, are broad in approach; mental health personnel are concerned with only one matter, are concerned with emotions only	9	14	8	6	6	7	6	7
One or both professions do not understand, appreciate each other's problems or the nature of their work	28	28	24	33	32	35	27	34
Public health personnel are bureaucratic, authoritarian, leadership clearer; mental health personnel are flexible, less arbitrary, favor less hierarchal organization	-	2	-	3	8	10	6	4
Public health personnel are active, effective; mental health personnel talk and confer	2	5	3	-	-	2	-	2
One or both professions do not accept each other as professional peers; they assert their viewpoint unduly	16	16	18	18	17	14	11	13
Other specific differences	14	7	8	3	8	9	9	7
Unspecified acknowledgment of differences	-	5	3	3	-	1	6	3
Don't know; indeterminate	-	8	9	15	6	6	8	9
Total per cent (some give more than one difference)	153	142	137	129	156	160	143	146
Base for percentages	(43)	(128)	(119)	(33)	(72)	(126)	(88)	(120)
No answer	(-)	(2)	(1)	(1)	(2)	(3)	(2)	(-)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-16

WHETHER PROBLEM-POSING DIFFERENCES IN APPROACH BETWEEN PUBLIC HEALTH AND MENTAL HEALTH PERSONNEL ARE ADVANTAGES OR DISADVANTAGES, BY TYPE OF RESPONDENT, IN PERCENTAGES

Judgment	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Advantage	5	12	21	18	19	27	24	18
Disadvantage	76	68	60	71	62	65	59	74
Both advantage and disadvantage, or neither[a].	7	7	2	-	3	3	4	2
Don't know	2	2	3	-	-	-	3	-
No difference[b]	10	11	14	11	16	5	10	6
Total per cent . .	100	100	100	100	100	100	100	100
Base for percentages . . .	(42)	(116)	(104)	(28)	(68)	(117)	(78)	(107)
Inapplicable (don't know or no answer)[b] . .	(-)	(12)	(12)	(6)	(6)	(11)	(9)	(11)
No answer	(1)	(2)	(4)	(-)	(-)	(1)	(3)	(2)
Total number . . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Response volunteered by respondent; if included as possible response in the question, the proportion giving this answer would probably have been larger.

[b]In response to question, "What differences ... in approach ... pose problems for cooperation?" (See Table B-15.)

TABLE B-17

INFERRED EVALUATIONS OF DIFFERENCES IN APPROACH BETWEEN PUBLIC HEALTH AND MENTAL HEALTH PERSONNEL, BY TYPE OF RESPONDENT, IN PERCENTAGES[a]

Evaluation	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Some negative evaluation only of public health personnel and/or orientation	-	8	3	11	21	20	23	27
Some negative evaluation only of mental health personnel and/or orientation	33	35	30	28	4	18	5	11
Some negative evaluation of both public health and mental health personnel or orientation	19	17	18	25	18	15	10	14
No negative evaluation of either public health or mental health personnel or orientation	39	29	35	25	41	42	52	42
No difference[b]	9	11	14	11	16	5	10	6
Total per cent	100	100	100	100	100	100	100	100
Base for percentages	(43)	(118)	(108)	(28)	(68)	(118)	(81)	(109)
Inapplicable (don't know or no answer)[b]	(-)	(12)	(12)	(6)	(6)	(11)	(9)	(11)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Respondents were not asked to evaluate their attitudes in this question, but the content of their responses was coded in terms of these categories.

[b]In response to question, "What differences ... in approach ... pose problems for cooperation?" (See Table B-15.)

TABLE B-18

OTHER DISADVANTAGES IN HAVING MENTAL HEALTH PERSONNEL WORKING IN HEALTH OR HEALTH RELATED PROGRAMS, BY TYPE OF RESPONDENT, IN PERCENTAGES

Disadvantages	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
None; no other disadvantages . .	73	67	63	52	54	51	46	47
Difficulties in dividing responsibilities, sharing work . . .	5	5	4	6	17	15	12	9
Difficulties in coordinating programs, administering properly .	7	6	7	9	13	11	7	15
Mental health personnel professionally isolated, lose professional identification, lose special contribution	5	2	2	6	7	5	6	9
Mental health program development hampered in general or by regulations, financing handicaps, etc.	5	1	3	3	6	7	4	2
Mental health personnel would not talk or work as freely or as effectively as they would in their own program	2	2	-	3	1	4	1	2
Mental health personnel dissipated, diverted from primary task	-	4	3	3	3	3	12	5
Public health personnel dissipated, diverted from primary task, would not talk or work as freely or effectively in own programs	5	-	3	-	1	1	2	1
Public health program development hampered generally or by specialized concerns of mental health personnel	2	1	4	6	1	4	1	3
Other difficulties affecting programs generally, such as salary differential	7	5	10	3	9	7	7	7
Other specific responses	2	2	4	3	9	8	3	6
Don't know, indeterminate	-	9	9	15	3	4	7	5
Total per cent (some give more than one disadvantage)	113	104	112	109	124	120	108	111
Base for percentages	(41)	(125)	(115)	(33)	(69)	(128)	(89)	(117)
No answer	(2)	(5)	(5)	(1)	(5)	(1)	(1)	(3)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-19

IMPORTANCE OF CERTAIN FACTORS AS BARRIERS TO MORE EFFECTIVE USE OF EXISTING MENTAL HEALTH PERSONNEL IN HEALTH AND WELFARE PROGRAMS, BY TYPE OF RESPONDENT, IN PERCENTAGES

a. Manpower Shortage

Importance of Manpower Shortage	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Very important	67	67	64	70	80	70	77	75
Somewhat important . . .	23	23	30	24	17	28	21	22
Not at all important .	5	5	3	3	3	1	2	2
Don't know	5	5	3	3	-	1	-	1
Total per cent .	100	100	100	100	100	100	100	100
Base for percentages . . .	(43)	(129)	(117)	(33)	(72)	(129)	(90)	(120)
No answer	(-)	(1)	(3)	(1)	(2)	(-)	(-)	(-)
Total number . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-19--Continued

b. Inadequate Tax Base, Lack of Resources

Importance of Inadequate Tax Base, Lack of Resources	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Very important	42	45	48	61	49	48	43	61
Somewhat important . . .	49	29	38	24	41	42	43	23
Not at all important . . .	7	12	9	9	7	5	8	12
Don't know	2	14	5	6	3	5	7	4
Total per cent . .	100	100	100	100	100	100	101[a]	100
Base for percentages	(43)	(129)	(117)	(33)	(71)	(128)	(89)	(120)
No answer	(-)	(1)	(3)	(1)	(3)	(1)	(1)	(-)
Total number . . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Does not equal 100 per cent due to rounding of figures.

TABLE B-19--Continued

c. Differences in Orientation and Values between Mental Health and Public Health Personnel

Importance of Differences in Orientation and Values	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Very important	14	22	19	21	17	16	20	13
Somewhat important	51	42	43	43	43	53	42	48
Not at all important . . .	30	25	33	18	39	27	26	30
Don't know	5	11	5	18	1	4	12	9
Total per cent . .	100	100	100	100	100	100	100	100
Base for percentages	(43)	(129)	(116)	(33)	(70)	(128)	(90)	(120)
No answer	(-)	(1)	(4)	(1)	(4)	(1)	(-)	(-)
Total number . . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-19--Continued

d. Unclear Division of Responsibility between Agencies--"Jurisdictional Disputes"

Importance of Unclear Division of Responsibility	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Very important	7	21	16	18	13	17	10	9
Somewhat important	44	33	33	43	37	41	41	39
Not at all important . . .	47	30	45	24	46	36	33	44
Don't know	2	16	6	15	4	6	16	8
Total per cent . .	100	100	100	100	100	100	100	100
Base for percentages	(43)	(128)	(117)	(33)	(71)	(128)	(89)	(120)
No answer	(-)	(2)	(3)	(1)	(3)	(1)	(1)	(-)
Total number . . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-19--Continued

e. Inappropriate Use of Personnel

Importance of Inappropriate Use of Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Very important	2	9	13	9	14	15	17	11
Somewhat important	40	26	21	40	33	39	37	26
Not at all important . . .	53	39	50	27	46	36	33	44
Don't know	5	26	16	24	7	10	13	19
Total per cent . .	100	100	100	100	100	100	100	100
Base for percentages	(43)	(128)	(114)	(33)	(70)	(129)	(90)	(120)
No answer	(-)	(2)	(6)	(1)	(4)	(-)	(-)	(-)
Total number . . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-19--Continued

f. Inadequate Agency Assessment of Need

Importance of Inadequate Agency Assessment of Need	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Very important	7	12	17	21	19	19	18	12
Somewhat important	51	35	31	40	38	42	42	35
Not at all important . . .	37	31	38	27	39	28	28	32
Don't know	5	22	14	12	4	11	12	21
Total per cent . .	100	100	100	100	100	100	100	100
Base for percentages	(43)	(128)	(114)	(33)	(69)	(127)	(89)	(120)
No answer	(-)	(2)	(6)	(1)	(5)	(2)	(1)	(-)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE 19--Continued

g. Resistance of Tax Appropriating Bodies

Importance of Resistance of Tax Appropriating Bodies	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Very important	39	32	37	49	44	49	40	42
Somewhat important	42	34	36	42	49	31	42	31
Not at all important . . .	14	18	18	3	7	15	10	19
Don't know	5	16	9	6	-	5	8	8
Total per cent . .	100	100	100	100	100	100	100	100
Base for percentages	(43)	(129)	(117)	(33)	(71)	(128)	(89)	(120)
No answer	(-)	(1)	(3)	(1)	(3)	(1)	(1)	(-)
Total number . . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

