

POLLING PUBLIC OPINIONS:
A PILOT STUDY IN MARKETING MENTAL HEALTH

By

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ABSTRACT

This paper provides preliminary information on consumer opinions and perceptions on various mental health issues. Recognizing that citizen in-put is an essential marketing tool for responsive and accountable program planning, the Canadian Mental Health Association - B.C. Division, is in the process of acquiring consumer data as part of its information bank. This pilot study has provided a 'dry run' of what is expected for future research projects. Through telephone interviews with 46 Vancouver City telephone subscribers and mail-out questionnaires to 46 community service personnel, the Canadian Mental Health Association was able to acquire some relevant information to aid in its decision-making process for planning mental health educational programs. The majority of survey respondents, for example, feel that information on coping with stress is the most important to them while information on the more serious mental disorders, such as schizophrenia, is least important. This has important implications for program planning if the organization is to enlist public support and market its services to a broader clientele. Focusing on promoting mental health and functional competence versus mental illness focused is recommended if the Canadian Mental Health Association hopes to attract normal population groups as its consumers. Furthermore, learning through friendship and familial support is the most desirable, and helping professionals should not place too much emphasis on pamphlets alone as an educational tool. Other implications arising from the consumer data are discussed in this paper. For the most part, the consumer data has served to verify assumptions about what decision-makers already know ... but the research process is able to ground such assumptions into fact ... and this helps to further legitimize and speed up action. This pilot study serves as an initial starting point for the organization in its attempt to incorporate consumer research as part of its overall planning process.

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INTRODUCTION

Information about consumers and potential consumers can be used as a valuable marketing tool in the health and social services. Consumer data can be used to guide decisions about a broad range of issues such as program design, service distribution and methods of service delivery. As such, the strategy of conducting consumer research can be used to generate public support while also generating useful information for program planning.

Chapter I of this paper introduces consumer research within the broader context of marketing. Marketing involves numerous components of which research is but one element. Human service agencies tend to neglect consumer research, despite its relevance in developing objective and responsive community programs. While some attempts have been made to address this problem, improvement is still needed. Chapter I further discusses the uses and benefits of consumer data and its value to social work.

The Canadian Mental Health Association - B.C. Division, is one non-profit voluntary organization which recognizes the need to acquire the opinions, attitudes and perceptions of its consumers and potential consumers. As such, the author undertook the role of research consultant and enabler in this agency, with the task of collecting consumer data as a pilot study for the organization. Chapter II provides a description and analysis of this

integrated community practice-research process.

Chapter III sets this research project in context. The issues of concern are: what are the opinions and perceptions of the organization's potential consumers that can help guide program planning? What direction should the organization take in terms of future direction for mental health education? Specific objectives of the pilot study are identified in this chapter. A theoretical orientation and definition of concepts relevant to the research are also discussed, along with a description of previous research related to this study.

An overview of the research design is presented in Chapter IV. The sampling design, methodological orientation and data collection method are detailed in this chapter. Other issues such as pre-testing, validity and reliability, ethical considerations and data analysis plan are also included here. Finally, limitations of the study are identified.

Chapter V is a summary of the survey results. The results are presented in a format that sets out to answer specific questions which the study was designed to address:

- 1) Is the public familiar with C.M.H.A.?
- 2) What mental health information is important to users and potential users and how, in their view, can it best be provided?
- 3) What are the most difficult problems in living experienced by the people in the community?
- 4) What are the public's thoughts and opinions about mental health and illness?
- 5) Is there community support for mental health education and information programs?

Finally, Chapter VI attempts to draw conclusions from the consumer data and presents possible implications for program planning and marketing strategies. Some recommendations for future research are suggested, but the direction for future research will largely depend on what decision-makers feel is important given findings from this study, available resources and other priorities. For the most part, C.M.H.A. - B.C. Division is headed in the right direction in planning mental health educational programs ... but much more needs to be done.

I. CONSUMER RESEARCH AS A MARKETING TOOL

INTRODUCTION

The need to provide accountability and to acquire information for developmental planning is the basis behind a growing trend in the application of social research and evaluation in the human service setting.

The human service professions, however, unlike the business professions, often neglect to seek advice or feedback from consumers or potential receivers of service. The deliberate search for consumer ideas and opinions is an effective marketing tool for promoting programs and services.

The purpose of this section is to introduce the general concept of marketing in the human services, and the relevance of consumer research as a component of marketing. The problem, however, is that acquiring consumer opinion, attitude and perceptions has not been a major priority for practitioners. While there has been a growing concern and response in this area, greater efforts are required to improve public communication between service providers and receivers. Researching the consumer has other major implications beyond a marketing function. Issues of accountability, credibility, financial and community support, as well as program effectiveness are addressed when program planners and administrators turn to their consumer and ask such questions as "what are your

opinions and perceptions in this area? What should our organization be concerned with?" As practitioners, social workers have an increasing responsibility to engage in or at least support consumer research and this is briefly discussed in this section.

MARKETING IN THE HUMAN SERVICES

A marketing approach to program delivery is a relatively new idea in the health and social services. Marketing has normally been associated with 'selling' and therefore alien to the 'noble' mission of non-profit organizations (Roberts & Roberts, 1985). However, economic restraints of the 80's in Canada and elsewhere have meant that planning and strategic management have become very important issues in the human services. Marketing, in this sense, has assumed a new orientation.

Marketing is used for the purpose of achieving organizational objectives. It is not, as Phillip Kotler declares, hucksterism; the real meaning is the concept of sensitivity serving and satisfying human needs (Kotler, 1975). Kotler defines marketing as the analysis, planning, implementation and control of carefully formulated programs --- marketing has become very much a system for the implementation of objectives. It is a systematic approach to establishing, cultivating and maintaining mutually beneficial relationships with those people you wish to reach (Kotler, 1975). Therefore, rather than concerned with selling, marketing has become a management function which takes planning, organizing, and funding considerations into account. It requires analysis and understanding of the needs, perceptions

and preferences of target markets. By marketing 'viable' projects, organizations are given a more legitimate and positive image.

As a management function, marketing is a set of activities concerned with research, planning, program development and implementation. More importantly, it is a bridge linking the organization with its external environment (Lovelock & Weinberg, 1984), thereby acknowledging consumers, potential consumers and other constituents as valuable resources to the organization.

MARKETING COMPONENTS

According to Rubright and MacDonald (1981), marketing generally consists of nine components:

1. selecting and preparing the marketing project
2. internal and external research
3. the market audit
4. setting objectives
5. targeting
6. strategies
7. special promotional tools
8. internal adjustments
9. evaluation/recycling

Marketing is a broad and complicated process and is an equally lengthy subject area. It is not within the scope of this paper to encompass the entire process of marketing. Instead, the external research element of the marketing plan is the major focus of this paper.

The external research aspect of marketing also contains many different perspectives and components. Research can take the form of collecting and analyzing existing data, informally turning to various agencies and

organizations as a source of information, approaching, exploring and observing the characteristics of different groups and individuals in the population. Information can be obtained in a number of different ways, but usually the methods chosen are determined by the resources of the agency in need of the information.

CONSUMER RESEARCH

Only by acquiring an extensive knowledge about consumers is it possible to influence and persuade them in various ways. Needs assessments, community surveys, polling, analyses and interviews are all embodied in the external research component. These research methods play an important role in helping planners and administrators to understand current, potential and former consumers. It also helps to provide information on consumers' awareness of and attitudes toward the organization and its offerings. Such information is a key factor to influencing the choice and nature of product markets (Lovelock & Weinberg, 1984).

In a community survey of 176 respondents, information was collected about the relative salience for the public of concerns at various sociopolitical levels (Plantz, 1980). Respondents were asked to express their hopes and fears related to personal and family considerations, neighborhood and community conditions, and larger societal issues. The objective of the community survey was to demonstrate that the application of the acquired citizen information, from a social marketing perspective, could be used in the design of promotional strategies for human service programs. Measuring

public opinion would therefore provide a description of public support which is necessary in the development of responsive programs. Plantz states that if human service program promoters are to be effective in eliciting public support for their programs, then according to social market principles, they must identify those program values or benefits that are most salient for the public.

Research findings from the Plantz study illustrated that concern for self and primary relationships dominated both hopes and fears of respondents, while concern for broader sociopolitical issues were expressed only by a small minority. From these findings, Plantz recommended that promoters of human service programs, seeking supportive public behavior, should devise promotional strategies that do not depend on the salience of broader sociopolitical concerns for the public. Instead of promoting programs on the basis of their societal impact, promotional strategies for human service programs might focus on the potential personal benefits to be gained.

A marketing approach, through consumer research, can guide decisions about a broad range of issues such as program design, service distribution and methods of service delivery. Such a strategy aims to generate public support while also generating useful information for program planning. Public support can be translated as financial contributions, votes, commitments of time, verbal approval or some other behavior. Support from the public is essential for the implementation and ultimate success of human service programs.

THE PROBLEM

Marketing is not a widely accepted practice in the human services and therefore external research has not been a high priority as a strategy to planning.

Even research for the sake of acquiring useful information, independent of any marketing initiatives, is seldom conducted in health and social service settings. Consumerism has not yet been fully recognized in these arenas.

Consequently there is a need to try out ways of obtaining citizen in-put into social programs in general, and mental health education in particular. This section presents arguments for this type of undertaking, and some reasons why citizen in-put has seldom been obtained.

A continuing dialogue between citizens and professionals is necessary in order to maintain objectivity in identifying needs which are responsive to the community. Given the continuing decline of resources, a greater number of health and social service agencies must begin to closely scrutinize their priorities and responsibilities. It has become essential that these organizations ask themselves if they are addressing the needs and interests of the client population. Establishing communication with the consumer, vis-a-vis community need assessments, surveys and polls, will assist these agencies to formulate more efficient and accountable community programs.

Reid and Smith (1978) define consumer data as the attitudes, opinion and perceptions of program recipients ... and that such data are obtained directly from the consumer through questionnaires, interviews and the like... and are direct expressions of the consumer's point of view. Consumer research serves to give the citizen decision-making power in program planning; but more importantly it serves to give the program planner greater power to take action.

Usually there has been an imbalance in power and information between providers and consumers in the health and social services. Professionals in the system tend to implement programs and services they perceive as appropriate based on their experience or expertise. Or these professionals, in their enthusiasm to identify a need, may often overestimate its size or mistake its character (Rossi, Freeman and Wright, 1979).

In reference to Community Mental Health Centres, Dinkel, Zinober and Flaherty (1981) assert that citizen participation has been a neglected potential to program planning and evaluation. They underscore the need to include citizen in-put to program planning because: 1) the values and perceptions of citizens and professionals can differ and conflict, and 2) there may be a tendency for professionals to bias programs toward their own self interests. Consequently, citizen in-put will address differences and balance biases which will lend to more objective and responsive community programs.

Multiple studies have demonstrated that opinions and perspectives of clients, caregivers and others differ regarding various agency services, goals and other organizational aspects (Windle & Paschall, 1981). Generally, citizen participation has been argued to assist in devolving power to citizens and reducing alienation, as well as improving effectiveness. Nevertheless, community in-put and a responsibility to acquire consumer data is rarely a priority for most human service agencies.

Acquiring consumer data shows an effort on the part of human service agencies to relate effectively to the environment they serve. In a survey of 220 community mental health centres, Cibulka (1981) concluded that these mental

health centre boards have not placed great effort on the function of public communication with community and civic organizations, local professional organizations, other human service organizations, residents and consumers. Regretably, Cibulka remarks, public communication has not been one of their major responsibilities (Cibulka, 1981: 31).

Many obstacles can be identified as preventing these organizations from conducting consumer research. The lack of time and financial resources preclude many organizations from implementing any such activities. The growing demand for service output and other more critical responsibilities are major obstacles to any commitment to conduct research of any nature. The lack of adequate manpower and expertise also hinder any motivation to assessing the attitude and opinion of the consumer. Similarly, where research expertise is available, working relationships between practitioners and researchers have not always enjoyed the most positive or utmost success. As such, the outcome of these efforts have not always been maximized to their greatest potential.

RESPONSE TO THE PROBLEM

An increasing sensitivity to the service needs of the community has developed in recent years, and human service providers have endeavoured to respond to those needs more effectively. The existing range of literature on needs assessments, for example, is an indication that assessing community needs is a growing practice in response to more effective service delivery (Jaffe,

1982; Moroney, 1977; Neuber, Atkins, Jacobson & Reuterman, 1980; Warheit, Bell & Schwab, 1976; Witken, 1984). Organizations, as such, are beginning to respond to the issue of acknowledging community in-put in program planning and goal setting.

There is a wide range of meaning attributed to the term 'needs assessment' and, in fact, some say that almost anything can pass for a needs assessment (Royse & Druse, 1982). A needs assessment can consist of epidemiological surveys, social indicator analysis, key informant interviews, community forums, rates under treatment methods; client or general population surveys. Needs assessment is not a unitary concept, but one that encompasses a variety of techniques and can be used for a variety of purposes. Collecting data directly from the consumer is only one method of acquiring important informational in-put for planning and administrative purposes. Despite the diverse methodologies and inherent problems in specifically conceptualizing needs assessments, there is consensus that the process itself is considered analogous to problem definition. One does not 'assess needs', but undertakes to look at problems --- problems in relation to resources, individual and group desires, and priorities (Stewart, 1979).

The emphasis on needs assessments and its subsequent outgrowth of literature on the subject was influenced by the Community Mental Health Centre Amendments of 1975 in the United States. This Amendment required that all community mental health centres spend at least 2% of their total budget in carrying out evaluation (Thackeray, Skidmore & Farley, 1979). While there is no such legislated evaluation program in British Columbia for mental health services, it is expected that evaluations be carried out on a yearly basis.

Continued funding for services is dependent upon annual appraisals of the service.

Appraisals of service, however, often consist of measuring system outputs, counting numbers of recipients and beneficiaries, and assessing cost-savings by altering eligibility requirements (Graycar, 1979). As such, evaluations need not be very comprehensive and therefore may ignore client feedback as an essential feature of evaluation. Consulting with the larger community beyond the client population is even further warranted.

Organizations, as mentioned previously, often lack the time, financial and professional resources to conduct comprehensive assessments. Despite the real and attempted moves by many agencies to conduct consumer research, improvement in this area is still needed.

USES OF CONSUMER DATA

Consumer data can serve to address several issues related to the planning and administration of programs and services in the human services. Increasing pressure on program administrators to provide accountability data for present and proposed programs have meant that assessing consumer needs and public support is a necessary function. When this information is presented to the community through radio, newspapers and other public presentations, a further measure of accountability is established.

Consumer data can also be used as a tool in the competition of resources. Dinkel et. al. (1981) refer to this as an advocacy role of information where citizens can provide credibility to the need for particular services.

Program administrators and decision-makers are sometimes seen as advocating for a particular program/service for their own self-interests. Acquiring the opinion and perspective of the citizen consumer adds a more credible dimension to the need for service.

Consumer in-put can be a highly useful means of locating trouble spots in a program or in providing confirming evidence about suspected areas of difficulties (Reid & Smith, 1978). Furthermore, client suggestions about program development or improvement can especially be helpful in providing a different viewpoint apart from the biases of the professional. In their effort to collect information from citizens, agencies reflect the image of wanting to improve their programs based on the feedback they receive.

Such information can help to guide program managers to improve the effectiveness of their programs. Issues of accountability, credibility, financial and community support are also addressed through consumer research.

Consumer research can assist to address more specific issues which certain organizations may be concerned with. Some of these issues are presented as follows:

- . What groups in the population need service?
- . Which segments of the population should the agency be addressing?
- . What are the organizations strengths and weaknesses?
- . How is the organization perceived by the community?
- . What does the client really need or want?
- . What should be changed to make this program more effective?
- . What future directions should the organization take in terms of programs/services/products? What should the organization be concerned with?
- . What are the people's opinions and attitudes?
- . What strategy should the organization use to develop future programs to reach clients?

Program planners and administrators are the major stakeholders involved with the issues identified above. To show that they are concerned with such questions, and their willingness to seek answers to them, further legitimizes financial and community support.

Similarly, the receivers of service are also involved with and affected by these issues. Unless clients and consumers are willing to participate in the provision of information needed by administrators and researchers, two-way dialogue cannot be successfully achieved. Therefore, for citizens to express their attitude, opinions and perceptions in an open and honest manner also indicates a concern on their part for the issues under study.

THE VALUE OF CONSUMER RESEARCH TO SOCIAL WORKERS

In the broader context of research, most social work practitioners have preferred to opt out from this area of practice. Social workers are better known for their clinical skills, community development skills, or administrative skills. Social work practice has usually been regarded as a distinct entity from social research.

Problems in the adequate provision of services to clients can result without an attempt to integrate at least some research principles into practice on the part of the practitioner. In a study to evaluate a group of anti-delinquency projects, an action-research organization was formed to provide the human dimension for urban renewal by planning and conducting a broadly defined program of community development (Aronson & Sherwood, 1977). A discussion of the study focussed on the relationship between the research

unit and the people responsible for designing and implementing the multi-service programs (not all social workers). It was found that the greatest source of discord among researchers and designers of programs "was the latter's preoccupation with the components of programs without reference to their objectives ... it seems only logical to specify the changes that will be sought before devising strategies to produce those changes, the designer of programs typically begins with the details of the program without first defining the kinds of changes that are the intervention targets" (Aronson & Sherwood, 1967:91). These findings would seem to indicate that social workers, as program planners, can learn to design better programs with some understanding of research principles. Practitioners often experience difficulty identifying specific goals for their program --- especially goals that can be defined in terms that can be operationalized and measured.

The Aronson and Sherwood study further confirmed that the researchers encountered little empathy or understanding from the human service practitioners. Attempts to obtain client information for evaluation purposes were met with refusals for fear of violating confidentiality between the client and social service worker. Researchers also experienced some opposition or resistance when they attempted to establish new programs without consulting program designers. This further affected the eventual success of such programs. "Much of the tension between researchers and practitioners resulted from the failure to convince the practitioners that what was being evaluated was the impact of a program and not their ability or competence (Aronson & Sherwood, 1967:94). The research-practice gap between practitioners and researchers is not a new phenomena and improvements in this area have been addressed in the literature (Patton, 1978; Tash & Stahler, 1982; Weiss, 1972).

The majority of social workers will, at some point in their careers, encounter some aspect of research practice: either as researchers themselves, as subjects of research, or as the receivers of research recommended program changes. It is therefore essential that social workers understand the dynamics of research, its concepts and principles. As research and evaluation are becoming inevitable components of the human services, social workers will find themselves becoming more entrenched in research practice. Because of the interdependence between research, program design and implementation, skills in collaboration as well as in research are important issues to human service practitioners.

Social workers, as advocates on behalf of clients and disadvantaged groups, are responsible for initiating change in the interest of the people they serve. Consequently, promoting and encouraging research to assess consumer opinion and perspectives can be used as a catalyst in the development of responsible and responsive social programs. Integrating research skills with other practice skills serves to broaden one's abilities as a social worker. Information collected from people affected by a given program or service, or the lack of service, can be used as a tool for mobilization and action.

CONCLUSION

Consumer research has the potential of providing accountability, credibility, financial and community support, as well as useful information for program planning to those organizations that are willing and able to engage in such

an undertaking. Social workers, as practitioners, have a responsibility to ensure that the viewpoints of their clients are heard; consequently, research can become an effective tool in the acquisition of these viewpoints which can help to precipitate action. Consumer research is not an innovative idea, but a much neglected one in the human service setting. As resources continue to decline, a marketing approach to the health and social services will gain greater ground. By learning something about its marketplace --- that is, about consumers and potential consumers --- human service organizations are in a better position to formulate more efficient strategies in promoting their image and their products.

II. INTERACTION OF PRACTICE & RESEARCH

INTRODUCTION

The purpose of this chapter is to provide a description and analysis of the integrated M.S.W. practice and research process undertaken by this writer in the 1986-87 academic term at the University of British Columbia. This combination program provided an opportunity to incorporate both community work skills and research skills. The final written product of any research project almost always excludes a background description of the social, political and environmental dynamics that are active determinants of the research process and final outcome. The following section accounts for these factors by describing the agency and key players involved, discussing various conceptual models of research guiding the process, and summarizing highlights of the consultation process from this particular case study. Finally, limitations and successes of the research practice are identified, followed by a discussion of 'what should or could have been done' in retrospect.

THE INTEGRATED PRACTICE & RESEARCH PROGRAM

In consultation with practice faculty, the student was to locate a field practice setting in which there was an opportunity to carry out a research study in an area of interest to the student. The field practice assignment involved the following (Crane, 1986):

- 1) Work with an agency or community group in the setting to formulate a researchable problem of suitable scope;
- 2) Carry out the research, in consultation with this group;
3. Help the group identify the policy and programming implications of the research and plan for utilization of the results;
4. Help with dissemination of the results.

The objective of this integrated program option was to prepare students to use practice skills to help community groups acquire information through research, and to implement the information such that its relevance would be maximized for on-going utilization.

THE SETTING

THE ORGANIZATION: The Canadian Mental Health Association - B.C. Division^{*} is the provincial office which provides leadership to twenty-three branch organizations and over five hundred volunteers throughout British Columbia in the field of mental health. The provincial structure facilitates the sharing of information and other resources on a province-wide basis. It increases the overall capability of C.M.H.A. in the province through technical projects, funding and publicity. The divisional office also acts as a resource to its branches by providing technical assistance and consultation in various areas of administration and development.

THE MANDATE: The mandate of C.M.H.A. is broad and diverse, simply because of the complexity of mental health issues. Their responsibilities range from advocating for improved care and rehabilitation of the mentally ill

^{*} Shall be referred to as C.M.H.A. in this paper

to public education, prevention and mental health promotion. The mandate is rather comprehensive in order to maintain the interests of and draw the experiences from a wide variety of clients and service providers.

Increasingly, however, its greatest continuing responsibility is providing information to the general public through a broad-based public awareness and education campaign. The divisional office is especially active in this area while also encouraging its branches to include educational services as an integral part of its programming.

THE PROBLEM: In relation to the background problem area in chapter 1, C.M.H.A. - B.C. has acknowledged a need to consult with its consumers to ensure the development of effective and responsive educational programs. There is uncertainty as to what information the public is looking for, how they would prefer to receive such information and what they already know or don't know. Consumer data would provide C.M.H.A. with knowledge about its target group, their opinions, and perspectives. As a planning tool, the acquired information should help guide the organization in program development and future planning. As an administrative tool, the consumer research might reflect a measure of accountability and credibility which will further promote financial and community support. By checking their reports and assumptions against samples of consumer data, the quality and confidence of the organization's existing data base could be enhanced.

ORGANIZATIONAL STRUCTURE: C.M.H.A.-B.C. Division has a staff of three: the executive director, one officer for volunteer development, and one secretary. The executive director is responsible for administration and

program planning for B.C. Division and is directly responsible to the Management Committee and Board of Directors. The officer for volunteer development serves as liaison and provides technical support to existing and developing branch offices. The management committee is the policy-making body of the organization acting on behalf of the provincial board of directors, who meet only three times annually. The management committee oversees the administrative functions of B.C. Division.

Given the limited staff and resources of B.C. Division, a great deal of its programs and services rest with volunteer committees which are formed to address a particular issue or to implement a particular program. Committee members are chosen on the basis of their expertise in a given area and may be representatives from other community agencies. The executive director serves as staff support to each of these working committees and reports any relevant progress to the management committee.

CULTURE OF THE ORGANIZATION: As a non-profit organization, the national, provincial and local branches of C.M.H.A. have a long history of volunteerism as the major impetus behind its existence. C.M.H.A. relies heavily on its volunteers who range from directors and committee members to front-line support and clerical staff. This emphasis on volunteerism is in keeping with its philosophy to involve members of the community as a community-based organization. B.C. Division has an on-going mandate to stimulate volunteer activity while promoting its organizational goals.

EXPERIENCE OF THE ORGANIZATION: C.M.H.A. - B.C. Division experienced some administrative difficulties which resulted in a hiatus for the organization

between 1983-84. The secretary and a few remaining board members continued to manage the essential functions of the organization. The present executive director, the officer for volunteer development, and the management committee are all relative newcomers to the organization with minimal background experience in the mental health field. Under new management, the agency is successfully re-establishing itself and is creating a stronger and more visible presence in the community.

The present organizational staff had no previous experience with survey research, but recognize the importance and benefits of conducting same. While C.M.H.A. has had student field placements in the past, the recent staff had no previous experience working with or supervising students.

RESEARCH PARTICIPANTS

It is necessary to identify the key participants prior to an overview of the research consultation process. A description of the roles assumed by these participants will provide additional insight to the development of the research project.

ADVISORY COMMITTEE: Because the student was not familiar with the organization, the executive director formed the necessary research advisory committee. The education coordinator from a local C.M.H.A. branch was asked to participate because of her involvement in the subject under study. Funding was requested from Mental Health Services to cover overhead expenses, and consequently a government representative who was interested in the research was asked to provide feedback throughout the course of the project.

Unfortunately, because the government representative was located in Victoria, meetings could not be easily arranged with this person. The student up-dated and consulted with this individual through occasional telephone calls and written material, but contact was kept to a minimum. In retrospect, it is felt a greater effort should have been made to consult with this individual as it could have positively influenced future funding for research projects. A conflict of interests in the purpose of the research due to different mandates was difficult to resolve by long distance. While the student attempted to accommodate the interests of both parties involved, the government representative subsequently acknowledged the sponsoring agency as the key information user.

As the research progressed, other individuals associated with the organization were consulted in the questionnaire construction stage. The officer for volunteer development and two board members became more fluid participants of the advisory committee.

The advisory committee, as key resource people, helped to provide professional expertise in focusing on relevant research questions to which they wanted answers. As individuals with different interests and level of knowledge, the information needs of each committee member had to be considered. However, major consideration was given to the needs of the sponsoring agency as the key information user.

THE EXECUTIVE DIRECTOR: The executive director was identified as the major user of the research data, and close consultation was maintained with this individual throughout the research process. It was the executive director

who expressed the need for a survey and who provided the major support and guidance for the student researcher. The accessibility of the executive director in the student's field placement setting contributed to informal discussion and consultation which was not possible with the advisory committee. While the advisory committee was formed to provide additional ideas and information, the executive director was the principle force behind the research. Utilization of the research results and recommendations would remain largely with the executive director for follow-up.

THE STUDENT: The student became involved in many aspects of the organization at the beginning of the term, with the intention of learning about the organization and gaining a variety of practice experience. At the onset of the program, the student assumed the traditional role of a student in a field placement: learning and experiencing through practical involvement by attending meetings and becoming involved in various committees and projects.

Because of other interests and responsibilities, the research aspect of the practice was not strongly pursued at the beginning of the term. The student consulted with the executive director concerning the problem area and issues for research. Copies of the written research proposal were sent to the advisory committee for feedback. The student assumed the more active role of research consultant during the second part of the academic term when more frequent committee meetings were arranged.

As it was difficult to maintain other responsibilities with the organization given time limitations and academic demands, the student found it necessary to withdraw from other commitments. The research project became more

time-consuming during the development of the interview schedule and during the implementation of the survey.

As enabler and researcher, the advisory committee left much of the control of the research to the student. When compromises could not be fully reached or decisions could not be accurately specified, the student had to assume responsibility to make such decisions due to time limitations.

FACULTY AND PEERS: The faculty at the university was available for technical support and guidance throughout the course of the research. Directed reading tutorials were assigned accordingly. Consultation periods were also arranged with student colleagues during pre-arranged seminars.

RESEARCH PARADIGMS

Paradigms provide a conceptual and philosophical framework which guide action. They break down the complexities of the real world, compartementalizing ideas from a broader perspective. Paradigms provide legitimate rules, basic principles and beliefs which regulate processes and procedures. Patton's Utilization-Focused Model for directed social change (Patton, 1978) served as the dominant paradigm for this particular research process. However, it would be useful to introduce three additional paradigms as overlapping theoretical models influencing the research. Reference is made to each of these models in the following section describing the research process.

RATIONAL MODEL: The rational model is perhaps the most frequently cited normative approach to the research process. The sequential structure of

the rational approach contains four consecutive steps (Martin, 1982):

- 1) formulate a theoretical problem
- 2) select appropriate research method, design and conduct study
- 3) analyze and interpret results
- 4) use results to confirm/deny theory.

The rational model, states Martin (1982), has a logical justification and is perhaps an idealized guide as to how research ought to be conducted.

It assumes that the research process is a purposive, objective and rational activity which operates in a highly sequential and logical manner.

GARBAGE CAN MODEL: Martin (1982) discusses a more accurate and realistic description of the research process initially introduced by Cohen, March and Olsen (1972). According to this model, the process of decision-making is conceptualized as a garbage can. The garbage can model recognizes that an organization "is a collection of choices looking for problems, issues and feelings looking for decision situations in which they might be aired, solutions looking for issues to which they might be the answer, and decision-makers looking for work" (Cohen et. al. 1972:2). Insight into this model provides a more realistic and identifiable understanding of the actual research process. "Decision situations or organizations ... are characterized by inconsistent and ill-defined preferences, unclear technology, and fluid participation in the decision-making process" (Martin, 1982:21). In the academic world, methodological textbooks often present the rational approach of doing research. Consequently, students often get 'hung up' on following the 'ideal' model, feeling frustrated when, in reality, actual practice fails to conform to the ideal. The garbage can model confirms to the student that research (or any other) decisions and actions are not necessarily rational, sequential or perfect.

INCREMENTAL MODEL: DeYoung and Conner (1982) state that decision-making in organizations is incremental. The incremental model recognizes that while information is important, it does not play a central role in decision-making. Instead, politics is a key factor: "decisions are based on current situational demands ... choice among alternatives is not necessarily based on theory or past research but rather on the experiences of the decision-maker and the demands of the situation" (DeYoung & Conner, 1982:433). In applying this to the research planning process, the incremental model understands that planners or decision-makers do not clarify goals; they evolve slowly over time out of previous experience and decisions of the moment. Unlike the rational model which is highly structured and goal-oriented, the incremental model acknowledges flexibility and change given current situations and conflicts.

UTILIZATION-FOCUSED MODEL: Patton's (1978) utilization-focused model share many similarities and principles with the latter two models described above. DeYoung and Conner, in fact, refer to Patton's model several times in their discussion of incremental research. The emphasis of Patton's model is on the utilization of research findings which will consequently lead to directed social change. The utilization-focused model disrobes the rational and scientific method of research to present a more amenable and realistic process --- a process which is more relevant and applicable in the organizational setting of the real world. While it is important to acquire the basic knowledge of traditional research methodology, this model detracts from the sequential and logical approach. Instead, it asserts that scientific systems of definitions and classification are perceptual, artificial and arbitrary and are determined by politics, persuasion,

paradigms and preference (Patton, 1978:237). The utilization-focused model does not concern itself with theory verification, objectivity or measurement precision; its emphasis is that the research process and findings have the ability to reduce uncertainty and thereby precipitate activity. Given the many dimensions which influence decision-making and subsequent action, the context and shareholders of the research process must be active, reactive and adaptive.

In reality, a single theoretical paradigm is seldom used to accurately guide a particular process, and as such, several overlapping models have been presented. In the following section, highlights from this case study are discussed. Reference is made to each of these models in various parts, with particular emphasis on Patton's utilization-focused model.

THE RESEARCH CONSULTATION PROCESS

ESTABLISHING THE PERSONAL FACTOR:

- . With an interest in the area of mental health education, the student contacted the Canadian Mental Health Association - B.C. Division about the possibility of a field placement. Coincidentally, the executive director had recently expressed to the Management Committee the need for the agency to conduct research. A contract was subsequently established between the agency, the student, and the School of Social Work. "The first step in the utilization-focused approach ... is the identification and organization of relevant decision-makers and information users of the evaluation (Patton, 1978: 61).

Organization of the advisory committee as other potential information users was left to the discretion of the executive-director.

- . Roles and responsibilities of committee members were not clearly identified at the beginning of the process. Terms of reference and expectations were not established. Because the executive-director was readily accessible and available in the field setting, the student neglected to actively consult with other committee members during the initial stages of planning.
- . The executive director introduced the student to the management committee and the board of directors, all of whom were in favor of the research project. As such, the student was given recognition and credibility at the beginning of the consultative process.
- . Committee members were personally contacted at different times throughout the research process for their in-put and feedback. Meetings became more regular and consistent during the second term as direction and expectations became clearer from the student's perspective.
- . The student had the opportunity to become more familiar with the organization as the term progressed through exposure to the setting and involvements with different aspects of the organization.

IDENTIFYING THE ISSUES FOR RESEARCH:

- . Given the broad scope of the organization's mandate, different needs of committee members, the relative newness of staff and some confusion over program direction, the process of identifying specific research issues was vague and complicated. As research consultant, the student would attend to the various concerns of the information users, and attempt to frame questions into a coherent context for research. Issues of choice and direction were shared with decision-makers.
- . Issues for research emerged out of the different interests of committee members. Consideration was given to the biases of the funding body representative, to the key information user, and to the student researcher. Issues remained broad given different needs and an inability to clearly identify or narrow specific problems.
- . Despite the lack of information, great complexity and multiple uncertainties, it was still necessary to make a decision regarding research issues. Decision-makers resorted to 'subjective rationality': simplifying the decision-making process through satisficing or making a decision which is 'good enough' (Patton, 1978: 125). As the consultation process continued and the researcher acquired more information, research issues were modified or changed accordingly.
- . Specific research questions were first raised, which then had to be fitted into general issues for research. Following this, a broad theoretical framework had to be developed from the

literature to justify the problem as a subject for investigation. In the garbage can model, the sequence of problems, resources, methodological choices and solutions are in constant fluctuation rather than in a fixed rational order. The sequence of the steps in the rational model can be scrambled, and in some cases, reversed (Martin, 1982).

DESIGN AND MEASUREMENT DECISIONS:

- . The organization initially requested a large-scale survey extending to various communities throughout the province. The intention was to use volunteers to assist the researcher in implementing the survey at different branch offices. A one-shot study was conceptualized which would produce information as a means to an end. In the rational model of the research process, results are the endpoint and are expected to make an impact by providing solutions to problems.
- . Both the student and the organization were inexperienced and unfamiliar with research design. As such, feasibility over the size and scope of the research was not initially questioned. The research proposal identified three communities and four different target groups to be surveyed. The initial process was delayed and influenced by high expectations and a lack of general understanding about the realities of research.
- . Consultation with academic advisors and student peers assisted to narrow the scope of the research. The recommendation to conduct a pilot study was agreed upon by the committee. Ongoing

consultation with students and faculty provided useful feedback and guidance to the more technical aspects of the research process. Classroom consultation also provided an opportunity to objectively pre-test the survey instrument for additional in-put.

- . It was necessary to negotiate the target group for the survey and the survey methodology. Decision-makers preferred to survey a population group which was quite broad and general, but this group was difficult to access given time and manpower limitations of the student. Flexibility of the student and the committee in an active, reactive and adaptive relationship resulted in a compromising and satisfying outcome.
- . According to the rational model, the nature of the theoretical problem should determine the choice of methodology (Martin, 1982). However, the methodology, sampling population and subsequent results were influenced and determined by available resources, the preferred target group, and ethical considerations, which are mentioned later in this paper.
- . The design of the interview schedule and specific research questions were influenced by the data collection method, for example: questions had to be kept short and simple for telephone interviews. The quality of the measurement instrument was therefore affected by this factor, as well as by confusion over goals and time constraints. "Design and data collection decisions are far from being neutral, objective or rational --- such decisions are political, subjective and satisficing" (Patton, 1978: 202).

- . As the research process continued, it became clear that the research project would not provide end-solutions to specific problems. The garbage can model permits empirical results to function as a starting point, rather than labelling results as 'solutions' (Martin, 1982). Although all research participants probably envisioned how the research process should have evolved and what could have emerged from the results, it is likely that these expectations did not fully consider political influences or realistic limitations: i.e. - conflicting values and preferences, ethical considerations, uncertainty of information, lack of clear direction, and time constraints. In reality, the process of making research decisions was one of "disjointed incrementalism, muddling though and satisficing in contrast to rational goal maximization" (Patton, 1978: 126).

UTILIZATION OF RESULTS:

- . The key to utilization-focused research is that plans are discussed for utilization even before the data is collected (Patton, 1978). In the early conceptualization stages of the research, utilization was discussed rather generally and vaguely. However, expectations were expressed that hopefully research results would lead to specific changes and direct action.
- . The over-riding need to consult with the public was the major concern of the sponsoring agency. Depending upon the research

results, suggestions for utilization included using the collected data: in funding proposals; in a press release for publicity; in an accountability report to funders; or as additional information to guide program planning or lobbying government for action.

- . As the research design changed, so did the issues and the scope of the survey. However, plans for utilization remained the same. Although the sampling size and other aspects of the research shifted from initial expectations, this did not affect the eventual utility of some of the research results. For example, parts of the collected data were used in a funding proposal shortly after the survey was completed. "Decision-makers are less concerned about methodological and research quality and more concerned that at least some relevant data is produced" (Patton, 1978: 253).
- . Adhering to the incremental and utilization-focused model, the author played an active role in the dissemination of results. Findings were presented to the advisory committee who were asked to provide feedback and further recommendations. The author also provided some insight and perspectives resulting from the collected data. Further discussions were held individually with the executive director, who was to present findings to the management committee.
- . At the time of this writing, the author had not yet documented final conclusions and recommendations. It is

expected, however, that a separate report may be prepared for the sponsoring agency. The committee will be convened for further discussion of the final written document. It is not expected that the time factor of two to three months will be a barrier to utilization.

- . Utilization of results are being planned and are taking place even before dissemination of the final report:

- some quantitative data has been and will be used in funding proposals;
- in consultation with the author, the executive director has prepared a brief news release about the preliminary research findings. The purpose of the news story is to demonstrate accountability and increased visibility for the organization, while also serving to inform and educate the public;
- the education coordinator is expected to follow-up on collected data concerning inter-agency networking for additional assistance in program planning;
- the research findings have helped to confirm certain speculations and/or shed light to new information which will be useful for future action or decision-making; for example: decision-makers have gained a better understanding of the potential consumer, have confirmed suspicions about public familiarity with the organization, have a better sense of future direction for research. "Information for prediction is information for control --- thus the power of evaluation" (Patton, 1978: 50).