Table B-19--Continued

h. Resistance of Executive Branch Leadership

Importance of Resistance of Executive Branch Leadership	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Very important	2	9	10	18	17	23	18	15
Somewhat important . . .	49	20	30	37	30	28	26	34
Not at all important . .	47	51	43	18	49	36	44	33
Don't know	2	20	17	27	4	13	12	18
Total per cent . .	100	100	100	100	100	100	100	100
Base for percentages	(43)	(128)	(115)	(33)	(70)	(128)	(89)	(120)
No answer	(-)	(2)	(5)	(1)	(4)	(1)	(1)	(-)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE 19--Continued

i. Lack of Public Support

Importance of Lack of Public Support	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Very important	23	21	23	55	34	31	37	24
Somewhat important	49	37	45	33	46	38	38	52
Not at all important . . .	23	33	25	12	20	28	20	21
Don't know	5	9	7	-	-	3	5	3
Total per cent . .	100	100	100	100	100	100	100	100
Base for percentages	(43)	(129)	(115)	(33)	(71)	(128)	(90)	(120)
No answer	(-)	(1)	(5)	(1)	(3)	(1)	(-)	(-)
Total number . . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-20

HOW PUBLIC HEALTH SERVICE OF THE FEDERAL GOVERNMENT CAN HELP IN BRINGING ABOUT MORE APPROPRIATE USE OF MENTAL HEALTH PERSONNEL IN HEALTH AND HEALTH RELATED PROGRAMS, BY TYPE OF RESPONDENT, IN PERCENTAGES

Public Health Service Activity	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Public Health Service should do less; do nothing . . .	-	5	3	-	3	1	1	3
Public Health Service should simply continue as present	5	9	3	3	8	13	8	5
Give consultation, advice services	36	21	20	18	26	32	31	23
Increase funds for community, state services; formula grants; more money	24	13	31	6	21	16	18	18
(Grants)(funds) demonstration projects	21	11	12	18	8	8	11	14
Provide more personnel (general); more training; provide other ways to obtain more personnel	14	11	13	6	14	12	8	9
Provide (more) (funds for) in-service training . . .	14	12	14	6	6	8	7	2
Provide (more) stipends, fellowships, training grants, scholarships . . .	12	8	14	12	10	9	14	8
Loan mental health personnel for limited time	12	9	12	3	3	5	1	1
Provide (more) funds for, sponsor workshops, institutes, conferences	7	7	8	18	6	10	7	6
(Funds for) research; research grants	14	4	6	18	11	5	19	13
(Funds for) evaluation studies; project grants; community surveys	10	2	7	9	7	3	4	4
Disseminate information about programs throughout country; assess programs and distribute findings; set standards	10	5	14	6	11	12	17	15

TABLE B-20--Continued

Public Health Service Activity	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Work more closely with local programs	5	3	9	6	7	12	3	13
Help educate the public, legislators, boards of directors	2	2	6	3	3	8	10	12
Be channeled through state government . . .	-	3	2	3	1	2	-	1
Be more de-centralized .	-	-	2	-	1	-	-	3
Take more leadership, initiative	5	6	1	6	1	4	2	3
Personnel should be better trained, more experienced	2	1	1	3	4	2	-	3
Be more supportive of innovation; of unique programs	-	1	1	-	4	2	4	3
Foster particular placement of State Mental Health Authority . . .	-	1	-	-	-	-	1	1
Other specific responses	10	5	2	6	7	9	6	7
Vague, general, or don't know	10	13	10	12	10	8	11	8
Total per cent (some give more than one suggestion) . .	213	152	191	162	172	181	183	175
Base for percentages	(42)	(128)	(120)	(34)	(72)	(129)	(90)	(119)
No answer	(1)	(2)	(-)	(-)	(2)	(-)	(-)	(1)
Total number . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-21

PREFERRED LOCATION OF THE STATE MENTAL HEALTH AUTHORITY, BY TYPE OF RESPONDENT, IN PERCENTAGES

Preferred	Public Health			Alcoholism	Mental Health			
	State		Local[a]	State	State			Local[a]
	Head	Other			Head	Other Commun.	Other Hosp.	
Department of Mental Health or Mental Hygiene	10	17		39	39	57	60	
Department, Board, of Public Health	74	71		46	29	30	11	
Department of Welfare, Public Welfare	2	2		-	8	3	12	
Department of Public Health and Welfare . . .	5	2		3	6	5	4	
Department of Corrections and Institutions	-	-		3	-	-	2	
Department of Institutions and Agencies	2	1		-	6	-	5	
Department of Hospitals, hospital	-	-		3	3	2	-	
Department of Health (Public Health and Mental Health equal) . .	5	4		-	3	1	1	
Other department, board, commission, or other combination of departments	-	2		3	3	2	5	
Don't know, doesn't matter	2	1		3	3	-	-	
Total per cent . .	100	100		100	100	100	100	
Base for percentages	(42)	(113)		(31)	(71)	(115)	(82)	
Inapplicable or no information . . .	(1)	(17)	(120)	(3)	(3)	(14)	(8)	(120)
Total number . . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Inapplicable; question asked only of state officials.

TABLE B-22

WHETHER INSTITUTIONAL AND COMMUNITY MENTAL HEALTH PROGRAMS SHOULD BE IN THE SAME OR IN SEPARATE DEPARTMENTS, BY TYPE OF RESPONDENT, IN PERCENTAGES

Preferred Arrangement of Institutional and Community Mental Health Programs	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
In same department	62	58	62	79	79	81	90	64
In separate departments. .	33	29	29	12	18	16	7	27
Don't know	5	13	9	9	3	3	3	9
Total per cent . .	100	100	100	100	100	100	100	100
Base for percentages	(42)	(129)	(120)	(34)	(72)	(129)	(90)	(120)
No answer	(1)	(1)	(-)	(-)	(2)	(-)	(-)	(-)
Total number . . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-23

RELATIONS CONSIDERED MOST DESIRABLE BETWEEN MENTAL INSTITUTIONAL PROGRAMS AND PUBLIC HEALTH DEPARTMENTS, BY TYPE OF RESPONDENT, IN PERCENTAGES

Type of Relations	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Close relations with public health departments generally . .	88	73	71	65	72	70	65	49
Close relations with a specific part or parts of public health departments, such as nursing, community clinics, or hospital inspection.	12	22	28	29	26	28	32	44
Few or no relations with public health departments	-	1	-	-	1	-	1	3
Don't know.	-	4	1	6	1	2	2	4
Total per cent. . . .	100	100	100	100	100	100	100	100
Base for percentages.	(42)	(128)	(120)	(34)	(71)	(128)	(90)	(118)
No answer	(1)	(2)	(-)	(-)	(3)	(1)	(-)	(2)
Total number.	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-24

PREFERENCE FOR USE OF PRESENT SUPPLY OF MENTAL HEALTH PERSONNEL IN CERTAIN FUNCTIONS, AS RANKED BY TYPE OF RESPONDENT, IN PERCENTAGES

a. In Mental Health Education for the Public

Rank of Preference for Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
First	15	23	25	41	10	8	15	7
Second	12	7	15	14	7	15	7	10
Third	15	18	8	12	5	10	12	7
Fourth	7	13	6	3	15	5	8	11
Fifth	9	8	8	3	5	7	10	7
Sixth	15	11	8	3	18	11	7	8
Seventh	7	5	8	9	10	13	17	13
Eighth	5	7	13	12	15	11	11	17
Ninth	15	7	8	3	15	18	13	18
Don't know	-	1	1	-	-	2	-	2
Total per cent	100	100	100	100	100	100	100	100
Base for percentages	(41)	(122)	(116)	(34)	(73)	(128)	(90)	(119)
No answer	(2)	(8)	(4)	(-)	(1)	(1)	(-)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-24--Continued

b. In Consultation with Other Public Health or Health Related Agencies

Rank of Preference for Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
First	7	22	12	6	8	22	11	8
Second	22	25	10	15	14	16	11	17
Third	15	12	19	6	14	20	9	22
Fourth	10	17	12	17	12	13	9	11
Fifth	10	3	9	-	14	5	10	12
Sixth	12	3	15	23	6	6	10	8
Seventh	7	8	9	9	9	9	12	11
Eighth	10	6	8	12	9	5	18	8
Ninth	7	3	4	12	14	2	10	3
Don't know	-	1	2	-	-	2	-	1
Total per cent	100	100	100	100	100	100	100	100
Base for percentages	(41)	(122)	(116)	(34)	(73)	(128)	(90)	(119)
No answer	(2)	(8)	(4)	(-)	(1)	(1)	(-)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-24--Continued

c. In Counseling or Guidance for People with Emotional Problems

Rank of Preference for Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
First	12	8	12	11	3	9	4	15
Second	12	10	27	32	14	12	12	24
Third	10	11	14	6	16	9	12	14
Fourth	7	14	9	6	11	10	18	8
Fifth	10	8	10	9	8	9	10	7
Sixth	12	17	8	9	11	9	12	8
Seventh	22	13	9	9	14	14	10	12
Eighth	7	15	8	9	14	19	14	5
Ninth	7	2	1	6	9	7	7	5
Don't know	-	2	2	3	-	2	-	2
Total per cent	99[a]	100	100	100	100	100	99[a]	100
Base for percentages	(41)	(122)	(116)	(34)	(73)	(128)	(90)	(119)
No answer	(2)	(8)	(4)	(-)	(1)	(1)	(-)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Does not equal 100 per cent due to rounding of figures.