- . While the data collected is interesting, not all the information is useful. Some information will lead to action, some information will lead to new discoveries, some information will merely bolster a preconceived viewpoint.
- . Research findings are but one of many in-puts into the political decision-making process of planning. The other in-puts include

the opinions and outlooks of other political constituents, the interests of other groups, and the ideologies of the decision-makers themselves. As such, "concrete and observable effect on specific decisions and program plans resulting from research findings and recommendations will not be immediate ... change is small and slow" (Patton, 1978: 30).

While it is useful to have a thorough understanding of the rational approach to research, it does not fully prepare the researcher to the obvious realities of the actual process. A look at other research models is especially useful to the student researcher and other practitioners to better prepare them for the realities ahead. Alternative, open-system models appear to confirm to research participants that it is not out of the ordinary to experience an incremental, garbage can model of research; that despite the gaps, uncertainties, imperfections and frustrations --- relevant information can still be obtained and put to use because it is the people, and not the method or quality, that will make the difference.

LIMITATIONS AND SUCCESSES OF COLLABORATIVE PROCESS

The practice-research option of the M.S.W. program provided an opportunity for the student to apply practical skills while learning about research. At the same time, it provided an opportunity for a community-based agency to interface with the academic institution while benefiting from the production of research. Working and planning in collaboration with the needs, values, and limitations of others will obviously have its drawbacks

and rewards. From the viewpoint of the student, the limitations and successes of the research consultative process is discussed below.

LIMITATIONS:

a) Familiarity with the Organization

According to the utilization-focused model of research, the role of the research evaluator is to provide illuminations and perspectives to decision-makers and information users. The evaluator is expected to assist in the formulation of organizational problems and provide program direction. It is assumed that the researcher will have sufficient background knowledge about the organization that will help to enhance one's role as enabler and illuminator.

Because the student was not familiar with the organization in the early stages of planning, it is felt that the ability of the student to help the agency define their problem and knowledge needs was somewhat limited. The muddling through process of identifying issues and clarifying objectives was further hindered by the fact that the student did not fully understand organizational dynamics, program contingencies, or past/present difficulties. Given time constraints, decisions had to be made and action had to be taken. However, it is felt that initial difficulties in identifying organizational problems and needs could have been reduced with the advantage of previous experience or knowledge about the sponsoring agency. Certainly, a better understanding of the formal and informal organizational arrangements would have helped to maximize one's confidence and influence.

b) Research Consultation Expertise

The lack of research skills and adequate background knowledge of the organization created an initial barrier for the student to overcome in the early stages of the research process. The student was learning about the technicalities of research and about organizational dynamics at the same time the student was to provide research consultation. The effectiveness of the student in the role of researcher and consultant was somewhat curtailed by these two factors.

c) Organizational Expertise & Resources

Crane (1987: 13) points to a relevant change in assumption needed in the utilization-focused model of research: that the "tasks of formulating research questions, development of working designs in a complex environment, instrument development and testing, software and analysis selection and development can rarely be performed adequately by practitioners, no matter how enthusiastic and well provided with consultation". Such a statement would confirm the experiences of this consultative process. Practitioners have strong 'doing skills' versus 'planning skills'. As such, it can only be expected that there will be some confusion over organizational direction, an inability to focus on problematic issues, and a lack of constructive input to the more technical demands of research.

One plan for utilization emerging from this research involves the implementation of a follow-up study. Change is incremental and develops slowly as more knowledge is acquired: an additional study utilizing the

information acquired from this pilot study can produce even more relevant information to guide further action leading to a more developmental approach of research. Follow-up research, however, will be determined by future resources and opportunities for the agency. When the student researcher leaves the setting, the organization will lose the major manpower and organizer needed to implement further research. The likelihood that a follow-up study will be conducted will depend on the motivation of the agency to recruit the necessary personnel, on other priorities of the agency, and on available time and resources. It is difficult to implement follow-up research if the basic resources for their implementation are either minimal or absent.

d) Meeting Other Priorities/Objectives

No matter how interesting or important the research project may be, there are always other responsibilities to consider and objectives to fulfill. This is especially true in the human service setting where research has not always, and still is not, recognized as a high priority activity. Consequently, it is difficult to justify directing one's energy and constant thought processes to the demands of research; decision-makers cannot always be expected to provide useful or insightful feedback.

At the beginning of the term, the student had other items on the agenda for field practice and this initially affected the intensity of the research consultation process. It became evident that other involvements with the agency was not possible. Due to time limitations and other demands, not all practice objectives (i.e. hands-on experience with other agency projects) could be satisfactorily achieved. It was difficult to maintain a happy balance between 'other community work' and research practice. In retrospect, the student attempted to engage in 'too many other things'.

e) Time

Time constraints played a key factor to every stage of the research process... a discussion of decisions or issues could not always be adequately achieved given the realities of time. Additionally, the demand for time from decision-makers was not as extensive as the student would have preferred, but respect for their other responsibilities had to be considered.

The academic calendar does not permit the student to engage in active utilization of results to maximize its relevance. The student plays a key role in the dissemination of information, but it is felt further utilization through actual practice (eg. in this case, ensuring that follow-up research is initiated) is not possible.

The initial perception of research held by the student and other participants is an important factor in determining one's expectations and experiences. The student, for example, initially conceptualized the research process based on the rational, scientific model. This narrow perception influenced expectations and increased frustrations in the early stages of planning. The alternate, open-system of research acknowledges that limitations, irregularities and confusion are all a normal and expected part of the process. Limitations are only based on our perception of the ideal, maximal situation. An awareness of the political processes influencing the actual course of outcomes gives one a better perspective to existing circumstances. While limitations cannot always be resolved or avoided, they can at least be acknowledged and, if possible, acted upon the next time 'round.

SUCCESES:

a) Practising Applied Research

The opportunity for a student to engage in applied social research in collaboration with a community-based agency provides an invaluable learning experience. Pure academic research does not permit one to grasp the skills of learning to share control over content, pace, reporting and uses of one's research. The practical experience provides the student with a better insight to the actual research process that can, in turn, be carried over to future research projects in the work setting. It further provides the student an opportunity to enhance planning and consultative skills. Skills in research requires more than theoretical and technical knowledge. Diplomacy and the ability to work with others is just as important. The pragmatic nature of the research consultative process allows the student to learn while experiencing.

b) Educating the Organization

Quality research requires special training --- training which many practitioners in the human services do not possess. Creating a link with the university can provide the opportunity to refine one's research abilities. Despite the garbage can approach to the research design, the student and human service practitioners learn together as they up-grade their knowledge and skills in research through actual 'doing'. As one committee member commented, "having the opportunity to participate in this particular method of assessing community needs (as the most useful experience gained in research process) ... being able to substantiate my more informal methods of assessing mental health needs for educational planning". Research

is becoming an inevitable component of responsive and accountable program planning. The collaborative process provides an opportunity for agency personnel to become better acquainted with research dynamics and techniques. The student acts as the knowledge broker --- bridging the gap --- between administrators and the academic community.

c) Manpower for Non-Profits

The opportunity for a student to undertake research in an organizational setting gives the agency additional manpower to 'get things rolling'. Research is acknowledged as important, but is not often a priority for many organizations given limited staff, expertise and other agency demands. The contributions of a student, guided by academic support, provides the much needed manpower, expertise and incentive for non-profits to at least begin practising research.

d) Positive Working Relationship

The relationship between the student, the advisory committee and agency staff contributed to a positive experience from the perspective of the student. The student's in-put and suggestions were respected. The student was acknowledged as a worthwhile and credible resource and researcher and was given control over the research process. Committee members and agency staff were readily accessible and available to the student. Additionally, the student made every effort to accomodate committee needs within reasonable limits. Certainly the professional working relationship between the student and the agency strongly influences one's perception of the experience and the extent to which research results will be utilized.

e) Empowering Decision-Makers

The fact that the research produced some relevant information for decision-makers indicates its success. Patton (1978) debunks the 'ideal' view of utilization as one of immediate major impact on concrete decisions. Instead, utilization can be more accurately described as one piece of information that feeds into a slow, evolutionary process of change. Information leads to knowledge, knowledge reduces uncertainty ... thus reduction of uncertainty empowers the users of information (Patton, 1978). Bits and pieces of the research data will be used at different times by the decision-makers, arming them with persuasive ammunition to guide future planning and action.

The success of the collaborative process strongly lies with the ability for all research participants to actively work with and support each other. Moreover, it further lies with the determination and ability of the participants to forge ahead despite setbacks and frustrations. Overall success of the project can be determined by the outcome of research results and its utilization. Knowing that the research has resulted in some action and has reduced some uncertainty indicates a sense of accomplishment ... however small.

IN RETROSPECT

Given an overview of this case study and an appraisal of the limitations and successes of the collaborative process this student, in retrospect,

feels several things could or should have been done to enhance the research project. This is not to imply that the collaborative process was not worthwhile --- on the contrary, the successes of the experience far outweigh any limitations. However, no project is perfect and one can only learn by recognizing shortcomings and oversights. This case study may or may not be similar to other experiences in the practice-research option of the M.S.W. program, therefore the issues presented below are a reflection of the personal insights and experiences of this student only. The value of these issues to the broader context of the program will be left for others to consider.

1) Clarifying Expectations

The student attempted to engage in too many practice activities which affected the research early in the term. While there is no specific distinction between research practice and community work, there needs to be a clearer definition of what the School expects from research practice and 'other' practice. For example, it would have been more beneficial to define expectations in terms of 'projects' rather than 'number of hours'. From this student's experience, involvement in one other project (i.e. another working committee) apart from research responsibilities was felt to be an adequate balance.

2) Active Involvement in Recruiting & Consulting Committee Members

The student failed to assemble together the advisory committee for consultation early in the planning process. The accessibility of the executive director, the different work locations of each committee member, the lack of clear expectations and roles, are factors which contributed to

this oversight. Furthermore, because the student did not actively participate in contacting and recruiting committee members, this somewhat influenced a feeling of detachment and initial hesitancy to approach unfamiliar individuals. An initial introductory meeting arranged by the executive director would have assisted to overcome this initial problem. A discussion of committee responsibilities, expected time commitments, and perhaps an overview of rational versus alternative models of research might be included in the agenda for the first committee meeting.

3) Familiarity with Organization and with Social Planning

The student was neither familiar with the organization, with program planning, or with other aspects of community work. The clinical and casework background of the student did not adequately prepare the student as researcher or social planning consultant. It is felt that some familiarity with the organization, or at least familiarity with the problem area, would have helped to enhance the student's abilities as consultant. However, as education is supposed to provide opportunities for new learning experiences, the lack of knowledge in unfamiliar territory is probably more the rule than the exception. One can only act, react and adapt to a given situation.

4) Stronger Link Between Faculty and Agency

Both the student and the agency experienced some difficulty in the initial planning stages re: identifying and focusing issues and goals for research. Given the newness of staff, and the relative inexperience of both the student and staff in research design, it is felt more regular

faculty in-put with the student and agency, especially earlier in the planning process, would have provided a clearer sense of direction.

Faculty would assist in negotiating and consulting in conjunction with the student. As such, the student should have taken more initiative for convening such meetings as the need arose.

5) Understanding the Organization

Because of the organization's strong emphasis and reliance on volunteerism, consideration should have been given to recruiting volunteers for a task-oriented research committee. The executive director, as the key decision-maker and information user, would assume the role of staff support and agency advisor in terms of organizational needs. A task-oriented committee would be recruited on the basis of previous research experience and an interest and commitment in volunteering for the organization. The student would still serve as enabler and research consultant, equally sharing in research tasks while also assuming other responsibilities. With a voluntary task-oriented committee in place, follow-up research is more likely to be implemented once the student leaves the setting. Recruiting the necessary volunteers with the desired skills and interest would be the 'community work' responsibility of the student. Therefore, an understanding of the culture and structure of the organization should have been considered prior to recruiting the research committee. Nevertheless, while a voluntary task-oriented committee would be the desired ideal --- especially as a method of involving consumers in organizational planning for a community-based agency --- time constraints of the student and other unforeseen difficulties would have to be considered.

6) Sharing Political Processes with Peers

The student is exposed to a variety of political experiences in the collaborative process: choices have to be negotiated, limitations have to be imposed, and decisions have to be made. While students had the opportunity to share their more technical research process with peers, discussing the more political process was minimal (i.e. one practice-research seminar). The opportunity for more extensive seminars and discussion in this area could broaden the student's understanding in decision-making processes, organizational dynamics, management techniques, conflict resolution and consulting skills. Students, therefore, can share their experiences from the agency setting --- i.e. problems encountered, what was done to resolve the problem, what could have been done, how issues were identified, etc. --- and learn from each other. As such, an equal emphasis would then be placed on technical research skills as well as other practice skills.

In retrospect, it is felt that this student should have clarified expectations, should have consulted more with committee and faculty members, should have become familiar with alternate open-system models of research much earlier in the research process, could have produced a better quality questionnaire, could have acquired more useful data, could have done more to disseminate the results ... but political and personal dynamics can only result in satisficing rather than maximizing. The action process of research can be perceived as really one of reaction and adaption --- that is, "trying to make the best of things until uncertainty is sufficiently reduced or

external constraints have been sufficiently removed to permit a reassertion of activism" (Patton, 1978: 127). This practice-research, undoubtedly, has generated more information and improved skills that can be carried over to activate a more developmental, incremental learning and planning process.

III. THE RESEARCH PROJECT IN CONTEXT

INTRODUCTION

Chapter One discussed the relevance of consumer research for non-profit organizations, while Chapter Two provided a case study of the personal and political dynamics of this research. The following chapter sets this research project in context: It presents the issues selected for research followed by a short explanation of the rationale for selection of these issues. The specific objectives of the research project are identified and set forth, along with a statement of specific questions which guide questionnaire construction. The Community Mental Health Model to primary prevention and major concepts are introduced to provide a theoretical framework guiding the research. Finally, a discussion of other relevant research is presented to provide an indication of what has already been done in the field and how they might relate to this particular study.

RESEARCH ISSUES

As explained in the previous chapter, the Canadian Mental Health Association B.C. Division is recognized as assuming a growing responsibility in the provision of mental health information to the general public through a broad-based public awareness and education campaign. As a marketing and management

tool, the organization acknowledges the need to consult with its potential consumers in order to gain a better understanding of the marketplace.

As such, the major issues of concern are: What are the opinions and perspectives of our potential consumers that can help guide program planning? What direction should the organization take in terms of future direction for mental health education?

Through the acquisition of consumer data, the organization receives additional in-put into their decision-making and planning process. Furthermore, it will influence the selection and development of future product markets. As mentioned earlier, the organization is uncertain as to what direction to take; they do not know what the public wants, what the public knows or doesn't know. At present, direction for planning remains broad and general --- which is adequately reflected by the issues selected for research. It is felt that a pilot study will help shed some light into their uncertainties; and that the preliminary information will assist to guide both short and long term planning for mental health information and education programs.

OBJECTIVES OF THE STUDY

The purpose of the research, given the above issues, is to provide the Canadian Mental Health Association B.C. Division with information about its potential consumers. Specific questions guiding instrument construction, which the study will be designed to address, are as follows:

- . Is the public familiar with C.M.H.A.?
- . What mental health information is important to users and potential users and how, in their view, can it best be provided?
- . What are the most difficult problems in living experienced by the people in the community?
- . What are the public's thoughts and opinions about mental health and illness?
- . Is there community support for mental health education and information programs?

Given certain limitations imposed upon the research, it is not expected that the results will generate 'end solutions' to the questions asked. The pilot study, instead, will provide a beginning point for further planning and research. Consequently, a summary of goals identified for the pilot study include:

- 1) providing C.M.H.A. with information about its marketplace and recommendations for marketing strategies;
- 2) appraising the worth of collecting specific information prior to undertaking a larger study which is more costly;
- 3) identifying possible difficulties that could be encountered in a larger study; and
- 4) providing recommendations for future research.

In addition, the research will also serve to provide the organization with a measure of accountability and credibility to existing and potential supporters.

KNOWLEDGE-BUILDING FUNCTION OF RESEARCH

The particular functions that research serves in knowledge-building is one factor that influenced the design of the sample survey. The general objective of this particular research, given its nature and specific purposes, is to provide both exploratory and descriptive information.

The study is exploratory in nature because it is identified as a pilot study: the role of exploratory research is laying the groundwork for more definitive studies ... decisions are made in the absence of much knowledge, the results of an exploratory study can help inform action (Reid & Smith, 1981).

Selltiz, Wrightsman and Cook (1976) state that the major emphasis of exploratory studies is on discovery of ideas and insights. As such, the research design must be flexible enough to permit the consideration of many different aspects of a phenomenon.

In one way or another, all research can serve a descriptive function since it can provide at least some information about the characteristics of the phenomena studied (Reid & Smith, 1981). Because this study aims to acquire information about consumer needs, attitudes and perceptions, the knowledge-building function of this research is also descriptive in nature. Descriptive studies set out to portray the characteristics of a particular individual, situation, or group and also sets out to determine the frequency to which something occurs (Seltiz, Wrightsman & Cook, 1976). Description, states Warwick & Lininger (1975) lays the groundwork for the pursuit of other objectives as well, including explanation and evaluation.

THEORETICAL ORIENTATION AND DEFINITION OF CONCEPTS

The nature of public education and information in mental health is best understood within the broader theoretical framework of primary prevention. However, before discussing primary prevention and introducing some major concepts guiding the research, it is relevant to describe the

prevalence of the background problem to which education and information programs are perceived as intervention strategies.

The following statements convey the alarming incidence of mental illness in our society (Canadian Mental Health Association, 1984):

- . Mental illness is now the most urgent health problem in Canada. It claims more victims than any other disease. In any given day, nearly half the hospital beds in Canada are occupied by the mentally or emotionally ill.
- . Emotional problems cost Canadian business and industry in excess of \$50 billion annually.
- . Emotional problems strike more Canadians every year than all other health problems in Canada (including heart disease and cancer).
- . One in every three Canadians will suffer temporary emotional problems in their lifetime.
- . Approximately 50% of those seeking health care in Western societies suffer from illnesses such as stress, hypertension and psychosomatic disorders (DeMarco & Heughan, 1986: 316).

The above statements would justify the conclusion that mental disorders present a major public health and social problem, requiring measures to reduce the burden created by mental ill health. The contributions of primary prevention aims to reduce the incidence of mental disorders while enhancing the level of one's positive mental health. A definition of these concepts are presented below:

MENTAL DISORDER - A behavioral or psychological syndrom or pattern which results in either painful symptoms (distress) or impairment in one or more

areas of functioning (disability). The disorder is the result of biological, behavioral or psychological dysfunction (Mental Health Services, 1985).

MENTAL HEALTH - A multi-dimensional concept which refers to an individual's interaction with self, others and the environment. Mental Health is a dynamic state of personal adjustment which includes a discrete and positive sense of identity. It presupposes the development of personal potential and an adjustment to the world which promotes effectiveness and happiness (Mental Health Services, 1985).

PRIMARY PREVENTION - Encompasses those activities directed to specifically identified vulnerable high risk groups within the community who have not been labelled as psychiatrically ill; or to groups about which no assumption of risk is entertained ... measures are designed and undertaken to avoid the onset of emotional disturbance and or enhance the level of positive mental health. Programs for promotion of mental health are primarily educational rather than clinical in conception and operation with their ultimate goal being to increase people's capacities for dealing with crises and for taking steps to improve their own lives (Goldston, 1977; Randall, 1981).

COMMUNITY MENTAL HEALTH MODEL FOR PRIMARY PREVENTION

A theoretical framework, known as the Community Mental Health Model, provides the ideology and philosophy behind the impetus for primary prevention. This model is characterized as active-preventive in approach with a population focus (Nelson, Potasniak & Bennet, 1983). The community model is directly opposite the dominant medical model of service delivery which is passive-

receptive and individually focused. The medical model recognizes intervention techniques as largely focusing upon controlling mental illness and not preventing it. Major characteristics of the community mental health model include the following (Nelson et. al., 1983):

- . Services would be available to all members of the community, so that the whole population is perceived as clients of community mental health, and not just those who are labelled 'mentally ill'. This ensures a commitment to raising the level of mental health of the entire community.
- . A preventive approach would actively involve individuals in the process of assuming responsibility for the maintenance of their own well-being. It promotes the idea that consumers of health service, and not the providers, hold the key to health.
- . Prevention is perceived as a method of social intervention --- in an attempt to ward off or control the seriousness of illness --- rather than waiting for treatment after illness strikes.
- . Prevention is directed to normal and at-risk groups as well as toward a range of formal and informal care-givers in the community.
- . Professionals will collaborate with other community members to provide services to the larger community.

These major characteristics of the community mental health model are key considerations in the development of the research design, especially in the selection of the survey population.

The word 'prevention' can be misleading as it tends to imply that something is being prevented. Instead, this concept can be better defined through a

description of the major objectives of prevention/promotion activities

(Lorion, 1983; Ferguson, 1984):

- . to reduce emotional distress, maldadaptation and maladjustment
- . to reduce helplessness and useless tension
- . develop healthy and positive coping skills and problem-solving skills
- . improve functional competence.

Primary prevention, therefore, attempts to lower the rate of new cases of mental disorder in a population by counteracting harmful influences before they precipitate or cause illness, and/or raising the individual's competence in coping with difficulties.

Numerous methods are available to practising primary prevention and mental health promotion. Public information and education methods are the prime focus of this study, and these interrelated concepts are defined below:

MENTAL HEALTH EDUCATION OF THE PUBLIC - Mental health education of the public has three different emphases:

- 1) Education about mental health - informing people in general about the facts bearing on mental health in their communities so that they may work to improve relevant conditions;
- 2) Education about mental illness - focusing concern on the care, treatment and rehabilitation of the mentally ill as well as those institutions designed to provide such services; and
- 3) Education for mental health - helping individuals to manage their own lives better and to achieve better mental, emotional and social adjustment. This would include education about parent-child relationships, marriage and the family, stress, and so on (Sauber, 1973).

PUBLIC INFORMATION METHODS - Public information methods involve the dissemination of mental health information to relevant care-givers and populations in the community. This method is used for the purpose of:

- 1) Informing the public about available treatment and prevention services;
- 2) Increasing a community's knowledge and acceptance of the mentally ill; and
- 3) Influencing public policies that relate to mental health (Ketterer, 1981).

Mental health information and educational measures can only attempt to increase understanding and relieve the burden created by the problem of 'not knowing' or 'not understanding'. These measures can help to change attitudes, which in turn will not only foster the effectiveness of existing services, but also eventually contribute to reducing the size of the problem created by mental ill health (Freudenberg, 1979).

RELEVANT RESEARCH

Information and education measures represent one of the important tools in prevention. Numerous studies have been conducted which have led to a current state of knowledge in mental health education of the public. Some are mentioned here.

As specified earlier, one of the main concerns of public education and information is to increase a community's knowledge and acceptance of the mentally ill. Attitudes toward the mentally ill have been the subject of extensive research since about 1950. The Cumming and Cumming (1957) study concluded

that the community educational program they designed failed to reach its goal of diminishing people's feelings of distance and estrangement from former mental patients. They found that, on the whole, the people in the community studied did not wish to have very much contact with mental illness either on the personal or social level ---believing that the mentally ill "always shows some signs" (Cumming & Cumming, 1957: 108-109).

Since the Cumming and Cumming study, J. Rabkin (1974), in a review of the literature, documents a trend for increasingly accepting attitudes toward the mentally ill between the 1950's to 1970's. An attitude survey conducted by Bentz and Edgerton (1970) found that "the general public have more realistic information and attitudes about mental illness ... are optimistic about preventive and treatment efforts" and concluded that "educational campaigns over the past few years have had a tremendous influence for changing attitudes toward mental illness and phenomena related to its consideration" (Bentz & Edgerton, 1970: 472-473). Furthermore, success of educational efforts is more likely if the public's past experience with mental health advice and the available services has been reasonably good (Sauber, 1973). Aside from educational endeavours, another factor found to determine one's response in accepting and trusting the mentally ill has been the degree of exposure to the mentally ill. That is, the more extensive personal experience with individuals who require psychiatric care, the more favorable the attitude and acceptance (Trute & Loewen, 1978).

Research has indicated that local residents often have minimal knowledge about mental health services offered in their community (Elinson, Padilla & Perkins, 1967; Ketterer, 1981). Consequently, public information strategies can serve

to be an effective method of communicating relevant knowledge about available treatment and prevention services to the general public. In their community survey of 1500 housing units in New York City, Elinson et. al. (1967) also found that, in terms of orientation toward finding help, more people are inclined to turn to family and friends for initial advice for mental or emotional troubles.

Evaluative studies measuring the effectiveness of education and information programs have often been neglected. Baron (1980) criticizes the lack of concern on the part of public educators for systematic evaluation of their public education campaigns. He argues that this has been no oversight, and that the lack of systematic evaluation has left practitioners uncertain as to what types of approach are most effective (Dear, Taylor, Bestvater & Breston, 1985).

The Information & Action Program was one undertaking aimed to evaluate the long term impact of an ambitious public education campaign designed to increase community acceptance of the mentally ill (Dear et. al., 1985). A geographic representation of various communities were surveyed both before and after an advertising campaign in order that the effectiveness of the media campaign could be measured. Even prior to the campaign, the Phase I survey already indicated a generally positive attitude toward the mentally ill. However, the high level of awareness of media messages measured in the Phase II survey confirmed the benefits and utility of a media-based campaign: the majority of the survey sampled felt that the media had a positive influence, and that the messages were effective in serving to further educate the public about the problems and needs facing the mentally ill in the community.

There was strong consensus, however, that further promotional initiatives were needed stemming from the conviction that education promotes greater understanding, acceptance and support.

Mental health education of the public, apart from attempts to change attitudes towards illness, is also concerned with efforts to improve people's capacities to develop satisfying lives. Educational activities, therefore, include family life and human relationship programmes (Freudenberg, 1979) --- thus extending this into teaching/informing the public about coping skills when experiencing stressful life events.

Public health education was found to be effective if certain principles were observed. From a series of studies collecting opinions, knowledge and attitudes about mental health phenomena, Nunnally (1961) concluded and recommended that it is necessary to arouse public interest and motivation as a relevant communication strategy. Nunnally also suggested that before strategies for communicating about a particular topic can be established, it is necessary to determine where that topic resides in terms of priority or need. Public interest in mental health topics can vary considerably. The public is mainly interested in mental health information that will relieve immediate personal threats through provision of solutions for handling problems (Nunnally, 1961).

On the whole, Nunnally found that mental health topics have moderately high interest value, competing well against other subject matters such as physical health information and entertainment topics. Similarly, in an extensive review of existing research, Davis (1965) concluded that "audiences appear

eager to receive mental health information because they have few firm existing ideas and a great interest in the area" and furthermore "simple mass-media techniques appear to be as efficient as more complicated and sophisticated vehicles for conveying information (Davis, 1965:138).

Mass media is often stylized to fit the requirements of fiction and drama, thus conveying ideas about mental health that are less than correct (Nunnally, 1961). On the other hand, mass media communication has been found to be a highly popular means of disseminating health information as it tends to reach a large majority of the population (Feldman, 1966). In terms of specific sources of media, there is a high correlation between newspaper and magazine use and level of education; that is, the higher the education the more likely one is exposed to acquiring health information through newspaper and magazines. Conversely, listening to the radio and watching television requires no great intellectual ability and would, understandably, reach a greater proportion of the least educated group in the population (Feldman, 1966). Consequently, while mass media has had a detrimental effect to producing negative attitudes or erroneous information about mental health, it can also be used to effectively provide the public with better information and developing better attitudes.

The exploratory and descriptive function of this research will serve to provide information about potential markets for public mental health education, and will lay the groundwork for more definitive studies for program planning. The purpose of public mental health education is explained by the broader theoretical framework of primary prevention; guiding practice principles are

outlined through a definition of specific concepts for practice. Relevant research related to this study provides an indication of existing knowledge about the marketplace and about existing market strategies for developing public education material and programs. While the sample population of this research may or may not be similar to other research populations, the intention is to localize certain findings for a more accurate description of the population of concern.

IV. THE RESEARCH DESIGN

INTRODUCTION

The research design is a detailed plan outlining how observations will be made ... such as who will be studied, how these people will be selected, and what information will be gathered from or about them (Monette, Sullivan & Dejong, 1986: 9). This next chapter describes the research design plan of this study. Additionally, given resource and feasibility constraints, limitations of the research is also discussed.

RESEARCHER'S CONTROL OVER PHENOMENA STUDIED

This is a naturalistic study (Patton, 1980) as the research was conducted in the respondent's own environment. There was no attempt to manipulate the respondents or to influence them in any way. Respondents were free to make whatever comments and suggestions they wished within the context of the question format.

SAMPLING DESIGN

One of the major characteristics of the Community Mental Health Model is to make services available to the whole population; that is, so that normal

groups in the population are also receivers of service. A second characteristic is that professionals will collaborate with other community members and formal care-givers to provide services to the larger community. Given these two guidelines, the sample population comprised of two groups: (1) the general public; and (2) community service personnel.

1) THE GENERAL PUBLIC

DESCRIPTION: The general public is described as a heterogeneous group. Individual units of this group are characterized as over 18 years of age, male or female, about which no assumption is made or previous knowledge is known about specific socio-economic, geographic or demographic variables. Additionally, because the general public is defined in a very broad and vague sense, it is assumed they can also be described as normal and at-risk groups in the population who may well be potential or actual consumers of mental health information.

OBTAINING THE SAMPLE: A survey sample of telephone subscribers was chosen from the Greater Vancouver Telephone Directory. As it was necessary to select a survey population as free as possible from any biases or assumptions about socio-economic or other characteristics, yet accessible at low cost, this resource appeared to be the best choice. It should be noted that 'general public' is a broad concept which is difficult to define as one identifiable group. While it is not accurate to equate telephone subscribers with the general public as a whole, the bias towards 'non-poor' respondents is believed to be relatively small due to general use of telephones. As such, the survey sample of telephone subscribers are identified as the 'general public' for the purpose of this study, but caution

is advised against generalizing this group as representing the whole general population. Limitations are discussed in the following section.

A sample size of 100 respondents was drawn from the directory for the pilot study. Random sampling was used by selecting individual respondents at regular intervals from a fixed position. That is, the first name was chosen from every alternating column on every third page of the telephone directory. Places of business and individuals living outside the Vancouver City area were excluded from the sampling list. A final sample list of 124 Vancouver City Telephone Subscribers was drawn from the directory. From this final list, every 5th name was eliminated to provide a survey sample of 100 randomly chosen respondents.

LIMITATIONS OF SAMPLING METHODOLOGY: The telephone directory is one of the most popular sources for sampling, but it does have its limitations. In the first place, telephone subscribers are not a cross-section of the population of any community because the lowest economic groups who cannot afford telephones are omitted. Secondly, unlisted telephone subscribers are also not included --- and subscribers with unlisted numbers could constitute a highly select group in the population. Research has found, for example, that unlisted telephone subscribers are more anxious and evidence greater psychosocial dysfunction than their listed counterparts (Stefl, 1984). It is also well known that telephone subscribers are generally home-owners and tend to be over-represented compared to renters. Therefore, a sample of telephone subscribers is biased in favour of the stable groups in the population (Parten, 1950). These limitations present problems for securing a representative sample of the population of interest. Random digit dialing could have eliminated the latter two limitations by including unlisted subscribers and renters using a coincidental dialing method. However, given the university's ethical research guidelines, it was necessary to contact all respondents in advance of the telephone interviews.

2) COMMUNITY SERVICE PERSONNEL

DESCRIPTION: Community service personnel can be described as homogeneous in that the organizations surveyed are all in the helping professions. The organizations were chosen on the basis of their direct contact with certain normal and at-risk groups in the population, and on the basis that these organizations could also be consumers of mental health information as well as providers.

The community service population was divided into four different groups:

Schools (8) - included secondary schools, a native education centre and a community college.

Community & Neighborhood Organizations (15) - characterized as providing social and recreational activities to specific groups in the population as well as to the general public. Organizations listed in this category included community centres, neighborhood associations, drop-in centres and churches.

Social Service & Health Agencies (30) - identified as those organizations and/or professionals whose mandate is to meet specific physical and/or certain emotional needs of the population. Respondents listed in this category included family physicians, hospitals, psychologists and social service departments.

Employee Assistance Programs* (98) - EAP's consist of company-based or community-based agencies who provide education and/or counselling to bring about changes in thinking and behavior that are more healthy and less costly to both the individual and the employer (Goldmon, Reyes, Young, Barsamian, Thomas & Thuss, 1984).

OBTAINING THE SAMPLE: The schools and some community/neighborhood organizations and social service/health agencies were randomly chosen from the Vancouver Telephone Directory. Other agencies were chosen on the basis of preference from the sponsoring agency. The availability of a provincial list of EAP's, together with contact names, addresses and postal codes, resulted in total

* Shall be referred to as EAP's in this paper

inclusion of all EAP's into the survey sample.

LIMITATIONS OF SAMPLING METHODOLOGY: It is felt that obtaining the sample of community service personnel was done rather haphazardly with little systematic planning. Initially, a small sample was intended for this group. However, given the recent accessibility of the EAP listing, the fact that Mental Health in the Workplace is a growing program for the sponsoring agency, and the availability of funds to enlarge the sample for mailed questionnaires, the researcher was flexible to the needs of the agency. Obviously, the greatest limitation is the over-representation of EAP's over other organizations sampled. Consequently, results may be biased to the opinions and perceptions of this particular group over the other groups sampled.

CHOICE OF METHODOLOGICAL ORIENTATION

The methodological orientation of this research is quantitative in nature. The study is guided by a fixed conceptual framework -- a questionnaire -- with a set of specific questions constructed in advance. Observations are placed in numerical form, and this numerical data is assembled, classified and tabulated so that some meaning or information is obtained (Monnette et. al., 1986). Because of the sample size and design, minimal involvement with the survey population is necessary; qualitative analysis allows the researcher to reach a larger and more diverse population of respondents in a manner where data can be collected and analyzed in a relatively straight-forward and systematic manner.

DATA COLLECTION

A standardized survey instrument was designed for both the general public and community service personnel (See Appendix 6 & 7). Some questions were similar on both instruments for the purpose of comparing opinions between the two groups. However, for the most part each instrument was designed with the intention of acquiring relevant information specific to the differences of these two groups. That is, some questions that were asked of the general public was not appropriate or relevant to ask the community service personnel and vice-versa. As such, the differences between the two questionnaires best served the information needs of the sponsoring agency.

THE GENERAL PUBLIC: Methods of data collection also differed between the two groups. Telephone interviews were conducted with the general public as it is well known that people often refuse or neglect to complete and return a mailed questionnaire (Monnette et. al., 1986). With interviews, response rates are generally higher because of the personal contact.

Telephone interviews can generally be conducted quickly and economically with a fairly good response rate. The interview is much more flexible than the questionnaire as the interviewer has the opportunity to explain any ambiguities that emerge. A Letter of Introduction (Appendix 4) was initially sent to each of the 100 respondents, explaining the purpose of the survey and informing them to expect a call in the near future for a 10-15 minute telephone interview. The introductory letter served to save time by not having to repeat the purpose of the research upon telephone contact; it also served to add more credibility to the telephone survey. Follow-up calls were made to those individuals who could not be initially reached.

There are certain limitations involved in the telephone interview method. Interviews have to be quite short in duration so that only a brief number of items can be investigated. Furthermore, the time limitation restricts the volume of information that can be obtained, especially from open-ended questions that cannot be explored to any great depth. The telephone interview method also influences the type of questions asked and the method of asking them. Questions have to be kept relatively simple and uncomplicated.

COMMUNITY SERVICE PERSONNEL: Mailed questionnaires were sent to the community service personnel. It was assumed that this group would generate a greater rate of return given a professional interest and concern in the subject matter; therefore responding to mailed questionnaires with more enthusiasm than the general public group. The mailed questionnaires would eliminate the extensive time factor required of telephone interviews. Another advantage is that it would eliminate interviewer biases. Mailed questionnaires also allow respondents to complete the questionnaire at their convenience given other demands and priorities in the work setting. Stamped, self-addressed envelopes were included for convenience. Given time limitations of the study, no follow-up was conducted for the mailed questionnaires, however the cover letter (Appendix 5) did stress the tight schedule of the research project to encourage respondents to complete the questionnaire as soon as possible.

There are certain limitations imposed upon the use of mailed questionnaires. Firstly, there is always the problem of non-returns. There is no way of assessing the characteristics of those organizations who failed to respond

to the questionnaire, and to what extent their opinions and perceptions may differ from those who did respond. Those who answer the questionnaires may differ from the non-respondents thereby biasing the sample. There is also the possibility of misinterpreting the question or misreading the instructions, which is exactly what happened in some responses in this case. Some respondents failed to abide by the instructions of checking only one answer to specific questions, resulting in two or three checks to one question and biasing the final results. There is also the problem of some respondents neglecting or skipping over certain questions, and as such, no follow through is possible to clarify evasiveness.

PRE-TEST

General public questionnaires were pre-tested with student peers, friends and other agency personnel. A final pre-test was conducted with five respondents chosen from the sampling list. After each pre-test, changes and improvements were made accordingly. Given time limitations, the community service personnel questionnaire was pre-tested only with various agency staff and research committee members. Since one purpose of this pilot study is to assess the adequacy of the research instrument, conclusions and recommendations for further improvement/clarification will be discussed in the final chapter of this paper.

VALIDITY & RELIABILITY OF MEASURES

Most measurements used in both survey instruments were fairly straight-forward involving single indicators of a variable. As such, these direct measures

are recognized as both valid and reliable (Monnette et. al., 1986). Face validity was strengthened through discussion and by gathering opinions from other participants involved in the research process. Reliability was probably enhanced through the use of pre-structured instruments. Consequently, interviewer behavior was kept relatively uniform throughout the telephone interviews and could be more easily duplicated.

Probing was kept to a minimum in the telephone interviews to avoid interviewer bias and to keep the duration of the interviews within a reasonable time limit. While the interviewer attempted to take verbatim notes to open-ended questions, this was not always possible and it is recognized that some bias may have occurred in selecting 'high points' of what was said.

Three scales were devised for the general public questionnaire: 1) Importance on Mental Health Issues 2) Myths About the Mentally Ill, and 3) Community Acceptance Scale. The first scale was also used in the community service questionnaire.