TABLE B-24--Continued

d. In Individual Therapy of Persons with Manifest Psychotic or Neurotic Symptoms; Provision of Clinical Services

Rank of Preference for Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
First	17	12	16	26	41	27	31	46
Second	10	5	11	12	5	9	10	11
Third	10	7	6	9	7	9	6	11
Fourth	5	4	12	3	7	8	6	10
Fifth	2	5	10	6	5	10	9	3
Sixth	12	7	9	6	10	5	9	4
Seventh	7	21	10	9	5	5	9	3
Eighth	17	11	11	17	5	12	6	7
Ninth	20	26	13	9	14	14	14	13
Don't know	-	2	2	3	-	1	-	2
Total per cent	100	100	100	100	99[a]	100	100	100
Base for percentages	(41)	(122)	(116)	(34)	(73)	(128)	(90)	(119)
No answer	(2)	(8)	(4)	(-)	(1)	(1)	(-)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

e. In Research or Program Evaluation

Rank of Preference for Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
First	10	7	3	3	10	8	11	4
Second	5	7	4	6	10	9	11	6
Third	2	8	6	20	11	13	11	11
Fourth	10	7	9	14	12	11	10	14
Fifth	29	14	9	12	11	13	12	14
Sixth	10	11	8	12	13	6	19	16
Seventh	17	14	14	9	15	16	10	9
Eighth	5	17	17	12	10	7	10	9
Ninth	12	14	27	12	8	16	6	16
Don't know	-	1	3	-	-	1	-	1
Total per cent	100	100	100	100	100	100	100	100
Base for percentages	(41)	(122)	(116)	(34)	(73)	(128)	(90)	(119)
No answer	(2)	(8)	(4)	(-)	(1)	(1)	(-)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-24--Continued

f. In Community Development

Rank of Preference for Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
First	15	14	7	3	14	11	9	6
Second	10	10	10	9	14	11	12	7
Third	10	8	6	11	12	9	9	3
Fourth	20	11	10	15	7	15	7	8
Fifth	7	8	8	15	5	10	6	9
Sixth	5	8	10	9	7	10	9	15
Seventh	7	8	13	11	12	6	10	12
Eighth	13	13	14	15	18	13	16	20
Ninth	13	20	20	9	11	13	22	18
Don't know	-	-	2	3	-	2	-	2
Total per cent	100	100	100	100	100	100	100	100
Base for percentages	(40)	(117)	(115)	(34)	(73)	(127)	(89)	(118)
No answer	(3)	(13)	(5)	(-)	(1)	(2)	(1)	(2)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

g. In In-Service Training for Staffs of Other Agencies

Rank of Preference for Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
First	12	8	10	-	4	5	6	6
Second	12	17	11	3	7	11	13	8
Third	10	15	8	15	11	14	4	9
Fourth	12	11	15	12	17	15	14	13
Fifth	12	19	16	9	22	19	17	20
Sixth	5	10	12	17	15	17	10	18
Seventh	22	3	13	12	12	9	11	11
Eighth	7	5	8	12	8	5	8	11
Ninth	7	10	5	20	4	5	17	4
Don't know	-	2	2	-	-	-	-	-
Total per cent	99[a]	100	100	100	100	100	100	100
Base for percentages	(41)	(122)	(116)	(34)	(73)	(128)	(90)	(119)
No answer	(2)	(8)	(4)	(-)	(1)	(1)	(-)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-24--Continued

h. In Provision of Follow-up and Other Rehabilitative Services

Rank of Preference for Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
First	-	-	1	3	3	2	6	2
Second	3	7	3	3	14	11	11	6
Third	10	12	11	12	18	5	25	7
Fourth	15	12	16	20	7	14	18	16
Fifth	15	23	17	26	12	14	11	14
Sixth	10	19	16	6	14	21	16	8
Seventh	5	10	14	12	9	13	6	16
Eighth	31	13	11	6	12	11	6	12
Ninth	7	2	10	12	11	9	1	17
Don't know	-	2	1	-	-	-	-	2
Total per cent	100	100	100	100	100	100	100	100
Base for percentages	(41)	(122)	(116)	(34)	(73)	(128)	(90)	(119)
No answer	(2)	(8)	(4)	(-)	(1)	(1)	(-)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

Table B-24--Continued

i. In Case Finding, Diagnosis and Referral of Persons to Whatever Therapy Resources Are Available

Rank of Preference for Use of Mental Health Personnel	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
First	12	6	14	6	8	9	6	6
Second	10	12	8	6	17	8	12	12
Third	19	8	21	9	5	9	10	15
Fourth	15	11	9	9	12	8	11	11
Fifth	5	11	11	20	17	11	16	12
Sixth	19	13	11	12	7	13	8	11
Seventh	5	15	8	17	12	13	16	10
Eighth	5	12	8	3	8	14	12	10
Ninth	10	11	8	15	14	13	9	11
Don't know	-	1	2	3	-	2	-	2
Total per cent	100	100	100	100	100	100	100	100
Base for percentages	(41)	(122)	(116)	(34)	(73)	(128)	(90)	(119)
No answer	(2)	(8)	(4)	(-)	(1)	(1)	(-)	(1)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-25

OTHER USES OF MENTAL HEALTH PERSONNEL CONSIDERED AS IMPORTANT AS THOSE IN TABLE B-24, BY TYPE OF RESPONDENT, IN PERCENTAGES

Uses	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
None as important	89	91	96	91	85	82	82	85
Others as important[a] . . .	11	9	4	9	15	18	18	15
Teaching, training of mental health professionals	8	2	1	3	7	7	8	11
Teaching physicians, educators, recreational leaders . . .	3	5	1	-	3	3	3	3
Teaching medical students	-	2	-	3	-	1	3	4
Group therapy	-	-	-	3	3	1	-	2
Encouraging interest in mental health careers, work; teaching high school students . . .	-	-	-	-	-	3	2	-
Assuming positions in health departments, exercising leadership	-	1	1	-	-	1	-	-
Training lay citizens as mental health resources	-	1	-	-	-	1	-	-
Consultation with city planners, architects.	-	1	-	-	-	1	-	-
Supportive services for families of mentally ill	-	-	-	-	1	1	-	-
Use in private industry, business	-	-	-	-	-	-	1	-
Other specific responses	-	-	-	-	1	3	7	1
No answer	-	2	1	-	-	-	-	-
Total per cent .	100	100	100	100	100	100	100	100
Base for percentages . . .	(38)	(119)	(114)	(34)	(71)	(119)	(89)	(114)
No answer . . .	(5)	(11)	(6)	(-)	(3)	(10)	(1)	(6)
Total number . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Percentages of items listed do not always equal total because some respondents mention more than one other use as important.