Because of the great difficulty in defining health without resorting to the concept of the absence of illness, there has been a tendency in the mental health field to select specific areas of endeavour which there is reason to hope will prevent some illness and at best enhance mental health (Cumming and Cumming, 1957). For example, programs on coping with divorce/separation, stress, or enhancing self-confidence are undertaken in the belief that they will ultimately lower the incidence of mental illness and perhaps enhance mental health. Information on specific forms of mental illnesses, such as schizophrenia, paranoia and various eating disorders are expected to educate

formal and informal care-givers to improve understanding, strengthen support systems, and ease client transitions to community life --- thereby improving mental health. These assumptions form the basis of specific mental health issues included in this first scale. Furthermore, issues chosen were also specific subject matters of concern to the sponsoring agency --- many of the topics already being discussed and disseminated through various informational sources via the organization. As such, each item included in the scale was justified and assessed for content validity. A likert-type scale was used to measure the degree of importance assigned to each mental health item. Responses to this scale were divided into five levels of intensity varying from extremely important to not important at all.

The source of items used for the scale on Myths About the Mentally Ill was derived from a publication developed by the National Institute of Mental Health (1985) entitled "The Fourteen Worst Myths About Recovered Mental Patients". While the range of variation for responses to each item should have been broader than the actual three positions provided, consideration had to be given to avoid the repetition of another 5-point scale. It was felt that respondents might lose interest and attention to the interview if repetitive 'numerical' scale responses were requested; therefore a shift to a 'yes/no/don't know' category was used to provide variability to responses.

The Community Acceptance Scale was derived from a previous study (Johnson & Beditz, 1981) and was supported by reliability and validity analyses. The study recommended that the dichotomized range be expanded to avoid

social desirability bias, and a third category, 'don't know', was therefore included to parallel the above mentioned Myth Scale.

ETHICAL CONSIDERATIONS

Once the research design was complete, a Request for Ethical Review Form was submitted to the U.B.C. Behavioral Sciences Screening Committee for Research Involving Human Subjects (Appendix 1). Subsequent approval was given to conduct the research as outlined (Appendix 3). In accordance with U.B.C. research ethics, selected respondents for telephone interviews were initially contacted by letter prior to actual telephone contact. The letter of introduction identified the researcher and agency involved, explained the purpose of the study, stressed the confidential nature of the study, and the time commitment required for the interview. The letter also acknowledged that respondents were free to refuse to participate in the study (Appendix 4). A covering letter outlining similar details was also attached to the mailed questionnaires sent to the community service personnel (Appendix 5).

DATA ANALYSIS

A simple way of reducing and summarizing data is through frequency distributions in either raw or percentagized forms (Warwick, 1975). Frequency distribution tables were computer generated for each variable, and these are summarized in paragraph form in the following chapter which discusses survey results. Frequency tables have been compiled and presented in this next chapter where appropriate.

Mean scores were used to describe differences for interval level data, specifically in the Importance on Mental Health Issues Scale. Mean scores were also used to assess the average value measuring myths and community acceptance.

The analysis of variance (ANOVA) statistic was used to describe specific differences between the general public and community service personnel. ANOVA was also used to measure effects of certain independent variables to dependent variables: for example - the level of significance to which degree of importance on parenting information is related to sex, age, or marital status.

Open-ended questions were transcribed by choosing major themes from the raw data and categorizing individual responses into an established theme.

A margin of error is usually included in the presentation of polling results. However, it was decided not to include confidence intervals reflecting the margin of error as it would be misleading due to the high non-response rate.

The process of analysis can often become a lengthy and complicated one. Numerous statistical methods can be used to provide interesting information and analysis of collected data. It becomes necessary to pick and choose which statistics are more relevant than others. It can only be judged that, given specific goals and values of the researcher, the statistics chosen for analysis will adequately represent the needs and interests of the information users and other research participants.

LIMITATIONS OF THE STUDY

Several limitations are inherent in this study given certain limitations of resources and feasibility. Some limitations in scope and generalizability have already been mentioned given constraints of sampling methodology and the method of data collection used.

The final sample size of the general public population was small (N = 46). Sample sizes for the community service personnel was also small and disproportionate (N = 6 schools; 46 EAP's; 9 Social Service/Health Agencies; 5 Neighborhood/Community Organizations). Consequently, while sufficient data was collected to make the study worthwhile, care must be taken to refrain from over-generalization of the results based on the sample size of this study. While random sampling of the general public serves to enhance generalizability, final characteristics of the population sampled are still biased and this will be discussed later.

As mentioned earlier, extensive surveys have been conducted measuring public attitudes, perceptions and opinions about various subjects on mental health (Nunnally, 1961; Elinson et. al., 1967; Dear et. al. 1985). These studies have involved lengthy and exhaustive measurement instruments, especially in determining public knowledge and community acceptance of the mentally ill. As such, the scales used in this study cannot compare to the mature and extensive measurement instruments that should be used to assess a more accurate description of the phenomena under concern. Therefore, caution is advised against generalizations about final conclusions made concerning public adherence to myths and community acceptance of the mentally ill. The limitations of this study do not allow for more comprehensive assessments in these areas.

There are three sources of response bias in the study of mental health (Gove & Geerken, 1977): 1) the tendency for people to answer questions in either a positive or negative way irrespective of the content of the questions; 2) the tendency to choose the socially desirable response to questions; and 3) the degree of a person's need for approval from others (Monnette et. al., 1986:158). There is also the problem of non-response which further limits the generalizability of this study. How do respondents differ from non-respondents, and to what extent could these differences bias the results? While measures can be taken to include information about non-respondents (Monnette et. al., 1986: 149), it is often costly and time-consuming and beyond the resources and feasibility of this study. These sources of response and non-response bias could subsequently influence final results and can only be acknowledged within the context of this study. Again, any generalizations made must give careful consideration to these biases and limitations.

V. SURVEY RESULTS

INTRODUCTION

A summary of the results from the collected data are contained in this next section. The presentation of findings will be followed by a discussion of conclusions and recommendations in the final chapter of this paper.

RESPONSE RATE

TELEPHONE SURVEY:

Agreed to be interviewed	n = 46
Refused to be interviewed	n = 24
Respondent moved or phone disconnected	n = 14
Could not be reached	n = 10
Could not speak English	n = 4
Incomplete Interviews	n = 2
	<hr/>
	N = 100

A 46% response rate was obtained from the general public sample. The majority of respondents who refused simply and politely stated they were not interested in participating. For those who did offer specific reasons for refusing, 4 respondents cited ill health, 3 were too busy, 2 felt they

couldn't offer any opinion in the area, 2 others did not want anything to do with surveys, and one respondent did not want to discuss the subject. Two-thirds of those who refused were male.

The topic of mental health tends to create anxiety in some people and, while not verbally stated, it is possible this could account for some of the refusals. Some individuals are also wary of interviews that may get too personal --- especially in the area of mental health. While some respondents did initially sound somewhat hesitant to agree to the interview, the interviewer was able to reassure them that questions were not personal in nature, re-iterating the purpose of the survey, and confirming that they did have the right to refuse to answer any questions asked. This procedure appeared to reduce initial hesitancy in some cases and the interviewer was able to proceed with the interview.

The non-English speaking immigrant population was clearly not well represented in the survey sample. The more mobile population also constituted a loss in the representativeness of the population. These limitations were expected given the sampling and survey methodology used.

SURVEY OF COMMUNITY SERVICE PERSONNEL:

	Participated:
8 Schools	n = 6
98 Employee Assistance Programs	n = 50
30 Social Service/Health Agencies	n = 9
15 Community/Neighborhood Organizations	n = 5
	<hr/>
N = 151	n = 70

While the schools and EAP's fared a better rate of return than social service/health and community/neighborhood organizations, these latter two groups still responded above the unacceptably low 20% level (Monnette et. al., 1986). Babbie (1983) suggests that a 50% rate is adequate for analysis. Given that the total response rate for both survey groups was 46%, this is considered satisfactory for the study.

DEMOGRAPHICS

From the general public group, 44% of the sample population were male and 56% were female. The age range of respondents is described below:

TABLE 1: AGE BREAKDOWN OF TELEPHONE RESPONDENTS n = 46

AGE GROUP	18-24	25-29	30-39	40-49	50-59	60-69	70+
# of Respondents	11	5	10	7	6	3	4
% of Respondents	24%	11%	21%	15%	13%	7%	9%

The above statistics indicate the majority of respondents were of the younger age bracket and this reflects the college/university education of 61% of the respondents. The remaining 37% of the respondents completed high school education and 2% completed elementary level education.

The marital status of 48% of the population were found to be single while 37% of the population were married, 4% were divorced/separated, 4% were widowed and another 7% were living common-law. The marital status and age bracket of the general public population are consistent with the extremely high percentage of the population, 83%, who have no children under 18 years of age.

The majority of the general public population, 61%, were employed and only 2% unemployed, 17% of the respondents were students, 13% were retired and another 7% were homemakers. In terms of occupational status, the unemployed were obviously under-represented in this sample.

Respondents were asked what magazines and newspaper they read most often:

28% do not read any magazines, but 17% of the respondents read TIME magazine regularly and 9% of the respondents read MACLEANS magazine. Thirteen percent of the respondents do not read any newspaper, but 57% read THE SUN, 24% read THE PROVINCE, 4% read THE TORONTO GLOBE & MAIL, and the remaining 2% read other newspapers such as the community/neighborhood newspaper.

In summary, a profile of the dominant social characteristics of the general public sample population can be described as young adults with post-secondary education between the ages of 18-39, who are single and employed.

FAMILIARITY WITH THE CANADIAN MENTAL HEALTH ASSOCIATION (C.M.H.A.)

GENERAL PUBLIC: When asked if they had ever heard of the Canadian Mental Health Association, 72% said 'yes'. However, only 30% stated they were familiar with what the Association does. Even of the 30% who responded in the affirmative, some respondents failed to accurately describe C.M.H.A. activities. For example, six respondents confused C.M.H.A. with the Association for the Mentally Retarded who are well known for their clothing drives. Another respondent, while describing C.M.H.A. as a philanthropic,

benevolent organization, thought the Association had "something to do with the accreditation of psychologists". Those respondents who were able to correctly identify various C.M.H.A. activities mentioned advocacy for the mentally ill, pamphlets on stress, support groups, activity centres, responsible for the care of those already disturbed. 'Assisting the mentally ill' or 'helping mentally handicapped people' appeared to be the common theme from those who stated familiarity with the Association's activities. Only two respondents progressed beyond this description by acknowledging C.M.H.A. as "trying to promote a greater understanding of mental health in the community" and to "encourage mental health".

COMMUNITY SERVICE PERSONNEL: 87% of the community service agencies have heard about C.M.H.A. However, only 29% of the total respondents were familiar with the resources and programs provided by the Association. When broken down into agency responses, 83% of the schools, 72% of the EAP's, 50% of the social service/health agencies, and 80% of the community/neighborhood organizations were not familiar with what C.M.H.A. does.

A total of 81% for both groups sampled ($n = 116$) have heard about C.M.H.A., but only an average of 30% of the sampling population were familiar with what the Association does. While there is a significant difference between the two groups in terms of having heard about the Association --- that is, community service organizations are more likely to have heard about C.M.H.A. than the general public ($\chi^2 = 9.03$, $d.f. = 2$, $prob. = .01$) --- there is no difference between group membership and familiarity with what the Association does ($\chi^2 = .278$, $d.f. = 1$, $prob. = .87$). In other words, community service personnel do not significantly differ from the

general public in terms of familiarity with C.M.H.A. activities.

IMPORTANCE OF MENTAL HEALTH INFORMATION

GENERAL PUBLIC: Only 8% of the general public think about their mental health a great deal, 24% think about their mental health fairly often, a majority of 44% think about their mental health only occasionally, and 24% never think about their mental health.

While the majority of respondents tend not to pay a great deal of attention to their mental health, 67% still thought it was important for them to learn about mental health problems and how to deal with these problems. Table 2 describes the degree of importance placed on specific mental health information for the people surveyed.

Stress and self-confidence consistently ranked the highest under 'extremely important' and the lowest under 'not important at all'. While the average scores for each subject area do not differ significantly, the higher averages obtained for stress and self-confidence validate their position of importance against other subject areas.

Schizophrenia and separation/divorce ranked the highest under the 'not important at all' category, respectively scoring 50% and 57%. While schizophrenia remained consistent by placing as one of the lowest in the 'extremely important' category, separation/divorce did not follow this same pattern. If, however, scores from the upper end of the scale were added together, separation/divorce

TABLE 2: SELF-RATINGS OF IMPORTANCE OF MENTAL HEALTH
INFORMATION FOR TELEPHONE INTERVIEW RESPONDENTS

n = 46

	NOT IMPORTANT AT ALL	SOMEWHAT IMPORTANT	IMPORTANT	VERY IMPORTANT	EXTREMELY IMPORTANT	AVERAGE SCORE *
STRESS	4.3%	13.0%	26.1%	28.3%	28.3%	3.6
SELF-CONFIDENCE	17.4%	15.2%	23.9%	17.4%	26.1%	3.2
SEX EDUCATION	23.9%	6.5%	30.4%	15.2%	23.9%	3.0
PERSONAL CRISIS	19.6%	15.2	30.4	10.9%	23.9%	3.0
DEPRESSION	26.1%	19.6%	10.9%	26.1%	17.4%	2.9
PARENTING	37.0%	10.9%	15.2%	10.9%	26.1%	2.8
AGING & RETIREMENT	30.4%	19.6%	19.6%	10.9%	19.6%	2.7
CARE-GIVING IN THE HOME	32.6%	17.4%	19.6%	10.9%	19.6%	2.7
GRIEF & MOURNING	30.4%	15.2%	21.7%	15.2%	17.4%	2.7
FAMILY VIOLENCE	47.8%	2.2%	13.0%	13.0%	23.9%	2.7
PHOBIA	33.3%	24.4%	20.0%	4.4%	17.8%	2.5
DRUG & ALCOHOL	43.5%	10.9%	17.4%	8.7%	19.6%	2.5
SCHIZOPHRENIA	50.0%	16.7%	11.9%	11.9%	9.5%	2.5
SUICIDE	45.7%	13.0%	8.7%	21.7%	10.9%	2.4
EATING DISORDERS	39.1%	17.4%	15.2%	19.6%	8.7%	2.4
FAMILY & MARRIAGE	41.3%	19.6%	10.9%	17.4%	10.9%	2.3
SEPARATION/DIVORCE	56.5%	10.9%	15.2%	0	17.4%	2.1

* maximum of 5

would clearly rank the lowest --- which is consistent with its lowest average score. It is interesting that no respondents replied 'very important' for separation/divorce, yet those who did respond favorably did so at the extreme end of the scale. Given the demographic profile of the survey population where the majority of respondents are single, it is assumed that the subject of separation/divorce is not important to them. Those who did rank this subject as extremely important may have directly experienced the situation or have been indirectly affected by it, as some respondents commented, through their own parents. Consideration must also be given to response set in the type of scores obtained for each item. Some individuals may tend to assign a high score or a low score to all items, regardless of actual personal need for information in the subject area.

Improving functional competence and coping skills as objectives of primary prevention appear to be of greater interest to the 'normal' target population. People feel that information on the more serious mental health problems (eg. schizophrenia, eating disorders, phobias) are less important to them. Issues of more personal and immediate concern are more important than future-oriented or non-associative subjects to the individual. In other words, the general public population feel that information which is closer to their own personal experiences is more important to them than information which is not directly affecting them.

ANOVA (analysis of variance) statistical procedures were computer generated to compare mean scores with the socio-demographic variables age, occupation, education, marital status, having children under 18 years of age, and gender. For the most part, there was no relationship between the degree of importance placed on specific mental health information and socio-demographic variables.

Table 3 indicates the few cases where a relationship was shown to exist between mean scores and certain socio-economic variables. It should be kept in mind that these results are a subset of a large series of tests: the probability values should be viewed as tentative.

TABLE 3: SIGNIFICANCE OF RELATIONSHIP BETWEEN IMPORTANCE ON
MENTAL HEALTH INFORMATION AND SOCIO-DEMOGRAPHIC VARIABLES n = 46

MENTAL HEALTH INFORMATION SUBJECT AREA	RELATIONSHIP WITH VARIABLE	F STATISTIC	DEGREES OF FREEDOM	PROBABILITY
Parenting	Age	2.6	45	.03
Self-Confidence	Age	2.5	45	.04
Sex Education	Occupation	2.7	45	.04
Self-Confidence	Occupation	3.2	45	.02
Parenting	Have children under age 18	5.8	45	.02
Sex Education	Have children under age 18	5.3	45	.03
Depression	Gender	5.1	45	.03

The 25 - 29 age group and those who have children under 18 years of age are more likely to score higher means for information on parenting. Higher mean scores for information on self-confidence are also associated with the younger age bracket (18-39) as opposed to the older age group. The unemployed, home-makers and students place more importance for information on self-confidence than the employed and retired group. Home-makers, students and those with children under 18 years of age are also more likely to score higher means for information on sex education. Finally, there is a relationship between gender and mean scores on depression: females place more importance on information in this subject area than males.

IMPORTANCE ON MENTAL HEALTH INFORMATION

COMMUNITY SERVICE PERSONNEL: Each agency in this group was also asked how important it would be for their organization to have information on specific mental health topics. The results are shown in Table 4.

TABLE 4: SELF-RATINGS OF IMPORTANCE OF MENTAL HEALTH INFORMATION FOR
COMMUNITY SERVICE PERSONNEL

	N	NOT IMPORTANT AT ALL	SOMEWHAT IMPORTANT	IMPORTANT	VERY IMPORTANT	EXTREMELY IMPORTANT	AVERAGE SCORE *
STRESS	68	1.5%	1.5%	10.3%	22.1%	64.7%	4.47
DRUG & ALCOHOL	68	1.5%	4.4%	7.4%	23.5%	63.2%	4.43
DEPRESSION	68	5.8%	0	4.3%	36.2%	53.6%	4.32
FAMILY & MARRIAGE COUNSELLING	67	9.0%	1.5%	6.0%	20.9%	62.7%	4.26
DEALING WITH A PERSONAL CRISIS	66	3.0%	3.0%	15.2%	25.8%	53.0%	4.23
SEPARATION & DIVORCE	66	6.1%	6.1%	4.5%	27.3%	56.1%	4.21
SELF-CONFIDENCE	67	1.5%	3.0%	16.4%	31.3%	47.8%	4.21
FAMILY VIOLENCE & SEXUAL ABUSE	67	4.5%	4.5%	19.4%	35.8%	35.8%	3.94
SUICIDE	67	4.5%	10.4%	17.9%	25.4%	41.8%	3.89
PARENTING	66	9.1%	15.2%	10.6%	28.8%	36.4%	3.68
AGING & RETIREMENT	66	6.1%	16.7%	18.2%	33.3%	25.8%	3.56
GRIEF & MOURNING	68	8.8%	8.8%	27.9%	33.8%	20.6%	3.48
EATING DISORDERS	67	7.5%	14.9%	20.9%	35.8%	20.9%	3.47
SEX EDUCATION	67	14.9%	20.9%	20.9%	23.9%	19.4%	3.12
PHOBIAS	66	9.1%	27.3%	25.8%	22.7%	15.2%	3.07
CARE-GIVING IN THE HOME	65	21.5%	27.7%	24.6%	16.9%	9.2%	2.64
SCHIZOPHRENIA	66	22.7%	33.3%	16.7%	15.2%	12.1%	2.60

* maximum of 5

Given that the community service personnel were differentiated into four groups, mean scores were calculated for each group (Table 5). As indicated by the significance tests (F ratios), there is a significant relationship between the type of agency and the overall average importance (mean score) placed on particular types of mental health information. For example, schools and EAP's have a higher mean score on importance for information on family/marriage, separation/divorce, dealing with a personal crisis and stress in comparison to the mean scores in these areas for social service/health and community/neighborhood organizations. This is further substantiated by the ETA^2 statistic which indicates the significance of association between agency type and rating of importance on specific mental health information.

Relatively speaking, the mental health issues of stress, depression and dealing with a personal crises were all situated at the upper end of the Importance Scale on Table 2 and 4, indicating both groups surveyed feel information in these areas are the most important. Similarly, both groups placed eating disorders and schizophrenia at the bottom end of the scale.

On the whole, community service personnel place more importance on mental health information than the general public. The overall mean score for the former group was 3.74 out of a maximum of 5, while the latter group averaged a score of 2.97. Table 6 compares the mean scores between both group for each mental health issue, presenting the level of significance in the difference between means and their variances. The table indicates that the general public and community service personnel differ significantly in their mean scores for almost every subject area except schizophrenia, care-giving in

TABLE 5: MEAN SCORES ON IMPORTANCE OF MENTAL HEALTH INFORMATION FOR EMPLOYEES OF DIFFERENT COMMUNITY AGENCIES

	SCHIZOPHRENIA	DEPRESSION	SUICIDE	PHOBIA	EATING DISORDERS	FAMILY & MARRIAGE	SEPARATION & DIVORCE	AGING & RETIREMENT	CARE-GIVING IN THE HOME	GRIEF & MOURNING	PARENTING	SEX EDUCATION	DRUG & ALCOHOL	DEALING WITH PERS. CRISIS	FAMILY VIOLENCE	STRESS	SELF-CONFIDENCE
n =	66	68	67	66	67	67	66	66	65	68	66	67	68	66	67	68	67
SCHOOLS	2.2	4.5	4.5	2.3	3.5	4.0	4.2	2.0	1.8	2.8	3.2	3.8	4.2	4.3	4.2	4.3	4.3
EMPLOYEE ASSISTANCE PROGRAMS	2.5	4.4	3.9	3.3	3.5	4.6	4.4	3.7	2.6	3.6	3.9	3.1	4.6	4.4	4.0	4.7	4.2
SOCIAL SERVICE & HEALTH AGENCIES	2.8	3.7	3.3	2.8	2.8	3.1	3.3	3.8	3.5	3.6	3.3	3.0	3.6	3.5	3.1	3.9	4.1
NEIGHBORHOOD & COMMUNITY ORG.'S.	3.6	4.4	4.2	2.6	4.0	3.4	3.6	3.4	2.8	3.0	3.2	2.4	4.2	3.2	4.4	3.8	4.4
OVERALL MEAN	2.6	4.3	3.9	3.0	3.5	4.3	4.2	3.6	2.6	3.5	3.7	3.1	4.4	4.2	3.9	4.5	4.2
SIGNIFICANCE TESTS (F ratios)	.2853	.2246	.2439	.1848	.2602	.0035	.0318	.0228	.0993	.3682	.4185	.3770	.0274	.0073	.1107	.0213	.9413
ETA ²	.2425	.2539	.2521	.2727	.2475	.4387	.3628	.3764	.3113	.2185	.2104	.2182	.3637	.4185	.3008	.3736	.1787

TABLE 6: STATISTICAL SIGNIFICANCE OF DIFFERENCES IN MEANS AND VARIANCES BETWEEN THE GENERAL PUBLIC AND COMMUNITY SERVICE SAMPLES

	GENERAL PUBLIC MEAN SCORE	COMMUNITY SERVICE MEAN SCORE	TEST (t) STATISTIC	PROBABILITIES (MEANS)	PROBABILITIES (VARIANCES)
SCHIZOPHRENIA	2.5	2.5	- 1.0	.9430	.07
DEPRESSION	2.9	4.3	- 5.6	.0000	.0166
SUICIDE	2.4	3.7	- 4.8	.0000	.3017
PHOBIAS	2.4	2.9	- 1.7	.0882	.2954
EATING DISORDERS	2.4	3.3	- 3.5	.0007	.4130
MARRIAGE/FAMILY	2.4	4.1	- 6.2	.0000	.4461
SEPARATION/DIVORCE	2.1	4.0	- 6.5	.0000	.4533
AGING/RETIREMENT	2.7	3.4	- 2.4	.0193	.3775
CARE-GIVING IN THE HOME	2.7	2.5	.79	.4304	.2473
GRIEF & MOURNING	2.7	3.4	- 2.5	.0147	.1607
PARENTING	2.8	3.5	- 2.3	.0255	.3304
SEX EDUCATION	3.1	3.0	.36	.7175	.4851
DRUG & ALCOHOL	2.5	4.3	- 7.0	.0000	.0111
PERSONAL CRISIS	3.0	4.0	- 3.5	.0006	.4295
FAMILY VIOLENCE	2.6	3.8	- 4.0	.0001	.0242
STRESS	3.6	4.3	- 3.3	.0013	.4067
SELF-CONFIDENCE	3.2	4.0	- 3.3	.0013	.1446
OVERALL MEAN	2.97	3.74			

the home and sex education; however only the variances between depression, drug/alcohol addiction and family violence are statistically significant.

INFORMATION SYSTEMS

GENERAL PUBLIC: When asked who they would talk to if they had a problem that was affecting them emotionally, 51% of the respondents would first talk to a friend or family member. Another 29% would go to their family doctor, 11% would go to a professional counsellor, and a remaining 9% responded in the 'other' category. In the latter category, two respondents mentioned social services, one respondent said he would try to work it out himself, and another subject stated, "I would shut the problem out of my mind".

A majority of the respondents, 33%, felt that talking to people with similar problems would be the best way of providing mental health information to them, 24% felt television would be the best, 15% was rated equally for both educational talks and pamphlets, and 13% felt newspapers/magazines would be the best way of providing information. The personal, informal support system is the most preferable for receiving information on mental health issues --- which is consistent with the finding that most people would first talk to a friend or family member about an emotional problem.

At times, people are at a loss as to where to turn to in times of need. When asked what they would do if they didn't know where to turn for help, 58% replied they would ask somebody, such as a friend or family physician. 20% mentioned turning to a referral agency such as the Crisis Centre, 15% did not

know what to do, and only 8% mentioned turning to the telephone directory. While the Greater Vancouver Telephone Directory provides a list of community services at the front of the text with the names and numbers of agencies for specific sources of help, the general public do not appear to be too familiar with this service.

Respondents were asked where they would go if they needed information on various mental health subject matters they considered as most important. An average of 29% of the respondents did not know where to go for such information, 42% of the respondents were able to identify general sources such as a friend, a clergyman, the library, a college course, or family physician. Another 29% identified more specific resources such as the Community Health Clinic, U.B.C. Health Services, Ministry of Human Resources or the Crisis Centre. Only one respondent mentioned C.M.H.A., which was probably a result of the interview contact itself rather than previous knowledge of the Association. The survey population did not acknowledge any of the Mental Health Clinics or C.M.H.A. as a referral resource for information. Knowledge of any specific mental health agencies also appeared to be limited.

Eighty-seven percent of the respondents have known somebody who has suffered a mental illness or an emotional problem. To the best of their knowledge, 58% of these respondents said that the person did receive professional help. The majority, 33%, felt that the service was helpful to the person, 2% did not know, 11% felt the service was somewhat helpful, and 15% did not feel the professional service was helpful. This latter group provided comments such as "made matters worse, shock therapy screwed her up; don't believe in psychiatrists;

electro-shock treatment does more damage; don't believe in counselling". 20% of the respondents said the people they knew suffering from a mental illness or emotional problem did not receive professional help. Reasons given included: "scared to reach out; reluctance of the person to admit they need help ... want to say 'yes, everything is great and wonderful; scared to contact people because they might label you mentally ill". Denial, fear and negative stigma continue to be major barriers to seeking help.

COMMUNITY SERVICE PERSONNEL: Respondents were asked how C.M.H.A. could best provide mental health information to their organization. They were asked to choose one method from a list of four choices. Twenty-six of the seventy respondents failed to abide by these instructions and checked more than one answer; these responses were omitted from the computer coded results. Of the remaining forty-four respondents, 59% believe that pamphlets/brochures are the best way of providing information to them, 21% said availability of training films/video cassettes; 18% said workshops/seminars, and 2% felt that television and radio would be the best way of providing mental health information to them. Responses for the twenty-six missing cases were categorized manually: pamphlets/brochures were listed 17 times, training films/video cassettes were listed 16 times, workshops/seminars were listed 7 times and television/radio was listed twice. These responses did not appear to alter the previous order of responses --- that is, pamphlets/brochures were still the most preferable method of providing mental health information to community agencies.

In providing mental health information and education to their clients, 36% of the agencies felt that pamphlets would be the best method, 26% said

referral to appropriate resources, 23% said self-help groups, 9% said television, and 6% felt that educational talks would be the best method. Again, 17 agencies inappropriately responded to the question by checking more than one answer from the possible list of five choices and these answers were manually categorized. Overall, community service personnel believe that pamphlets would be the best vehicle for providing mental health information to their clients.

DIFFICULT PROBLEMS IN LIVING

GENERAL PUBLIC: When asked to list three of the most difficult problems experienced in their life, many respondents had trouble identifying three problems. It is likely that some did not want to reveal very personal issues to the interviewer; it is also likely that many of the respondents simply could not identify three problems in their life that actually stood out in their mind.

The death of a loved one (parent, spouse, child, friend) was mentioned the greatest number of times by respondents as one of the more difficult problem experienced in their life. A second theme emerged in the area of coping --- especially coping due to an illness or accident in the family or due to an adjustment to a new life. Work-related difficulties was the third most prevalent theme identified by respondents. Difficulties with relationships, physical difficulties, financial and school-related difficulties were other themes identified by the general public. While experiencing the death of a loved one was expressed by many of the respondents as a difficult time in

their life, information on grief and mourning was not a high priority item for this population. It is likely that people have adequately dealt with the past event and, as previously mentioned, they are more concerned with the present and more immediate experiences in their lives.

COMMUNITY SERVICE PERSONNEL: Respondents in this group were asked to list three of the most common problems experienced in the daily lives of the people they serve. Stress/anxiety were problems most commonly encountered. Difficulties with family and marital relationships was the second most prevalent theme, and alcohol/drug abuse was the third most common problem listed by this group. The area of self-esteem, personal identity and life skills in general was another common theme identified by community service personnel.

Assuming that the clientele for the majority of the community service personnel are characterized as individuals who are at-risk, it would appear that perceived problems in living differ to some extent between 'normal' population groups and at-risk groups in the population. While coping with a personal loss or with an illness in the family were identified as two of the more difficult life experiences for the majority of the general public, the helping professions did not encounter these same difficulties in the clientele they serve. While the community service personnel identified stress as the most common problem, the general public was able to focus on the more specific stress-related problems: work-related difficulties, relationship problems, physical and financial difficulties.

THOUGHTS & OPINIONS ON MENTAL HEALTH AND ILLNESS

While it would have been interesting to assess the thoughts and opinions of community service personnel toward mental health and illness, it was not felt as relevant. Therefore, this following section pertains to the general public group only.

1) Conceptions About Mental Health

When asked "What does mental health mean to you?", 55% of the respondents were categorized as providing non-appropriate answers and 45% were categorized as providing appropriate answers. 'Appropriate' was defined as those answers that drew similar ideas from the definition of mental health (Chapter III).

The following are some of the statements offered by the 45% appropriate answers: "stability; sound mind; being able to use all your capacities; ability to cope well with life situations and problems; people who can function in society comfortably; good healthy mind able to handle everyday problems; state of well-being; mental stability; happiness and self-confidence; happy and enjoying life".

Of the 55% categorized as attaching inappropriate responses to the meaning of mental health, the following responses were given: "people who find themselves under great strain; a person is mentally disturbed' disease of the mind; people struggling; handicapped; people that are upset or have a chemical disorder; not mentally stable". The 14% of the respondents who answered "don't know" were also placed under the non-appropriate category.

Respondents were asked, "do you think there are ways we can improve our mental health?" --- 57% responded yes, 17% responded maybe, 17% responded don't know and 9% responded no. Given that 55% inappropriately defined the concept, it would appear consistent that people who are not familiar with the principles of mental health are also unlikely to be knowledgeable about positive mental health practices.

While 57% of the respondents think we can improve our mental health, many of them could not describe what could be done to improve mental health. For those who did offer suggestions, a common theme of 'talking things out' emerged as the most popular response. "Talk about problems to a good friend; talk to someone who can offer help; learn to communicate better; reach out and ask for help; talk and get rid of it(stress); open up with emotions" --- were some of the responses provided. 'Reading and learning' was the second most prevalent suggestion offered by the general public when asked what we could do to improve our mental health. "Read more books... try to find out more about it; keep learning; learn from everyday life; read self-help books" --- were the comments of some respondents. Other themes which emerged from the question about mental health practice included diet/exercise, physical health, taking responsibility to change one's lifestyle, and keeping busy or active.

2) Rejection of Myths About the Mentally Ill

Respondents were asked to reply to a number of statements which are known to be prevalent myths about recovered mental patients. Results are shown in the following table:

TABLE 9: REJECTION OF MYTHS ABOUT THE MENTALLY ILL

n = 46

	AGREE	DISAGREE	DON'T KNOW
1. One of the main causes of mental illness is the lack of personal strength and willpower.	22%	70%	8%
2. A majority of people with mental illness are unpredictable.	39%	39%	22%
3. A person who has been mentally ill can never be normal.	4%	96%	0
4. A schizophrenic is a person with a split personality.	46%	35%	19%
5. If a person has been mentally ill for a long time, there isn't much hope for recovery.	20%	54%	26%

In the five-item rejection of myth scale, the average scores could range from a low of 5 (if the respondent agreed to every statement) to a high of 15 (if the respondent disagreed to every statement). The problem of response pattern anxiety was avoided by interspersing the statements read to the respondent with statements from the community acceptance scale, so that there was a mixture of high-valued 'disagree' statements followed by high-valued 'agree' statements. The average score for the myth scale was 11.7 out of a possible high of 15. This indicates the survey population as positively skewed toward the upper end of the scale, so that generally, the population would tend to reject the commonly held myths about the mentally ill. The problem of response bias, however, almost always occurs in this type of research --- so that there must be some question as to what people 'actually' believe and what they feel they 'should' believe to be socially acceptable. Given the

influence of response bias, the average rejection of myths score is probably lower than actually indicated.

Some myths still prevail --- such as unpredictability of the mentally ill and the split personality of schizophrenics. Therefore, while some notable gains have been made in improving the knowledge and attitudes of the general public toward the mentally ill, there is still room for improvement. As Nunnally (1961:47) would suggest, "much of the dread of the mentally ill might be removed if the public could learn some meaningful patterns and consistencies of psychotic behavior, so that it is more understandable and more predictable".

3) Scaling Community Acceptance

TABLE 10: COMMUNITY SUPPORT SCALE

n = 46

	AGREE	DISAGREE	DON'T KNOW
1. I believe that ex-patients of a mental hospital can function well in the community.	85%	2%	13%
2. I would object if someone who had been previously mentally ill moved next door to me.	11%	83%	6%
3. I can imagine myself become a close friend with someone who is mentally ill.	61%	15%	24%
4. I would object if a half-way house for mentally ill people was located in my neighborhood.	15%	74%	11%
5. If a mentally ill person asked for help in getting a job where I work, I would be willing to help.	86%	7%	7%
6. I would regularly participate in programs in my neighborhood which help mentally ill people.	41%	31%	28%

Community support and acceptance is expected if mentally ill persons are to ease back into community living. Items from the above community acceptance scale were differentiated into active and passive components to discriminate level of support. The passive requirement, for example, involves a consensus of public opinion and an absence of protest. Active support, on the other hand, involves the personal involvement of community members in helping behaviors (Johnson & Beditz, 1981). With the exception of statement #5, the two active statements (#3 & 6) scored considerably lower than the passive statements. It would appear that, as observed by the National Institute of Mental Health (1977), "the willingness to tolerate proximity to former patients is not equivalent to active support defined through behaviors" (Johnson & Beditz, 1981: 154).

Most people are willing to actively help a mentally ill person get a job where they work. Three explanations are offered for the 86% score. Firstly, a number of respondents who agreed they would help commented they would do so --- depending only upon the skill of that person. Therefore, while some reservations were placed on the specific situation, these respondents generally agreed to the statement and were consequently recorded as agreeing to help. The actual extent of help, however, is unknown. A second explanation is what is known as response bias. Rather than being perceived as non-supportive to the interviewer, respondents may have answered favorably because it is more socially acceptable to do so. A third explanation for the 86% score is the possibility that people would genuinely try to help a mentally ill person find a job at their place of work.

In the six-item community acceptance scale, the average score could have ranged

from a low of six to a high of eighteen. For the population surveyed, the community acceptance scale averaged 15.5 out of a high of 18, which indicates the population as positively skewed toward the upper end of the acceptance scale. Generally, the sample population appears to be supportive of the mentally ill but again, the problem of response bias should be considered as a limitation to making any final conclusions.

4) Conceptions About Mental Illness

The general public was asked, "What do you think of when you hear the words 'mental illness'?". Responses were categorized into three themes: 1) a technical or objective theme where subjects responded in a matter of fact manner; conceptions drew similar parallels to the definition of mental illness (Chapter III). Responses included short statements such as, "a person who has trouble functioning; degrees of illnesses; unable to cope with daily routines; serious emotional problem; mental or emotional disorder; instability". The majority of responses were categorized into this technical/objective theme. 2) an almost equal number of replies were categorized into an image theme; people have a subjective association to the term mental illness, such as "my daughter, my brother; aunt". Other people in this category portrayed other images: "people wandering around; unhappy people; somebody that's clinging to the edge; someone crazy". 3) a small number of responses elicited attitudes or feelings: "shock; pity the people; feel bad for those people; feel sorry ... it's tragic when somebody's like that". Three respondents replied "don't know" to this question.

For the most part, people do not have overtly repulsive ideas about the mentally ill; but popular stereotypical images still persist. Beliefs and

attitudes toward the mentally ill are not negative per se; improvement in this area has been made as a result of increased community awareness and education programs.

COMMUNITY SUPPORT

GENERAL PUBLIC: The majority of the sample population, 76%, felt that education in mental health could be improved, 12% felt it could not be improved, and another 12% stated they did not know. A common theme of 'awareness' and 'accessibility to information and resources' were the most predominant among those who were able to provide suggestions for improvement. Education through the school system was a third common theme: "what you are doing has got to be good ...a lot of people that needs help out there ... personal approach is better, one-to-one. Personal visits to young people in the classroom is better than pamphlets which people don't really read". In terms of awareness, one respondent commented, "people should be made more aware of how common these problems are ... many will say 'it's interesting but it doesn't apply to me'. People are ashamed of mental illness, it's like the plague. We're not prepared to face ourselves ... there's tremendous ignorance about mental illness".

COMMUNITY SERVICE PERSONNEL: When asked if their organization would like to have more information and education on mental health and mental health problems, 81% responded 'yes'. Of these who responded in the affirmative, 83% of the schools, 84% of the EAP's, 56% of the social service/health agencies and 100% of the community/neighborhood organizations all said 'yes'.