TABLE B-26

ARRANGEMENT FOR MEETING MENTAL HEALTH NEEDS IN LOCAL COMMUNITIES WHICH SHOULD HAVE HIGHEST PRIORITY, BY TYPE OF RESPONDENT, IN PERCENTAGES

Arrangement	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Local health centers, including mental health centers	88	84	84	70	58	60	54	44
Separate mental health centers	2	5	8	9	30	21	20	27
Separate mental health clinics	5	1	3	3	7	5	7	16
Separate child guidance clinics	-	1	1	-	-	-	-	7
Working through other agencies to effect treatment	5	8	4	15	5	13	19	6
Don't know	-	2	-	3	-	1	-	-
Total per cent	100	100	100	100	100	100	100	100
Base for percentages	(42)	(130)	(120)	(34)	(73)	(129)	(90)	(120)
No answer	(1)	(-)	(-)	(-)	(1)	(-)	(-)	(-)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-27

EXPECTED CHANGES IN NEEDS FOR MENTAL HEALTH PERSONNEL IN PUBLIC AGENCIES IN NEXT FIVE YEARS, BY TYPE OF RESPONDENT, IN PERCENTAGES

Expected Changes	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Will increase greatly . .	67	58	65	65	68	76	72	76
Will increase somewhat. .	31	38	29	32	28	21	25	20
Will stay about the same.	1	-	4	3	4	2	3	2
Will decline.	-	-	-	-	-	1	-	1
Don't know.	-	4	2	-	-	-	-	1
Total per cent. . . .	100	100	100	100	100	100	100	100
Base for percentages.	(42)	(130)	(119)	(34)	(72)	(129)	(90)	(120)
No answer	(1)	(-)	(1)	(-)	(2)	(-)	(-)	(-)
Total number.	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-28

HOW DIRECT, NON-INSTITUTIONAL MENTAL HEALTH AGENCY PROGRAMS SHOULD BE FINANCED, BY TYPE OF RESPONDENT, IN PERCENTAGES

Preferred Method of Financing	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Primarily by tax-supported agencies . .	76	65	62	56	64	51	49	51
Primarily by privately supported agencies . .	-	-	4	-	1	5	3	3
About equally by both .	24	33	32	38	35	42	48	45
Don't know	-	2	2	6	-	2	-	1
Total per cent . .	100	100	100	100	100	100	100	100
Base for percentages	(42)	(130)	(120)	(34)	(72)	(128)	(90)	(120)
No answer	(1)	(-)	(-)	(-)	(2)	(1)	(-)	(-)
Total number . . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-29

WHICH LEVEL OF GOVERNMENT IN STATE SHOULD HAVE RESPONSIBILITY FOR PROGRAMMING TREATMENT OF FULLY INSTITUTIONALIZED PERSONS, BY TYPE OF RESPONDENT, IN PERCENTAGES

Preferred Responsibility	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Exclusively State	21	21	32	21	29	20	26	21
Primarily State	48	43	37	44	39	35	36	37
Shared about equally . .	29	28	26	32	31	38	34	36
Primarily local	2	5	3	-	1	6	4	4
Exclusively local	-	-	1	-	-	-	-	1
Don't know	-	3	1	3	-	1	-	1
Total per cent . .	100	100	100	100	100	100	100	100
Base for percentages	(42)	(129)	(120)	(34)	(72)	(129)	(90)	(119)
No answer	(1)	(1)	(-)	(-)	(2)	(-)	(-)	(1)
Total number . . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-30

WHICH LEVEL OF GOVERNMENT IN STATE SHOULD HAVE RESPONSIBILITY FOR PROGRAMMING TREATMENT OF MENTALLY ILL IN DAY HOSPITALS, NIGHT HOSPITALS, HALF-WAY HOUSES, AND FOSTER HOMES, BY TYPE OF RESPONDENT, IN PERCENTAGES

Preferred Responsibility	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Exclusively State . . .	10	5	8	-	6	5	6	3
Primarily State	38	26	18	26	22	17	19	22
Shared about equally . .	38	55	48	56	68	60	62	58
Primarily local	7	9	22	15	4	16	13	14
Exclusively local . . .	5	2	2	-	-	1	-	2
Don't know	2	3	2	3	-	1	-	1
Total per cent . .	100	100	100	100	100	100	100	100
Base for percentages	(42)	(129)	(120)	(34)	(72)	(129)	(90)	(119)
No answer	(1)	(1)	(-)	(-)	(2)	(-)	(-)	(1)
Total number . . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-31

WHICH LEVEL OF GOVERNMENT IN STATE SHOULD HAVE RESPONSIBILITY FOR PROGRAMMING TREATMENT OF MENTALLY ILL IN CLINICS, BY TYPE OF RESPONDENT, IN PERCENTAGES

Preferred Responsibility	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Exclusively State	-	2	7	9	4	2	1	-
Primarily State	17	18	3	12	8	5	5	7
Shared about equally . .	57	53	45	61	64	64	66	58
Primarily local	24	22	38	15	21	27	25	32
Exclusively local	2	2	6	-	3	2	2	2
Don't know	-	3	1	3	-	-	1	1
Total per cent . .	100	100	100	100	100	100	100	100
Base for percentages	(42)	(129)	(120)	(33)	(72)	(129)	(89)	(119)
No answer	(1)	(1)	(-)	(1)	(2)	(-)	(1)	(1)
Total number . . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-32

AMOUNT OF LEADERSHIP FEDERAL GOVERNMENT SHOULD HAVE IN THE FIELD OF MENTAL HEALTH, BY TYPE OF RESPONDENT, IN PERCENTAGES

Preferred Amount of Federal Government Leadership	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Should have more	40	33	38	44	43	36	47	42
Should have less	-	5	9	3	7	5	5	9
Should remain as it is .	60	50	42	41	49	54	47	42
Don't know	-	12	11	12	1	5	1	7
Total per cent .	100	100	100	100	100	100	100	100
Base for percentages	(42)	(129)	(120)	(34)	(72)	(129)	(90)	(120)
No answer	(1)	(1)	(-)	(-)	(2)	(-)	(-)	(-)
Total number . .	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-33

PREFERRED STATEMENT OF DEGREE OF PROFESSIONAL TRAINING NEEDED TO PROVIDE HELP IN EMOTIONAL PROBLEMS, BY TYPE OF RESPONDENT, IN PERCENTAGES

Preferred Statement	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Emotional problems are so complex that only persons who have been especially trained for many years can give help which will not do more harm than good . .	17	26	26	26	21	20	17	28
Although emotional problems are very complex, persons with even a little training--and good common sense--can provide considerable help to many people . .	83	72	72	74	76	78	81	71
Don't know; can't say[a] .	-	2	2	-	3	2	2	1
Total per cent. . . .	100	100	100	100	100	100	100	100
Base for percentages.	(42)	(127)	(119)	(34)	(71)	(128)	(90)	(119)
No answer	(1)	(3)	(1)	(-)	(3)	(1)	(-)	(1)
Total number.	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Response volunteered by respondent; if included as possible response in the question, the proportion giving this answer would probably have been larger.

TABLE B-34

PREFERRED STATEMENT OF GENERAL MISSION OF LOCAL, STATE, AND FEDERAL PUBLIC HEALTH DEPARTMENTS, BY TYPE OF RESPONDENT, IN PERCENTAGES

Preferred Statement	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Public health departments should be concerned primarily with preventive programs, leaving actual treatment to other public agencies or private practitioners	17	37	47	35	49	40	47	44
Although maintaining their present preventive functions, public health departments should assume more responsibility for the actual treatment of patients .	62	41	38	47	35	42	30	35
Although maintaining their present preventive functions, public health departments should greatly increase their treatment activities. .	21	20	13	18	15	17	19	18
Don't know, or other choices	-	2	2	-	1	1	1	3
Total per cent. . . .	100	100	100	100	100	100	100	100
Base for percentages.	(42)	(128)	(118)	(34)	(72)	(129)	(90)	(120)
No answer	1	2	2	-	2	-	-	-
Total number.	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-35

PREFERRED STATEMENT OF MISSION OF PUBLIC HEALTH AND MENTAL HEALTH AGENCIES IN THE CASE OF SEVERE PERSONALITY DISTURBANCES, BY TYPE OF RESPONDENT, IN PERCENTAGES

Preferred Statement	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Public health and mental health agencies should not try to provide actual therapy, but work on programs which will reduce the incidence of such illnesses (e.g., counseling in well-child clinics) or which will create a climate supportive for seeking therapy (e.g., public education campaigns).	14	23	27	18	25	19	28	28
Public health and mental health agencies should place major emphasis upon preventive programs, but provide some therapeutic services.	62	54	57	44	38	53	45	44
Public health and mental health agencies should maintain preventive programs, but provide extensive therapeutic services.	24	21	16	35	33	27	27	27
Don't know.	-	2	-	3	4	1	-	1
Total per cent.	100	100	100	100	100	100	100	100
Base for percentages. .	(42)	(128)	(117)	(34)	(72)	(129)	(90)	(119)
No answer	(1)	(2)	(3)	(-)	(2)	(-)	(-)	(1)
Total number.	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-36

AGE, BY TYPE OF RESPONDENT, IN PERCENTAGES

Age	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Under 35.	-	3	7	18	7	11	13	14
35-44 years	5	22	18	18	24	45	38	52
45-49 years	17	10	11	20	17	17	17	7
50-54 years	38	24	26	15	15	14	22	12
55-59 years	26	19	15	23	19	7	4	5
60 and over	14	22	23	6	18	6	6	10
Total per cent. . . .	100	100	100	100	100	100	100	100
Base for percentages.	(42)	(129)	(119)	(34)	(72)	(128)	(90)	(120)
No answer	(1)	(1)	(1)	(-)	(2)	(1)	(-)	(-)
Total number.	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-37

DEGREES EARNED BEYOND HIGH SCHOOL, BY TYPE OF RESPONDENT, IN PERCENTAGES

Degree	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
None	-	4	2	24	4	-	1	-
B.A., B.S.	67	71	75	62	67	79	67	68
M.A.	7	25	6	35	23	47	42	20
M.S.[a]	2	2	4	3	1	5	6	1
M.S.W.[a]	-	1	-	-	3	12	21	5
Ph.D.	2	1	3	12	14	22	22	11
M.D.	93	34	90	18	62	20	16	73
M.P.H., D.P.H.	86	45	58	12	1	7	-	3
R.N.[a]	-	10	2	-	-	6	4	-
Other	2	5	4	6	3	5	1	2
Total per cent (some have more than one degree)	259	198	244	172	178	203	180	183
Base for percentages.	(43)	(129)	(120)	(34)	(73)	(129)	(90)	(120)
No answer	(-)	(1)	(-)	(-)	(1)	(-)	(-)	(-)
Total number.	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]These degrees were included in the coding for those who volunteered the information. If these had been listed as pre-codes, probably more respondents would have been reported as having these degrees.