It is likely that social service and health agencies are less inclined to want more information in mental health if they are already providing same.

While 57% of the agencies would prefer to have more information on the resources available for assistance and support, 17% responded equally to the need for information on the symptoms of mental illness and information on prevention in mental illness, 7% said information on how to become more understanding and accepting toward the mentally ill is most preferable, and 2% of the agencies prefer information on the causes of mental illness. The need for information on the resources available is consistent with the finding that 61% of the total respondents were not familiar with any other mental health educational programs in their community.

Respondents were asked to state the one most important mental health service C.M.H.A. could provide for the community. Seven of the seventy respondents checked more than one response and were therefore excluded from the computer coded results. Of the remaining 61 responses, 53% said information/education, 41% said development of community resources, 12% said rehabilitation and 5% said advocacy and lobbying government would be the most important mental health service. The seven missing cases were categorized manually with information/education and development of community resources both listed 5 times and advocacy/lobbying government listed 3 times. One respondent commented that "all the services are important" and therefore did not choose any answers from the list provided.

Of the agencies surveyed, 51% presently do not provide any mental health educational programs or informational material. Of these agencies, 27% would

be interested in doing so in the future, 21% would 'maybe' be interested and 3% would not be interested in providing mental health education or information.

It is felt that agency liaison and cooperation will help to enhance efforts to provide mental health educational programs and resources. Of the agencies surveyed, 21% would be interested in working with C.M.H.A. to plan such programs and resources, 52% would 'perhaps' be interested and 28% would not be interested.

The above opinions and feedback from the general public and community service personnel would indicate that there is general support and agreement to C.M.H.A.'s endeavours in the area of mental health education and informational programs. However, while passive support is useful and important, assessing and recruiting active support can be especially beneficial. There is potential to incorporate this recruiting strategy in future community surveys.

VI. IMPLICATIONS OF CONSUMER DATA

INTRODUCTION

A summary of survey results was presented in the preceeding chapter. In essence the acquired data has provided additional insight and understanding into the opinions and perceptions of the consumer and potential consumer of mental health information. But what final conclusions can be drawn from the data, and what implications do they have in planning and developing marketing strategies for effective and responsive programs? Furthermore, what can the organization do next in the way of future research? This chapter will address these proposed questions.

CONCLUSION #1: The name 'Canadian Mental Health Association' generates a high level of public awareness. While there is strength associated with the agency name, a major weakness is the low public familiarity with the organization's activities. Furthermore, whatever familiarity is acknowledged tends to focus on the 'illness' aspect rather than overall mental health.

IMPLICATIONS:

People recognize the C.M.H.A. name and this is important for gaining the trust of the consumer who will then perceive the Association as providing reliable and credible information.

C.M.H.A. - B.C. Division has already established an objective of producing and distributing a minimum of four press releases per calendar year. This is an effective strategy for raising the awareness and visibility of the organization while also serving to educate the public.

It is understandably difficult to concentrate on one specific focus given the broad mandate of C.M.H.A. As a marketing principle however, it is necessary to focus one's efforts to establish strong public recognition in one's products. Whatever image is created will determine which members in the community will perceive themselves as likely consumers and subsequent supporters of the organization. If C.M.H.A. is largely perceived as a service for the mentally ill, a stronger focus on positive mental health and enhancing functional competence is required to attract the interest and consuming behavior of normal groups in the population.

CONCLUSION #2: Stress is the most important mental health issue to the general public sample population and community service personnel. In terms of priority, both groups also rate information on the more serious disorders (i.e. schizophrenia) as least important to them. Issues of a more personal and immediate concern are more relevant to the normal population group than extrinsic and future-oriented issues.

IMPLICATIONS:

In seeking supportive public behavior, a focus on what consumers perceive as important to them is an essential strategy. In order to establish a relationship with specific target groups it is necessary to design competitively viable products in response to that market. While an abundance of material may already exist on the subject of stress, there is some question as to the

accessibility, affordability and awareness of these resources --- this could be an area to investigate for future research. At present, C.M.H.A. has not developed any information or educational programs on stress. As such, the organization may want to explore strategies for packaging and disseminating information on stress and stress management on a broad-scale basis.

Walsh (1981) refers to marketing as often depending on 'opportunistic serendipity' --- or taking the opportunity to make the most of a given situation. If, for example, stress and sex education are high interest topics and high profile media items, it would be rewarding to take advantage of the situation --- either by developing market products or at least producing a news release that editors are sure to publish because of the intensity of the subject at a given moment in time. Strategies which are undertaken during opportunistic moments can serve to educate the public while promoting the visibility of the organization --- but without the initial effort of having to attract the public's attention or interest. At present, developing information/education programs on stress and other topics that are more salient to similar public groups (eg. depression, dealing with a personal crisis) can be used to effectively draw potential consumers from the larger population.

CONCLUSION #3: The findings from this research supports previous findings (Bentz & Edgerton, 1970; Dear et. al., 1985; Rabkin, 1974) that public beliefs and attitude toward the mentally ill have improved over time and are generally positive. The effect of community awareness and education programs and increased exposure/proximity to the mentally ill are factors contributing to this improvement. Nevertheless, certain stereotyped images and myths about the unpredictability and

split personalities of the mentally ill continue to persist --- probably as a result of media influences. Furthermore, passive support of the mentally ill is more evident than active support.

IMPLICATIONS:

While broad-based education campaigns are effective in educating the public about the mentally ill (Davis, 1965), according to the results of this survey such information is not as salient to the public as other information needs.

Direct exposure to the psychiatric patient in a role that can be perceived as being within normal limits --- representing 'normal behavior' --- is a strategy that will increase community acceptance of the mentally ill and improve understanding of their behaviors. Direct exposure, for example, would involve encouraging employers to hire more psychiatric patients in the workplace. If, as indicated in this study, people are willing to help a mentally ill person find work at their place of employment, the extent of active support can be ascertained through a survey of employers with follow-up contact with those who agree to help. While such a strategy is not as high key as a media-based campaign, it is more aggressive. Media-based campaigns, instead, can focus on issues which are more salient to the broader population.

Because media continues to portray negative images of the mentally ill, it is important that, as an advocate for the mentally ill, C.M.H.A. be prepared to issue media releases that aim to correct misperceptions or uninformed stories reported through the media. A communications officer or a publicity committee in place can serve to promote the organization and its activities at strategic moments when the opportunity arises.

CONCLUSION #4: Mental health still has negative connotations associated to it; people are not clear on what mental health is or what constitutes positive mental health practice. Furthermore, mental health does not generate a great deal of thought or personal concern: the majority of the general public 'only occasionally' or 'never' think about their mental health.

Mean scores indicate that community service groups are more interested consumers of mental health information than the general public. As Walsh (1981:274) comments, "marketing ideas to our colleagues is the easy part. It is applying the process to our constituents that the greater challenge lies". The general public population feels that mental health information is important to them, but that it is not very or extremely important. The middle ground attitude of the general public might suggest a passive acceptance to any type of information given our information-based society.

IMPLICATIONS:

The term 'mental health' is not used in any frequent or consistent basis in the various informational material produced by C.M.H.A. (eg. the Coping series). By exposing the term on a more casual and regular basis within the context of the educational messages, people will become accustomed to associating 'mental health' with aspects of everyday living (eg. stress in the workplace, parenting, coping with growing older). Rather than perceiving mental health in a negative manner, increased utilization of the term might generate a greater sense of understanding into what mental health is and how it is incorporated into one's own personal life.

It is useful to consider the principles of primary prevention and community mental health practice when devising information/education programs. One such

principle involves the active participation and responsibility of individuals for the maintenance of their own well-being. However, personal control and responsibility over one's own mental health cannot be encouraged if people give only minimal consideration to their own mental health and have inadequate knowledge about positive mental health practice.

In promoting mental health information, the goal is not to elicit passive acceptance but to trigger active behavior. Consequently, effective marketing strategies must consider arousing public interest and motivation in addition to informing and educating. Interest and motivation will be determined by the degree of importance individuals attach to certain health matters.

Greene and Simons-Morton (1984) identify two variables --- personal control and health importance --- as providing a general background of readiness or apathy toward health education. Taking these variables into consideration, they offer the following guidelines that can be applied to a wide variety of situations in health education:

- 1) Provide the learners with a realistic appraisal of the risks associated with poor health behavior
- 2) Help the learners develop a realistic view of their susceptibility to the health threat in question
- 3) Help the learners develop confidence in the effectiveness of the recommended health practice
- 4) Help the learners correct any exaggerated views they may have of the risks and difficulties the recommended behavior may involve
- 5) Provide frequent reminders of the need and opportunity for specific health actions
- 6) Encourage the learners to place high value on their health
- 7) Help people recognize their own power to change their lives.

The above guidelines provide practical strategies that can be applied to the planning and development of mass media material or educational programs.

Unless people are made aware that they are susceptible to specific illnesses or problems, they will not perceive such difficulties as important to them.

Furthermore, unless they feel they are in charge and can make things happen, they are generally not motivated to take action --- hence apathy results.

These factors should be considered when developing effective market products that aim to motivate potential consumers.

CONCLUSION #5: While the majority of the general public sample population prefer to receive mental health information through personal and informal methods, community service groups prefer to provide such information to their clients through the distribution of pamphlets and brochures. Perceptions pertaining to the best method of meeting information needs appear to differ between these two groups. Community service personnel, however, believe that it is equally important for C.M.H.A. to engage in both community development and public education. There is consensus among both groups as well that information about available resources is poorly lacking.

IMPLICATIONS:

Pamphlets, by themselves, are not effective educational tools (Goldston, 1969) and community service groups should not place too much emphasis on written material alone. The public prefers personal and informal contact as a method of learning and subsequent support. Media, such as audio-visual materials or pamphlets, can be used in conjunction with external, environmental support that reinforces a desired behavior and provides incentives for change. Self-help groups can be one kind of environmental support; or activating family support and encouragement can also be effective. Utilizing education materials, as

Goldston (1969) suggests, does not automatically result in changes in behavior, regardless of the allure of the media. By integrating mental health educational activities with media programs, the information can be more meaningful to individuals and therefore lead to action toward optimal mental health.

The finding that family and friends are more important sources of social and emotional support than are professionals is substantiated by other research (Gottlieb, 1983; Campbell & O'Neill, 1985). Effective preventive services should therefore exhibit much more concern with social networks and informal help-giving. Multi-media campaigns such as "Friends Can Be Good Medicine" (Taylor, Lam, Roppel & Barter, 1984) have been implemented to promote personal relationships along with physical and mental health. The possibility of designing similar health campaigns --- that is, encouraging the public to consider the value of initiating, maintaining and strengthening personal relationships --- can serve to be a viable and attractive strategy to promoting mental health and increasing the visibility of C.M.H.A. to potential consumers.

The development of self-help groups, neighborhood-based helping networks, and the use of volunteers can strengthen a community's ability to meet the needs of its members in a personal yet informal manner. Community organization, in this respect, is a worthwhile endeavour for C.M.H.A. The benefits of survey research can serve a dual purpose: acquiring consumer data while also enlisting the support of volunteers who would be interested in assisting C.M.H.A. with program planning and community development.

Further attention is required in an attempt to promote better knowledge of existing resources. While advertising professional and/or non-profit mental

health services is considered neither acceptable nor ethical, there needs to be some mechanism implemented to improve this long-standing problem. One suggestion might be to enhance the visibility of a central referral agency so that people at least know where to start looking for help. Pamphlets and handbooks on available resources already exist --- so it is a matter of acquiring the adequate funding that will help further promote the awareness and accessibility of such material to the broader population.

CONCLUSION #6: Telephone subscribers were chosen as the target population for this study because it was believed that this group was typical of a broader reference population --- the general public. However, each study population has its own distinctive features. The representativeness of telephone subscribers for this study was biased toward the young, employed and well-educated group in the population.

Responses from community service personnel were biased toward the EAP group, although a breakdown of agency responses were able to distinguish differences among the four agency types. Some agencies place more importance on mental health information than others. The characteristics of specific groups play a determining factor as to who are more likely to be interested consumers and supporters of specific mental health issues.

IMPLICATIONS:

The general public is not an identifiable group with an identifiable need. In its broadest sense, the general public is made up of people who follow a wide variety of culturally-based lifestyles. In marketing principles, as in survey sampling, it is essential that the general public, or subpopulations to be served, be clearly defined. One agency cannot offer all community mental health needs equally well to all clients, just as a single research project cannot expect to survey the whole population equally well.

Programs must reflect the differences between community agencies, target populations and needs. While this study was able to describe the characteristics and needs of two survey groups, it is still necessary to identify 'who' C.M.H.A. wants to establish as the target of their educational efforts. Different target markets needs different services that must then be promoted through different media (Walsh, 1981). If, for example, the target market of C.M.H.A. is EAP's, then target products will differ from target products for community/ neighborhood organizations or of telephone subscribers.

It is important that the Association focus on 'whose' interest, participation and support is wanted. The constituency of C.M.H.A.--- in reality --- is everyone because mental health should be everyone's concern. Nevertheless, due to other realities --- such as funding constraints, manpower limitations, the need to focus priorities and to develop viable programs for those who really need it --- it is necessary to identify at least key groups in the population who will use and benefit the most from the programs and services provided by the Association. Whose needs are you trying to satisfy? What is the objective of your efforts?

W.G. Albert (1981: 184) provides an outline of established principles which cannot be ignored in any attempt at public education, of whatever scale:

- 1) Exposure to the message or messages must be assured through careful consideration of audience/target group characteristics
- 2) Attention to the message must be assured through the use of appropriate media, communicators and message content
- 3) Acceptance of a message is aided by: a) credible sources
b) concise and simple content c) motivation, arousal and entertainment value d) repetition, and e) social/interpersonal support
- 4) The probability of behavior change is enhanced by message strategies that provide explicit instructions for change

- 5) The probability that behavior change will be lasting is improved when a socially supportive environment reinforces the change.

The above set of conclusions and implications are not meant to be hard and fast rules, nor are they meant to be simple solutions to a series of complex problems. Instead, they are suggestions that will serve to further enhance the incremental decision-making process for the research consumer. Limitations of this study --- as mentioned in previous parts of this paper --- must again be re-iterated so that conclusions and generalizations are taken with caution. It is acknowledged that, whatever suggestions and recommendations offered here will constitute only a minor part of the overall planning process. Whatever decisions and final programs are implemented will largely be influenced by other factors: the availability of manpower and other resources, the existence of other programs, the priorities of the organization, and the values and preferences of decision-makers.

RECOMMENDATIONS FOR FUTURE RESEARCH

Chapter V contained a summary presentation of consumer opinions and perceptions on various mental health issues. This was followed, in the preceeding section, by conclusions about the marketplace and implications for market strategies and program planning. Finally, in keeping with the objectives of this study, a list of recommendations is offered which C.M.H.A. might find useful for future research projects.

The adequacy of the research instruments was sufficient for the purposes of this study but, as in any research, there is always room for improvement. For example:

. Some community service personnel failed to abide by the instructions on the questionnaire and responded with more than one check mark in the open blanks. Question format should have asked respondents to indicate their selection by placing a number in a box corresponding to each alternative to force respondents to give a single response.

. Due to an over-riding concern for confidentiality, community service personnel were not requested to put their name on the completed questionnaire. This resulted in some problems locating those respondents who replied they would be interested in working with C.M.H.A. While names and telephone numbers were matched between the sampling list and returned responses indicating their agency name, there was no guarantee that questionnaires were actually completed by those individuals to whom questionnaires were mailed on the sampling list. Future questionnaires should request the name and telephone number of respondents who acknowledge a willingness to help.

. Question #13 on the general public questionnaire asks respondents if they feel mental health education could be improved. This is a leading question --- because, as one respondents commented, "anything can be improved" --- and should be re-worded to avoid biasing the results.

. Question #12 asks respondents where they would go to get information on _____ if they needed it. The blank was filled in with whatever mental health issue each respondent rated as most important in the preceeding scale question. The problem, however, was that respondents rated several issues equally, and the interviewer had to randomly pick and choose which mental

health issue to place in the blank. For a more consistent and reliable measure, the blank should be replaced with a series of two or three pre-determined mental health topics --- so that all respondents would be asked to respond to the same set of questions.

. Measuring the attitudes and community acceptance of the mentally ill could well be developed into a separate and more comprehensive survey in itself. Such studies, however, have been extensively conducted. What is lacking is information from the mentally ill themselves --- what are their experiences and perceptions based on their treatment from community members? What observations can more participatory research uncover in communities that are planning half-way houses? Alternate research methods can serve to counter-check responses from the traditional approach which tends to be influenced by social desirability bias.

An overall revision of the survey instruments will be determined by what decision-makers feel is important, given the findings from this study, for future research. This pilot study has initiated more questions than answers and future research questions may want to consider the following:

- . Is there sufficient and adequate material on stress? Consumers feel it is important to have such information, but is more needed? What resources are already available to the public?
- . Is C.M.H.A. willing to address the more salient topics of stress, self-confidence and drug/alcohol addiction? What are the priorities of the organization?
- . What factors will motivate people to take more responsibility for their mental health? How can programs be implemented to activate their interest?
- . How can C.M.H.A. work more cooperatively with community agencies in providing mental health information to their clients? What community development programs can be developed to best meet the needs of specific target groups?

These are but a few questions that this study has prompted and future research will likely lead to more. To continue asking questions and to persistently seek for their solutions provides vitality and innovation to programs in response to changing needs.

In considering future research methodology, the following suggestions are provided:

. The 46% response rate from telephone interviews would suggest that telephone surveys is a reasonable and economical method of collecting consumer data. This method also serves to educate the public and create more visibility for the organization on a personal basis. Careful consideration, however, should be given to adequate training of interviewers in a large scale survey. The validity and reliability of survey results can be jeopardized with inconsistent interviewer behavior and bias.

. There are certain limitations in surveying telephone subscribers through telephone interviews. While computer-generated random digit dialing will include non-subscribers and the more mobile groups in the population, there is still the problem of overlooking the lower income and non-English speaking groups. Incorporating other data collection methods, such as group administered questionnaires to pre-selected groups, can ensure an adequate cross-section of a broader population base.

. In surveying community service groups, mail-out questionnaires is both convenient and time-efficient. However, depending upon the numbers and the geographic dispersion of these groups to be surveyed, one-to-one interviews can be beneficial in drawing tangible community support --- especially where

C.M.H.A. branches are just in the developing stages. Where large numbers are surveyed and only minimal information is needed, post-card questionnaires have been known to produce a good response rate (Abramson, 1984).

. C.M.H.A. - B.C. Division is interested in conducting a large scale survey that would be representative of all parts of the province of British Columbia. There is no ideal method or magical number to ensure perfect representation. To stratify a sample by city size (large urban centre, small urban centre, rural centre) and by region (east, central, west, north) is one method of acquiring a geographic representation of communities across the province. Within each population stratum, choosing at least one centre with a C.M.H.A. branch office will provide a mix of samples with and without C.M.H.A. branches. According to a similar study (Dear et. al. 1985), a sample size of 100 responses for large urban centres, 75 responses for small urban centres, and 50 responses for the rural centres would provide for a reasonable population size. While it is risky to provide a number of 'how many people should be surveyed' for such a large scale study, a ball-park figure of approximately 1,000 (based on the Dear et. al. study, 1985) is suggested. This estimated number, however, will be determined by the purpose of the research, data collection methods, and available manpower and resources. It is impossible to obtain an ideal sample, and limitations of the study should be acknowledged prior to making any conclusions or generalizations.