TABLE B-38

UNIVERSITIES GRANTING DEGREES IN PUBLIC HEALTH, AMONG THOSE REPORTING SUCH DEGREES, BY TYPE OF RESPONDENT, IN PERCENTAGES

University	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
University of California (Berkeley).	6	9	5					
Columbia University . . .	3	5	5					
Harvard University. . . .	39	30	16					
Johns Hopkins University.	33	19	32					
University of Michigan. .	8	15	12					
University of Minnesota .	-	11	5					
University of North Carolina.	-	5	7					
University of Pittsburgh.	-	2	-					
University of Puerto Rico	-	-	-					
Tulane University Medical School.	6	-	7					
Yale University	3	2	6					
Other	3	2	5					
Total per cent. . . .	101[a]	100	100					
Base for percentages.	(35)	(54)	(66)[b]	(3)[b]	(1)[b]	(8)[b]	(-)	(3)[b]
Inapplicable or no answer.	(7)	(76)	(54)	(31)	(73)	(121)	(90)	(117)
Total number.	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Does not equal 100 per cent due to rounding of figures.

[b]Too few to percentage.

TABLE B-39

MAJOR PROFESSIONAL FIELDS, BY TYPE OF RESPONDENT, IN PERCENTAGES

Professional Field	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Public health	83	36	87	12	3	3	-	2
Pediatrics, obstetrics	-	1	2	-	1	-	-	-
Public health nursing	-	36	2	-	-	9	-	-
Mental health nursing	-	2	-	-	1	13	1	-
Psychiatry, child psychiatry	-	-	-	9	53	20	13	72
Psychiatric nursing	-	-	-	-	-	4	18	-
Clinical psychology	-	1	-	3	10	21	26	10
Psychiatric social work	-	-	-	12	5	23	29	15
Administration, Hospital administration	21	22	12	47	40	9	12	5
Education (mental health)	-	-	-	9	1	2	1	-
Other	-	7	5	18	5	8	6	-
Total per cent (some give more than one field).	104	105	108	110	119	112	106	104
Base for percentages	(42)	(129)	(120)	(34)	(73)	(129)	(90)	(120)
No answer	(1)	(1)	(-)	(-)	(1)	(-)	(-)	(-)
Total number	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-40

YEARS EMPLOYED IN PROFESSIONAL FIELD,
BY TYPE OF RESPONDENT,
IN PERCENTAGES

Years	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Fewer than 2 years. . . .	-	1	2	-	3	2	-	2
2-4 years	-	2	3	15	1	6	9	7
5-9 years	-	2	13	20	12	26	15	30
10-14 years	14	17	12	23	16	24	27	22
15-19 years	19	10	11	12	10	15	19	12
20-24 years	33	19	22	18	23	16	12	13
25-29 years	22	19	16	6	14	6	12	7
30 or more years.	12	29	21	6	25	5	6	7
Total per cent. . . .	100	99[a]	100	100	104[b]	100	100	100
Base for percentages.	(42)	(129)	(120)	(34)	(73)	(129)	(90)	(120)
No answer	(1)	(1)	(-)	(-)	(1)	(-)	(-)	(-)
Total number.	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Does not equal 100 per cent due to rounding of figures.

[b]Some respondents give more than one answer to cover more than one field.

TABLE B-41

YEARS EMPLOYED IN PRESENT JOB,
BY TYPE OF RESPONDENT,
IN PERCENTAGES

Years	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Fewer than 2 years. . . .	17	8	14	26	19	32	29	16
2-4 years	22	16	20	21	29	35	28	38
5-9 years	26	26	24	38	29	18	29	24
10-14 years	26	26	21	9	14	12	8	11
15-19 years	7	14	5	6	4	2	4	6
20-24 years	-	7	7	-	5	-	2	2
25-29 years	2	1	2	-	-	1	-	2
30 or more years.	-	2	7	-	-	-	-	1
Total per cent. . . .	100	100	100	100	100	100	100	100
Base for percentages.	(42)	(129)	(120)	(34)	(73)	(129)	(90)	(120)
No answer	(1)	(1)	(-)	(-)	(1)	(-)	(-)	(-)
Total number.	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

TABLE B-42

SETTINGS IN WHICH RESPONDENTS HAVE WORKED,
BY TYPE OF RESPONDENT,
IN PERCENTAGES[a]

Settings	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
Private practice.	57	39	58	21	51	43	31	66
Non-governmental hospital	36	40	25	21	31	29	39	39
Other non-profit, non-governmental organization	24	32	13	30	33	49	39	70
Business organization . .	21	21	15	42	18	19	15	8
Federal governmental organization.	48	38	43	45	54	35	44	53
State governmental organization.	100	100	62	100	100	99	100	69
City or county governmental organization . .	57	52	92	39	24	36	24	47
Total percentage (some give more than one category)	343	322	308	298	311	310	292	352
Base for percentages.	(42)	(127)	(120)	(33)	(72)	(127)	(88)	(118)
No answer	(1)	(3)	(-)	(1)	(2)	(2)	(2)	(2)
Total number.	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

[a]Includes present employment.

TABLE B-43

ADDITIONAL TRAINING BEYOND HIGHEST DEGREE,
BY TYPE OF RESPONDENT,
IN PERCENTAGES

Type of Training	Public Health			Alcoholism	Mental Health			
	State		Local	State	State			Local
	Head	Other			Head	Other Commun.	Other Hosp.	
In-service training . . .	58	72	62	50	56	65	64	44
Night school or special courses	33	45	35	56	36	40	39	23
School of public health .	30	28	33	9	6	8	2	2
Formal full-time training at graduate level, but not leading to a degree	40	29	33	44	46	31	41	55
None.	9	12	12	6	17	13	11	12
Total per cent (some give more than one category)	170	186	175	165	161	157	157	136
Base for percentages.	(42)	(128)	(118)	(34)	(72)	(127)	(90)	(120)
No answer	(1)	(2)	(2)	(-)	(2)	(2)	(-)	(-)
Total number.	(43)	(130)	(120)	(34)	(74)	(129)	(90)	(120)

APPENDIX C

THE INTERVIEW SCHEDULE

In addition to the interview schedule, the interviewers were sent an Identification Sheet for each respondent. The Identification Sheet, among other items, indicated which questions should be omitted for each respondent.

The interviewers were instructed to make a few changes in the interview schedule when administering it. In question 5, if the budget was reported to be $3,000,000 or more, the specific figure was obtained. In the note on page 4, the following was inserted in the first paragraph: "'Mental health personnel' includes generic social workers if they have had some experience in a 'direct' mental health program; it also includes social scientists if they have had some experience in a 'direct' mental health program." Question 9 was asked only of heads of public health and mental health programs. In question 13. A., statement 2, "other" was inserted after the word "with." In question 28. B., the phrase "and mental health agencies" was added to the introductory portion of the question. Question 28. C. was omitted.

What is your job title?

14-

What services are provided by the program or the part of the program for which you are responsible? (CIRCLE AS MANY AS APPLY.)

a.	Individual therapy	15- 1	a.	Communicable diseases	16- X
b.	Group therapy	2	b.	Chronic diseases	0
c.	Consultation on individual cases .	3	c.	Aging	1
d.	Periodic review of cases	4	d.	Dental health	2
e.	Consultation for programs	5	e.	Maternal and child health	3
f.	In-service training of other staff.	6	f.	Nursing	4
g.	Education of public	7	g.	Environmental sanitation	5
h.	Research	8	h.	Occupational health	6
i.	Other (SPECIFY) _____		i.	Health education	7
			j.	Hospitals and medical facilities . .	8
			k.	Vital statistics and research	9
			l.	Rehabilitation	17- X
			m.	Accident prevention	0
			n.	Juvenile delinquency	1
			o.	Drug addiction	2
			p.	Alcoholism	3
			q.	School health	4
			r.	Family service	5
			s.	Mental health in education	6
			t.	Crippled children	7
			u.	Health and welfare council	8
			v.	Local health services	9
			w.	Other (SPECIFY) _____	

3. What are the three most important problems that confront you in providing these services?

18-

19-

20-

---

4. What is the total number of persons under your own direction? (Include all persons paid from your department or clinic--clerical and professional persons.)

Less than 30	21- y
30-59	X
60-99	0
100-199	1
200-299	2
300-499	3
500-699	4
700-899	5
900-1,999	6
2,000-5,999	7
6,000-9,999	8
10,000 or more	9

ASK ONLY HEADS OF PUBLIC HEALTH AND MENTAL HEALTH DEPARTMENTS.

5. What is the total budget for your department for the current fiscal year?

Less than $50,000	22- y
$50,000-$99,999	X
$100,000-$199,999	0
$200,000-$499,999	1
$500,000-$999,999	2
$1,000,000-$1,499,999	3
$1,500,000-$1,999,999	4
$2,000,000-$2,999,999	5
$3,000,000 or more	6

A. To whom are you, officially, directly responsible?

B. To whom is (he)(she), officially, directly responsible?

C. And to whom is (he)(she), officially, directly responsible?

	A To whom you are responsible	B To whom (A) is responsible	C To whom (B) is responsible
a. Electorate*	23- y	25- y	27- y
b. Governor	X	X	X
c. Special State Board or Commission	0	0	0
d. Head, State Department of Public Health	1	1	1
e. Head, State Department of Mental Health (Hygiene)	2	2	2
f. Head, State Department of Institutions and Agencies	3	3	3
g. Head, State Department of Corrections and Institutions	4	4	4
h. Head, State Department of Welfare	5	5	5
i. Head, State Department of Health and Welfare	6	6	6
j. Head, State Local Health Services	7	7	7
k. Head, State Hospitals or Clinics	8	8	8
l. Other State Official (SPECIFY) _____	9	9	9
m. Mayor	24- y	26- y	28- y
n. City Manager	X	X	X
o. City or County legislative body	0	0	0
p. Special City or County Board or Commission	1	1	1
q. City or County Department of Public Health	2	2	2
r. City or County Department of Mental Health (Hygiene)	3	3	3
s. City or County Department of Welfare	4	4	4
t. City or County Department of Health and Welfare	5	5	5
u. Other Local Official (SPECIFY) _____	6	6	6
v. Private Board of Directors*	7	7	7
w. Dean of Medical School	8	8	8
x. Other non-governmental official (SPECIFY) _____	9	9	9

*NOTE: The Electorate and the Private Board of Directors may be considered to have final responsibility.

General note and definitions: We are especially interested in the use, if any, of mental health personnel, with their concepts and techniques, in health, or health related programs, outside of "direct" mental health programs. In order to be able to compare answers from different people, we must follow some specific and perhaps arbitrary definitions.

By "mental health personnel" we mean a person who is employed in an agency (hospital or community, public or private) full or part-time, and who has at least some professional training in one of the following fields: psychiatry, clinical psychology, psychiatric social work, psychiatric or mental health nursing, or mental health education. (This definition excludes persons in private practice, unless they spend some of their time in work with an agency.)

By "direct" mental health programs are meant agency programs in which the primary responsibility is either: 1) care, treatment or rehabilitation, on an in-patient or out-patient basis, of persons whose primary disorder has been labeled as mental or emotional disorder; or 2) mental health education and promotion for the general public; or 3) some combination of the above two types of functions. (Thus, a vocational rehabilitation agency which concerns itself with the rehabilitation of some mental patients does not have that responsibility as its primary or major function, and would not be defined as a "direct" mental health program. If mental health personnel talk with parent-teacher groups on occasion, that would be defined as part of a "direct" mental health program, but if they consult, provide in-service training or mental health education for the school or other agency program, that will be considered as the use of mental health personnel, with their concepts and techniques, in other health or health related programs.)

---

7. A. Is your (department)(clinic) currently recruiting or considering recruitment of any mental health personnel?

Yes	29-	1*
No		2
Don't know		3

*B. IF YES: For what position or positions?

30-

3. A. (FOR PUBLIC HEALTH PERSONNEL.)

1. Are there any mental health personnel, as defined earlier, with whom you personally have any dealings or interaction in the course of your professional work?

Yes . . . . . 31- y*
No X

*IF YES:

a. In what positions are they?

32-
33-

b. What is the purpose of the interaction?

34-
35-

B. (FOR MENTAL HEALTH PERSONNEL.)

1. Are there any public health personnel with whom you personally have any dealings or interaction in the course of your professional work?

Yes . . . . . 36- y*
No X

*IF YES:

a. In what positions are they?

37-
38-

b. What is the purpose of the interaction?

39-
40-

9. A. Is there a separately organized government office, department, bureau, or division which has primary responsibility for community mental health programs in (STATE) (LOCALITY)?

Yes . . . . . 41- y*
No X

*IF YES:

B. Please tell me in what year that was organized?

42-43-

C. Does this separately organized office perform any of these activities:

1. Clinical services?

Yes . . . . . 44- 1#
No 2

#IF YES:

a. In what year did that start?

45-46-

2. Case consultation?

Yes . . . . . 47- 4+
No 5

+IF YES:

a. In what year did that start?

48-49-

3. In-service training?

Yes 50- 7/
No 8

/IF YES:

a. in what year did that start?

51-52-

SK QUESTIONS 10 AND 11 ONLY OF HEADS OF PUBLIC HEALTH AND MENTAL HEALTH DEPARTMENTS.

10. In (STATE)(LOCALITY), please tell me, for each of the following "direct" mental health programs whether or not any personnel from each of the public health departments listed in the headings below are in any way involved. (CIRCLE AS MANY AS APPLY.)

BEGIN DECK 2

Program	Maternal and child health	Nursing	Health education	Vital statistics and records	Hospital and medical facilities	Local health	No such personnel used	No such (STATE)(LOCAL) program
a. Diagnosis 10-	1	2	3	4	5	6	7	8
b. Therapy 11-	1	2	3	4	5	6	7	8
c. Supportive services for patients receiving therapy 12-	1	2	3	4	5	6	7	8
d. Supportive services for families of patients 13-	1	2	3	4	5	6	7	8
e. Services for patients leaving or formally in mental hospitals. 14-	1	2	3	4	5	6	7	8
f. 24-hour emergency service 15-	1	2	3	4	5	6	7	8
g. Mental health education 16-	1	2	3	4	5	6	7	8
h. Utilization of nursing homes, half-way houses, sheltered work shops, etc. . 17-	1	2	3	4	5	6	7	8

11. A. Now, in general, in (STATE)(LOCALITY), would you please indicate the extent to which mental health personnel are utilized in each of the following (STATE)(LOCALITY) programs? (CIRCLE THE NUMBER OR NUMBERS UNDER THE APPROPRIATE HEADING OR HEADINGS FOR EACH PROGRAM; CIRCLE AT LEAST ONE NUMBER FOR EACH PROGRAM.)

B. FOR EACH PROGRAM IN WHICH MENTAL HEALTH PERSONNEL ARE BEING UTILIZED: What kind of mental health personnel is being used and what kind of service does he provide? (CIRCLE AS MANY AS APPLY FOR EACH PROGRAM; USE THE CHART ON THE FACING PAGE.)

Program	Full-time person(s) employed	Part-time person(s) employed	Frequent consultation (at least once a week)	Occasional consultation	In-service training	No utilization	Don't know	No program at (STATE)(LOCAL) level
a. Communicable diseases 19-	1	2	3	4	5	6	7	8
b. Chronic diseases 20-	1	2	3	4	5	6	7	8
c. Aging 21-	1	2	3	4	5	6	7	8
d. Dental health 22-	1	2	3	4	5	6	7	8
e. Maternal and child health 23-	1	2	3	4	5	6	7	8
f. Nursing 24-	1	2	3	4	5	6	7	8
g. Environmental sanitation 25-	1	2	3	4	5	6	7	8
h. Occupational health 26-	1	2	3	4	5	6	7	8
i. Health education 27-	1	2	3	4	5	6	7	8
j. Hospitals and medical facilities 28-	1	2	3	4	5	6	7	8
k. Vital statistics and research 29-	1	2	3	4	5	6	7	8
l. Rehabilitation 30-	1	2	3	4	5	6	7	8
m. Accident prevention 31-	1	2	3	4	5	6	7	8
n. Juvenile delinquency 32-	1	2	3	4	5	6	7	8
o. Drug addiction 33-	1	2	3	4	5	6	7	8
p. Alcoholism 34-	1	2	3	4	5	6	7	8
q. School health 35-	1	2	3	4	5	6	7	8
r. Family service 36-	1	2	3	4	5	6	7	8
s. Mental health in education 37-	1	2	3	4	5	6	7	8
t. Crippled children 38-	1	2	3	4	5	6	7	8
u. Health and welfare council 39-	1	2	3	4	5	6	7	8
v. Local health services 40-	1	2	3	4	5	6	7	8
w. Public assistance 41-	1	2	3	4	5	6	7	8
x. Correctional and penal system 42-	1	2	3	4	5	6	7	8

1. B.

Program		No such program or No utilization of mental health personnel or Don't know	Kind of Profession: Psychiatrist	Psychologist	Social worker	Nurse	Educator	Don't know	Kind of Service: Program consultation	Case consultation	Direct diagnostic services	Direct therapeutic services	In-service training	Other (SPECIFY)
a. Communicable diseases . .	44-	R	y	X	0	1	2	3	4	5	6	7	8	9
b. Chronic diseases	45-	R	y	X	0	1	2	3	4	5	6	7	8	9
c. Aging	46-	R	y	X	0	1	2	3	4	5	6	7	8	9
d. Dental health	47-	R	y	X	0	1	2	3	4	5	6	7	8	9
e. Maternal and child health	48-	R	y	X	0	1	2	3	4	5	6	7	8	9
f. Nursing	49-	R	y	X	0	1	2	3	4	5	6	7	8	9
g. Environmental sanitation .	50-	R	y	X	0	1	2	3	4	5	6	7	8	9
h. Occupational health . . .	51-	R	y	X	0	1	2	3	4	5	6	7	8	9
i. Health education	52-	R	y	X	0	1	2	3	4	5	6	7	8	9
j. Hospitals and medical facilities	53-	R	y	X	0	1	2	3	4	5	6	7	8	9
k. Vital statistics and research	54-	R	y	X	0	1	2	3	4	5	6	7	8	9
l. Rehabilitation	55-	R	y	X	0	1	2	3	4	5	6	7	8	9
m. Accident prevention . . .	56-	R	y	X	0	1	2	3	4	5	6	7	8	9
n. Juvenile delinquency . . .	57-	R	y	X	0	1	2	3	4	5	6	7	8	9
o. Drug addiction	58-	R	y	X	0	1	2	3	4	5	6	7	8	9
p. Alcoholism	59-	R	y	X	0	1	2	3	4	5	6	7	8	9
q. School health	60-	R	y	X	0	1	2	3	4	5	6	7	8	9
r. Family service	61-	R	y	X	0	1	2	3	4	5	6	7	8	9
s. Mental health in education	62-	R	y	X	0	1	2	3	4	5	6	7	8	9
t. Crippled children	63-	R	y	X	0	1	2	3	4	5	6	7	8	9
u. Health and welfare council	64-	R	y	X	0	1	2	3	4	5	6	7	8	9
v. Local health services . .	65-	R	y	X	0	1	2	3	4	5	6	7	8	9
w. Public assistance	66-	R	y	X	0	1	2	3	4	5	6	7	8	9
x. Correctional and penal system	67-	R	y	X	0	1	2	3	4	5	6	7	8	9

ASK EVERYONE FOLLOWING QUESTIONS:

12. Now we are interested in your own considered judgment about what use should be made of mental health personnel, as defined earlier, in the programs in (STATE)(LOCALITY). Please answer in terms of realistic developments which could take place within the next five years.

A. First, to what extent do you think mental health personnel should be used, if at all, in each of the programs listed?

BEGIN DECK 3

Program	Full-time person(s) employed	Part-time person(s) employed	Frequent consultation (at least once a week)	Occasional consultation	In-service training	No utilization	Don't know	No program at (STATE) (LOCAL) level
a. Communicable diseases 10-	1	2	3	4	5	6	7	8
b. Chronic diseases 11-	1	2	3	4	5	6	7	8
c. Aging 12-	1	2	3	4	5	6	7	8
d. Dental health 13-	1	2	3	4	5	6	7	8
e. Maternal and child health 14-	1	2	3	4	5	6	7	8
f. Nursing 15-	1	2	3	4	5	6	7	8
g. Environmental sanitation 16-	1	2	3	4	5	6	7	8
h. Occupational health 17-	1	2	3	4	5	6	7	8
i. Health education 18-	1	2	3	4	5	6	7	8
j. Hospitals and medical facilities 19-	1	2	3	4	5	6	7	8
k. Vital statistics and research 20-	1	2	3	4	5	6	7	8
l. Rehabilitation 21-	1	2	3	4	5	6	7	8
m. Accident prevention 22-	1	2	3	4	5	6	7	8
n. Juvenile delinquency 23-	1	2	3	4	5	6	7	8
o. Drug addiction 24-	1	2	3	4	5	6	7	8
p. Alcoholism 25-	1	2	3	4	5	6	7	8
q. School health 26-	1	2	3	4	5	6	7	8
r. Family service 27-	1	2	3	4	5	6	7	8
s. Mental health in education 28-	1	2	3	4	5	6	7	8
t. Crippled children 29-	1	2	3	4	5	6	7	8
u. Health and welfare council 30-	1	2	3	4	5	6	7	8
v. Local health services 31-	1	2	3	4	5	6	7	8
w. Public assistance 32-	1	2	3	4	5	6	7	8
x. Correctional and penal system 33-	1	2	3	4	5	6	7	8

12. Continued

12. Continued

B. Please tell me which three of the above programs you believe <u>most</u> need increased services of mental health personnel in (STATE)(LOCALITY). (USE THE IDENTIFYING LETTERS.)

1. Program _____ 34-35-

2. Program _____ 36-37-

3. Program _____ 38-39-

C. Why do you say each of those programs most need increased services?

1. 40-

2. 41-

3. 42-

13. A. Below are seven statements concerning possible arrangements between mental health and other health, health related, and welfare programs.

Please indicate which statement comes closest to expressing your opinion about the best possible relationship in (STATE)(LOCALITY). Which is next best? And which is third best? (CIRCLE THE NUMBER FOR THE STATEMENT WHICH IS RANKED FIRST IN COLUMN 43, THE SECOND IN COLUMN 44, AND THE THIRD IN COLUMN 45.)

1. Mental health activities are very distinctive and should be organized into separate programs.

2. Mental health activities should be separately and autonomously organized but have provision for consultation with programs regarding special problems.

3. Mental health activities should be separately and autonomously organized, but should have provision for regular and frequent liaison with other programs.

4. Mental health activities are a part of public health and should be a division in the department of public health.

5. There should be a distinct mental health unit within one of the (STATE)(LOCAL) agencies, with a small staff, and other mental health personnel should be assigned to other agencies for varying periods of time.

6. Mental health relates to all programs of health and welfare and mental health personnel should be dispersed among these various programs, with the provision that they meet for periodic conferences, perhaps with a chairman.

7. It really does not matter where the mental health group is placed or who the "mental health authority" is, provided there is an identifiable group and they are willing to work with other agencies as needs and time permit.

First choice:	43- 1	2	3	4	5	6	7
Second choice:	44- 1	2	3	4	5	6	7
Third choice:	45- 1	2	3	4	5	6	7

B. Which statement comes closest to describing the present situation in your (STATE)(COMMUNITY)?

46- 1 2 3 4 5 6 7

14. A. Each profession and group of professions have their particular way of looking at matters related to their work. From your own experience and from what you have heard, what differences are there in approach between public health and mental health personnel that sometimes pose problems for cooperation between them?

47-

B. With respect to the effectiveness of health or health related programs, do you think that such problems are an advantage or a disadvantage?

Advantage 48- 1

Disadvantage 2

C. Aside from differences in orientation, what disadvantages are there in having mental health personnel working in health or health related programs (i.e., outside of "direct" mental health programs)?

49-

15. A. How important do you consider each of the following factors are as barriers to the more effective use of existing mental health personnel in your (STATE)(LOCAL) health and welfare programs? (CIRCLE ONE NUMBER FOR EACH POSSIBLE BARRIER.)

		Very important	Somewhat important	Not at all important	Don't know
1.	Manpower shortage 50-	1	2	3	4
2.	Inadequate tax base, lack of resources . . 51-	5	6	7	8
3.	Differences in orientation and values between mental health and public health personnel 52-	1	2	3	4
4.	Unclear division of responsibility between agencies--"jurisdictional disputes" . . . 53-	5	6	7	8
5.	Inappropriate use of personnel 54-	1	2	3	4
6.	Inadequate agency assessment of need . . . 55-	5	6	7	8
7.	Resistance of tax appropriating bodies . . 56-	1	2	3	4
8.	Resistance of executive branch leadership . 57-	5	6	7	8
9.	Lack of public support 58-	1	2	3	4

B. IF ANY BARRIER MENTIONED AS VERY IMPORTANT:

We would appreciate your judgment as to what should be done to improve the situation; that is, what could be done to reduce these barriers?

1. 59-

2. 60-

3. 61-

4. 62-

5. 63-

6. 64-

7. 65-

8. 66-

9. 67-

BEGIN DECK 4

5. In what ways do you think that the Public Health Service of the Federal Government can be of more help in bringing about more appropriate use of mental health personnel in your (STATE)(LOCAL) health and health related programs?

10-

---

7. FOR STATE OFFICIALS ONLY:

A. Where is the "mental health authority" located in (STATE)?

B. Where do you think the "mental health authority" should be located?

	A. Where it is	B. Where it should be
Department of Mental Health (Hygiene)	11- 1	12- 1
Department of Public Health	2	2
Department of Welfare	3	3
Department of Public Health and Welfare	4	4
Department of Corrections and Institutions	5	5
Department of Institutions and Agencies	6	6
Other (SPECIFY) _____		

C. IF A DIFFERENT LOCATION IS PREFERRED TO THE ACTUAL ONE: Why do you think the other location is better?

13-

---

8. A. Do you think the institutional and the community mental health programs in this State should be in the same department or in separate departments?

NOTE: Question refers to public agencies only; institutional refers to mental institutions only.

Same	14- 1
Separate	2
Don't know	3

B. Why do you think they should be in (the same)(separate) departments?

15-

19. A. Would you say the mental institutional program in this State has:

(a) Close relations with public health departments generally 16- 1

(b) Close relations with a specific part or parts of public health departments, such as nursing, community clinics, or hospital inspection 2

(c) Few or no relations with public health departments 3

B. Which of the three alternatives do you consider most desirable?

(a) Close relations with public health departments generally 17- 6

(b) Close relations with a specific part or parts of public health departments, such as nursing, community clinics, or hospital inspection 7

(c) Few or no relations with public health departments 8

(d) Don't know 9

20. Now, a question about new developments in your (STATE)(LOCAL) programs:

A. In the past three years, have there been any changes or new developments in the use of mental health personnel in health or health related programs, aside from mental health programs per se?

Yes . . . . . 18- y*

No X

Have no idea . . . 0

*B. IF YES: Please describe the new developments briefly.

19-

20-

C. IF MORE THAN ONE DEVELOPMENT IS MENTIONED: Which one would you say is the most important?

21-

QUESTION 20 CONTINUED ON FACING PAGE.

). Continued

D. Please tell me what persons or organizations were involved in the origin of the (most important) new development.

22-

E. Were there special pressures from the public or from a special group in your (STATE)(COMMUNITY)?

Yes . . . . . 23- 1#
No 2

#IF YES: What group(s)?

24-

F. How was the new development funded?

25-

G. Were other programs dropped or curtailed as a result of this new development?

Yes . . . . . 26- 8+
No 9

+IF YES: Which one(s)?

27-

NOTE: Up to now we have been considering mental health personnel in programs other than mental health ones. Now we have some questions about the use of mental health personnel in all programs, including "direct" mental health programs.

21. A. Bearing in mind the present supply of mental health personnel, but disregarding their present use, please rank the following functions of mental health personnel according to your judgment of what should be their importance. (RANK ALL THE ITEMS. WRITE IN NUMBER TO INDICATE RANK.)

1. Mental health education for the public . . . . . 28-____
2. Consultation with other public health or health related agencies . . . . . 29-____
3. Counseling or guidance for people with emotional problems . . . . . 30-____
4. Individual therapy of persons with manifest psychotic or neurotic symptoms; provision of clinical services . . . . . 31-____
5. Research or program evaluation . . . . . 32-____
6. Community development . . . . . 33-____
7. In-service training for staffs of other agencies . . . . . 34-____
8. Provision of follow-up and other rehabilitative services . . . . . 35-____
9. Case finding, diagnosis and referral of persons to whatever therapy resources are available . . . . . 36-____

B. Are there any other uses of mental health personnel which you think are as important as those on the list above?

Yes 37- 8*

No 9

*IF YES:

a. What is that?

38-

C. Considering the function you have ranked as the most important one, please tell me whether each of the following kinds of mental health personnel would be essential to the performance of that function, would be adequate, or would make little or no contribution:

		Essential	Adequate	Little or no contribution	Don't know
1. Clinical psychologist	39-	1	2	3	4
2. Mental health nurse	40-	1	2	3	4
3. Mental health educator	41-	1	2	3	4
4. Psychiatrist	42-	1	2	3	4
5. Social scientist	43-	1	2	3	4
6. Psychiatric social worker	44-	1	2	3	4

D. Finally, in which one government agency do you think personnel serving that function could be most advantageously employed?

45-

22. Among the possible arrangements for meeting mental health needs in local communities or--in sparsely populated areas--regions, which one of the following should have the highest priority?

1.	Local health centers, including mental health centers	46- 1
2.	Separate mental health centers	2
3.	Separate mental health clinics	3
4.	Separate child guidance clinics	4
5.	Working through other agencies to effect treatment	5

---

23. Do you think the needs for mental health personnel in public agencies will increase greatly, increase somewhat, stay about the same, or decline in the next five years?

Increase greatly	47- 1
Increase somewhat	2
Stay about the same	3
Decline	4
Don't know	5

---

24. Excluding care for the institutionalized mentally ill, should the "direct" mental health agency programs of your (STATE)(LOCALITY) be financed primarily by tax supported agencies, primarily by privately supported agencies, or about equally by both?

(NOTE: "Mental health needs" refers to needs for therapy and for prevention.)

Primarily tax support	48- 1
Primarily private	2
About equally	3

---

25. A. Apart from questions of financing in this State, should programming for treatment of fully institutionalized persons be exclusively a State government responsibility, primarily a State government responsibility, shared about equally between State and local governments, primarily a local government responsibility, or exclusively a local government responsibility?

B. What about treatment of the mentally ill in day hospitals, night hospitals, half way homes, and foster homes?

C. Finally, what about treatment of mentally ill in clinics?

	A. Institutionalized	B. Semi-Institutionalized	C. Clinics
Exclusively State	49- 5	50- 5	51- 5
Primarily State	6	6	6
Shared about equally	7	7	7
Primarily local	8	8	8
Exclusively local	9	9	9

26. Considering the relationship among the Federal, State, and local government agencies as they are at present, do you think the Federal government should have more, less, or about the same amount of leadership it now has in the field of mental health?

Federal government should have more	52- 4
Federal government should have less	5
Should remain as it is	6
Don't know	7

---

27. Which statement comes closest to expressing your judgment:

1. Emotional problems are so complex that only persons who have been especially trained for many years can give help which will not do more harm than good	53- 8
2. Although emotional problems are very complex, persons with even a little training--and good common sense--can provide considerable help to many people	9

---

28. Finally, I want to ask you some questions about what the mission of public health departments should be, whether at the local, State, or Federal level.

A. First, do you think public health departments should be

1. concerned primarily with preventive programs, leaving actual treatment to other public agencies or private practitioners	54- 0
2. although maintaining its present preventive functions, it should assume more responsibility for the actual treatment of patients	1
3. although maintaining its present preventive functions, it should greatly increase its treatment activities	2

B. In the case of non-institutionalized persons with severe personality disturbances which seriously interfere with work or marital relations, should public health agencies

1. not try to provide actual therapy, but work on programs which will reduce the incidence of such illnesses (e.g., counseling in well-child clinics) or which will create a climate supportive for seeking therapy (e.g., public education campaigns)	55- 4
2. place major emphasis upon preventive programs, but provide some therapeutic services	5
3. maintain preventive programs, but provide extensive therapeutic services	6

C. For such severely disturbed, non-institutionalized persons, if public health agencies provide any therapy, should it be

1. available to all who ask for it on a first come first served basis	56- 8
2. restricted to indigent persons	9

. What is your age?

57-58-

. Respondent's sex.

Male . . . 59- 8
Female . . 9

. A. What degrees, if any, have you earned beyond high school?

B.A., B.S. 60- 1
M.A. 2
Ph.D. 3
M.D. 4
M.P.H. . . . . 5 *
Other (SPECIFY) _____

*B. IF YOU HAVE EARNED A DEGREE IN PUBLIC HEALTH: What university granted the degree in public health?

University of California (Berkeley) . . . . . 61- y
Columbia University X
Harvard University 0
Johns Hopkins University 1
University of Michigan 2
University of Minnesota 3
University of North Carolina 4
University of Pittsburgh 5
University of Puerto Rico 6
Tulane University Medical School 7
Yale University 8
Other (SPECIFY) _____ 9

. What do you consider to be your major professional field?

Public health 62- 0
Pediatrics 1
Public health nursing . . . 2
Biostatistics 3
Mental health nursing . . . 4
Psychiatry 5
Psychiatric nursing 6
Clinical psychology 7
Psychiatric social work . . 8
Administration 9
Other (SPECIFY) _____

33. How many years have you been employed in your professional field?

Fewer than 2 years . .	63-	1
2-4 years		2
5-9 years		3
10-14 years		4
15-19 years		5
20-24 years		6
25-29 years		7
30 or more years . . .		8

34. How many years have you been employed in your present job?

Fewer than 2 years . .	64-	1
2-4 years		2
5-9 years		3
10-14 years		4
15-19 years		5
20-24 years		6
25-29 years		7
30 or more years . . .		8

35. Have you ever been employed in-- (CIRCLE AS MANY AS APPLY.)

a. private practice	65-	1
b. a non-governmental hospital		2
c. an other non-profit, non-governmental organization		3
d. a business organization		4
e. a Federal governmental organization		5
f. a State governmental organization		6
g. a City or County governmental organization		7

36. Have you had any additional training beyond your highest degree through any of the following methods?

a. In-service training	66-	1
b. Night school or special courses		2
c. School of Public Health		3
d. Formal full-time training at graduate level, but not leading to a degree		4

37. A. Did you look through a copy of this questionnaire before the interview?

Yes	67-	1
No		2

B. Did you discuss the questionnaire with any colleagues?

Yes	68-	4
No		5