. Establishing a working research committee at the division level is recommended to provide the necessary manpower to plan and conduct on-going research. A committee structure would also provide the needed support and guidance for branch level surveys. Committee members should include relevant

decision-makers, information users, and research consultants to provide the necessary technical expertise.

. In order to gain the full cooperation and participation of all branches in a provincial survey, the research committee should consider the involvement of various branch personnel at different stages of the planning process. Early and periodic involvement in the research process will enhance one's sense of belonging and commitment to the project. It will further serve to educate the individuals in survey research and encourage branch personnel to utilize survey results on a local basis.

It is felt that any recommendations for more concrete suggestions for future research would be premature at this point in time. Once a research committee is established, it is hoped that the data and experiences from this study will be used to generate on-going direction. The next time 'round can only get better.

AIMING IN THE RIGHT DIRECTION

By learning something about its marketplace --- that is, about consumers and potential consumers --- C.M.H.A. is in a better position to formulate more efficient strategies in promoting its image and its products. The organization is headed in the right direction in planning mental health educational programs. For the most part, the information generated by this research has accurately achieved what the utilization-focused research model (Patton, 1978) would confirm: that evaluation research gives additional knowledge to support facts already known, broadening the scope and verifying suspicions.

The Depression Program, "Listen to Me", is one example which indicates C.M.H.A. - B.C. Division is accurately responding to consumer needs.

Depression was one topic which both survey groups in this study rated as one of the most important. The strategy taken to incorporate audio-visual material with classroom teaching serves to enhance the learning process. Furthermore, the emphasis on 'friendship support' is an approach that would appeal to learners.

The Mental Fitness campaign is another program which would indicate C.M.H.A. - B.C. Division is cognizant of the needs and interests of potential consumers. In enlisting the support of consumers from a broader population base, the organization is appealing to their needs by promoting mental health and enhancing functional competence. The mass media campaign can successfully educate the public and increase their awareness about C.M.H.A. as 'mental health' focussed.

Professionals and other care-givers, too, lack adequate information and they are often neglected consumers of any community-based programs. By showing a sensitivity to their needs, C.M.H.A. is effectively enlisting their support to provide better programs and services to their clients.

Primary prevention and mental health promotion are likely to become even more salient topics once the public becomes fully aware of what mental health is, that they do have personal control over their mental health, and that it is important to maintain their mental well-being. Critics of primary prevention, however, have contended that the lack of demonstrated effectiveness of preventive efforts can only mean that they are merely shots in the dark

(Lamb & Zusman, 1979), and such criticism have severely influenced funding for preventive educational programs. Consequently, C.M.H.A. should place equal emphasis on evaluating the effectiveness of their educational efforts --- it is essential that empirical support be documented to further enhance the credibility of overall preventive programs.

It is evident from this study that people are not as interested in learning about the more serious mental disorders. The attitudes and community acceptance of the mentally ill are generally positive --- but there is still room for improvement. While C.M.H.A. attempts to focus on positive mental health and appeal to consumers perceived to be normal groups in the population, the needs of the mentally ill cannot be overlooked. More low-key yet aggressive strategies can be used to educate the public about the mentally ill (give them what they need to know), while high-key educational campaigns can be used to promote mental health (give them what they want to know). A delicate balance of both can be achieved through strategical planning and management.

IT'S A BEGINNING ...

This pilot study has served as an initial starting point for a series of other research which C.M.H.A. - B.C. Division hopes to eventually undertake. The organization is to be commended for its endeavours to collect consumer data for incorporation as part of its information bank for program planning. It represents a sensitivity to the needs and perceptions of the consumers and an effort to establish a continuing dialogue between the receivers and providers of service. Such an endeavour also serves to enhance the accountability and credibility of the organization in the eyes of present and potential supporters.

It is evident from this study that, despite the gaps and pitfalls, survey research can produce worthwhile information --- nothing earth-shattering, but useful nonetheless. Apart from sharpening the research skills of those involved in the process, the acquired data has served to reduce some uncertainties which is important to decision-makers because it makes them more confident and determined. In the words of the executive-director of C.M.H.A. - B.C. Division: "The fact that we have something completed clearly shows the need for a lot more work and that future work will be able to be grounded on fact ...it's a great beginning ... at least some of our planning has grounding ... much more needs to be done".

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12 Summary of methodology and procedures.

This study is a naturalistic research which involves investigating and acquiring information without any form of manipulation. This research will basically serve to provide for a descriptive measurement function to knowledge building.

The study is based on a community oriented needs assessment model. Utilizing this model, information is collected from 1) key informants and 2) general public.

Data will be collected from key informants and general population through standardized questionnaire with a set of specific closed-ended questions and a number of open-ended questions. Questionnaires for key informants will slightly differ from questions for general population.

The research tool will largely provide for quantitative measures through rating scales and frequency counts. While data analysis will primarily concern itself with statistical inferences, some qualitative description will also be included.

Data will be collected quickly and easily through telephone interviews with the general population. This method of data collection will be used as it is cost-effective and it is relatively easy to draw a large, geographically dispersed population--- both of which meet the requirements of the Canadian Mental Health Association. An initial contact letter will be sent to individuals chosen to participate in the survey.

Key informants will be surveyed with mail-out questionnaires. A follow-up telephone call will be made to those respondents who do not reply by a given date, with the possibility of interviewing them over the phone if permission is given. A stamped, self-addressed envelope will be included in the mail-out questionnaire for their convenience.

DESCRIPTION OF POPULATION

13 How many subjects will be used?

How many in the control group?

100 key informants and 100 general public

14 Who is being recruited and what are the criteria for their selection?

Various doctors, clergy, social service workers, and other personnel in the human service profession will be chosen as key informants.

The criteria is that they will be involved in direct care-giving roles.

The general public will be chosen from the Vancouver Telephone Directory.

15 What subjects will be excluded from participation?

Subjects outside the Vancouver City area will not be included in the study.

16 How are the subjects being recruited? (If initial contact is by letter or if a recruitment notice is to be posted, attach a copy.) NOTE that UBC policy absolutely prohibits initial contact by telephone.

The general population will be recruited from the Vancouver City Telephone Directory on a systematic random basis --- choosing every nth name on alternating columns from the Directory. The general public will be contacted by letter approximately one week prior to the telephone interviews.

17 If a control group is involved, and if their selection and/or recruitment differs from the above, provide details.

n/a

PROJECT DETAILS

18 Where will the project be conducted? (room or area)

From the C.M.H.A. office and in my own home.

19 Who will actually conduct the study?

The student.

20 Will the group of subjects have any problems giving informed consent on their own behalf? Consider physical or mental condition, age, language, or other barriers.

Possible language barrier from the general public population, depending on the likelihood of choosing an ethnic family where no adult member speaks English.

21 If the subjects are not competent to give fully informed consent, who will consent on their behalf?

n/a

22 What is known about the risks and benefits of the proposed research? Do you have additional opinions on this issue?

This proposed research will benefit C.M.H.A. by providing community in-put for program planning and goal setting according to the needs and perceptions of potential consumers. At the same time, it will provide for a process of creating a public awareness on mental health issues through the survey contact.

23 What discomfort or incapacity are the subjects likely to endure as a result of the experimental procedures?

Respondents may not wish to cooperate with the interview upon telephone contact. If permission is not given to proceed, the interview will be terminated.

24 If monetary compensation is to be offered the subjects, provide details of amounts and payment schedules.

n/a

25 How much time will a subject have to dedicate to the project?

The telephone interview will take approximately 10 minutes to complete.

26 How much time will a member of the control group (if any) have to dedicate to the project?

n/a

DATA

27 Who will have access to the data?

The student researcher, the faculty advisor, and the CMHA survey advisory committee will have access to the data.

28 How will confidentiality of the data be maintained?

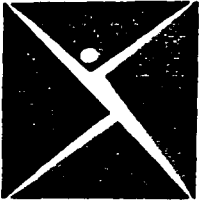
Names of respondents will not be included in the final research report and respondents will not be identified on the completed questionnaire form

29 What are the plans for future use of the data (beyond that described in this protocol)? How and when will the data be destroyed?

Data collected will be shredded and disposed of three months after the research report is completed.

30 Will any data which identifies individuals be available to persons or agencies outside the University?

n/a



CANADIAN MENTAL HEALTH ASSOCIATION

BRITISH COLUMBIA DIVISION

692 EAST 26th AVENUE
VANCOUVER, B.C. V5V 2H7
TELEPHONE: (604) 873-1633

CANADIAN MENTAL HEALTH ASSOCIATION
is a registered charitable organization supported
by voluntary contributions

January 23, 1987

Behavioral Sciences Screening Committee
The University of British Columbia
Vancouver, B.C.

Dear Screening Committee Members,

Re: Request for Ethical Review

This letter is to confirm that JoAnne Toh has been given agency consent to conduct research for the Canadian Mental Health Association, B.C. Division. The survey research will consist of telephone interviews to randomly chosen respondents from the Metro Vancouver Telephone Directory. JoAnne is provided with on-going supervision and consultation from our ad-hoc Survey Advisory Committee.

Yours very truly,

Chloe Lapp
Executive Director

CL/hb



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CANADIAN MENTAL HEALTH ASSOCIATION
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Your name has been randomly chosen from the Metro Vancouver Telephone Directory to participate in a telephone survey conducted by the Canadian Mental Health Association, B.C. Division. This letter is to explain the purpose of the research to you.

We would simply like to get your opinions in a variety of areas related to mental health. Your opinions will help the Canadian Mental Health Association with planning its programs for the benefit of the community at large. Your identity will be kept strictly confidential, therefore all information will remain anonymous.

The telephone interview will take approximately 10 minutes. You will be contacted within the next week. If you are not available, any other adult member of your household can be interviewed. You do, of course, have the right to refuse to be interviewed and this can be done so when you are contacted. You are also free to refuse to answer any questions or to end the interview at any time. Should you or another adult household member agree to cooperate with the interview, it will be assumed that consent has been given.

Should you have any questions concerning this up-coming survey, you may contact: Chloe Lapp, Executive Director, at the above address and telephone number.

Thanking you in advance for your cooperation,

Yours sincerely,

Jo-Anne Toh
Graduate Student in Social Work
University of British Columbia



CANADIAN MENTAL HEALTH ASSOCIATION

BRITISH COLUMBIA DIVISION

692 EAST 26th AVENUE
VANCOUVER, B.C. V5V 2H7
TELEPHONE: (604) 873-1633

CANADIAN MENTAL HEALTH ASSOCIATION
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The Canadian Mental Health Association is conducting a community needs assessment on mental health education. A sample of the general public population and a sample of community service personnel have been randomly chosen to participate in the study.

Because your agency provides a direct care-giving service to the community, we believe your opinions will be of great value to us. The feedback provided by key informants such as yourself will help the Canadian Mental Health Association with planning its programs for the benefit of the community at large.

Please find enclosed a copy of a questionnaire for you or one of your colleagues to complete. Your identity will be kept strictly confidential, therefore all information will remain anonymous.

Due to limited time constraints, we would appreciate a reply as soon as possible. A stamped, self-addressed envelope is enclosed for your convenience. If, however, you do not have the time to reply within the next two weeks, a follow-up telephone interview can be arranged.

A copy of the research results will be available upon request. Should you have any questions concerning this research, please feel free to contact: Chloe Lapp, Executive Director, at the above address and telephone number.

Thank you for your assistance. Your in-put is appreciated.

Yours sincerely,

Jo-Anne Toh
Graduate Student in Social Work
University of British Columbia

1. First of all, have you ever heard about the Canadian Mental Health Association?

(DO NOT
READ) 1 No
 2 Sort of
 3 Yes

2. If SORT OF or YES: Are you familiar with what the Association does?

(DO NOT
READ) 1 Non-applicable
 2 No
 3 Yes: Can you describe what you know about the organization?

3. What does "mental health" mean to you?

4. Would you say you think about your mental health:

(READ) 1 a great deal
 2 fairly often
 3 only occasionally, or
 4 never

5. Do you think it is important for you to learn about mental health problems and how to deal with these problems?

(DO NOT
READ) 1 No
 2 Maybe
 3 Yes

6. How do you presently learn about these things?

7. If you had a problem that was affecting you emotionally, who would you talk to about it?

(READ) 1 a doctor
 2 a friend or family member
 3 a professional counsellor
 4 other

8. What would you do if you didn't know where to turn to for help? (DO NOT READ)

- 1 Don't know Ask Somebody
2 Phone book
3 Referral Service

9. All people face problems in their daily lives. What are three of the most difficult problems you have faced in your life?

1)

2)

3)

10. On a scale of one to five, with one as 'not important at all' and five as 'extremely important', how important is it for you to have information on:

	not important					extremely important	don't know
1) Schizophrenia	1	2	3	4	5	o	
2) Depression	1	2	3	4	5	o	
3) Suicide	1	2	3	4	5	o	
4) Phobias	1	2	3	4	5	o	
5) Eating Disorders	1	2	3	4	5	o	
6) Family and Marriage Counselling	1	2	3	4	5	o	
7) Separation and Divorce	1	2	3	4	5	o	
8) Aging and Retirement	1	2	3	4	5	o	
9) Care-giving in the Home	1	2	3	4	5	o	
10) Grief and Mourning	1	2	3	4	5	o	
11) Parenting	1	2	3	4	5	o	
12) Sex Education	1	2	3	4	5	o	
13) Drug and Alcohol Addiction	1	2	3	4	5	o	
14) Dealing with a Personal Crises	1	2	3	4	5	o	
15) Family Violence and Sexual Abuse	1	2	3	4	5	o	
16) Coping with Stress	1	2	3	4	5	o	
17) Improving Self-Confidence	1	2	3	4	5	o	

11. What is the best way of providing this kind of information to you? (READ)

- 1 by educational talks 4 through newspapers & magazines
2 through television 5 talking to other people with similar
3 by reading pamphlets problems

12. Where would you go to get information on (a) _____ if you needed it now

What about information on (b) _____? (CHOOSE HIGH SCORES FROM #10)

(a) 1 don't know _____

(b) 1 don't know _____

13. Do you feel education in any of these areas could be improved?

1 No

2 Don't know

3 Yes ---> How do you feel it could be improved?

14. What do you think of when you hear the words "mental illness"?

15. I would like you to answer the following set of statements with 'agree', 'disagree' or 'don't know':

	AGREE	DISAGREE	DON'T KNOW
(a) One of the main causes of mental illness is the lack of personal strength and willpower.	1	3	2
(b) A majority of people with mental illness are unpredictable.	1	3	2
(c) A person who has been mentally ill can never be normal.	1	3	2
(d) A schizophrenic is a person with a split personality.	1	3	2
(e) If a person has been mentally ill for a long time, there isn't much hope for recovery.	1	3	2
(f) I believe that ex-patients of a mental hospital can function well in the community.	3	1	2
(g) I would object if someone who had been previously mentally ill moved next door to me.	1	3	2
(h) I can imagine myself become a close friend with someone who is mentally ill.	3	1	2
(i) I would object if a half-way house for mentally ill people was located in my neighborhood.	1	3	2
(j) If a mentally ill person asked for help in getting a job where I work, I would be willing to help.	3	1	2
(k) I would regularly participate in programs in my neighborhood which help mentally ill people.	3	1	2

16. Have you ever known anybody who has suffered a mental illness or an emotional problem?

(DO NOT
READ)

1 No response
2 No
3 Yes

17. If YES: Did this person receive professional help?

(DO NOT
READ)

1 Non-applicable
2 Don't know
3 No
4 Yes

18. If YES: To the best of your knowledge, was the service helpful to this person?

(DO NOT
READ)

1 Non-applicable
2 No
3 Somewhat
4 Don't know
5 Yes

19. In your opinion, do you think there are ways you can improve your mental health?

(DO NOT
READ)

1 No
2 Maybe
3 Yes

20. If MAYBE or YES: Can you describe what you might do to improve your mental health?

21. Finally, I have a few personal information questions: What magazines do you read?

1 none 2 _____

22. What newspaper do you read? (DO NOT READ)

1 none 2 The Sun 3 The Province 4 Globe & Mail 5 _____

23. What age group do you belong to:

(READ)

1 18 - 24
2 25 - 29
3 in your 30's
4 40's
5 50's
6 60's
7 70's
8 80 and over

24. What is your occupation? 1 student
2 employed - Occupation: _____
 (READ) 3 unemployed
4 homemaker
5 retired

25. What is your highest level of education?

1 no education
 (DO NOT 2 grade 1 - 8
 READ) 3 grade 9 - 12
4 college or technical level
5 university level

26. Your marital status is: 1 single
2 married
 (DO NOT 3 divorced
 READ) 4 widowed
5 common-law

27. Do you have any children under the age of 18?

1 No
 (DO NOT 2 Yes
 READ)

28. Gender: 1 Male 2 Female

29. Finally, do you have any questions you would like to ask me or do you have any final comments about mental health and illness?

COMMUNITY SERVICE PERSONNEL

QUESTIONNAIRE

1. Have you ever heard about the Canadian Mental Health Association?

- ☐ No
☐ Sort of
☐ Yes

2. If SORT OF or YES: Are you familiar with the resources and programs provided by the Association?

- ☐ No
☐ Yes: Can you please describe or list the resources and programs you are familiar with.

3. Would your organization like to have more information and education on mental health and problems affecting mental health?

- ☐ No
☐ Maybe
☐ Yes

4. If MAYBE or YES: How could the Canadian Mental Health Association best provide this information to you? (Check one only)

- ☐ workshops and seminars
☐ television and radio
☐ pamphlets and brochures
☐ availability of training films and video cassettes
☐ other: _____

5. What do you believe are the three most common problems experienced in the daily lives of the people you serve?

1)

2)

3)

6. How could the Canadian Mental Health Association best provide mental health information and education to your clients? (Check one only)

☐ educational talks
☐ television
☐ pamphlets
☐ self-help groups
☐ referral to appropriate resources

7. On a scale of one to five (with "1" as NOT IMPORTANT AT ALL and "5" as EXTREMELY IMPORTANT), how important is it for your organization to have information in each of the following areas: (Please circle)

	Not Important				Extremely Important
	1	2	3	4	5
1) Schizophrenia					
2) Depression					
3) Suicide					
4) Phobias					
5) Eating Disorders					
6) Family and Marriage Counselling					
7) Separation and Divorce					
8) Aging and Retirement					
9) Care-giving in the Home					
10) Grief and Mourning					
11) Parenting					
12) Sex Education					
13) Drug and Alcohol Addiction					
14) Dealing with a Personal Crisis					
15) Family Violence and Sexual Abuse					
16) Coping with Stress					
17) Improving Self-Confidence					
18) Other: _____					

8. What area would your organization prefer to have more information on: (check one)

- ☐ The causes of mental illness
☐ The symptoms of mental illness
☐ The resources available for assistance and support
☐ Prevention in mental illness
☐ How to become more understanding and accepting toward the mentally ill

9. In your opinion, how do you feel present mental health education could be improved?

10. Does your organization presently provide any mental health educational programs or informational material?

☐ No ---> 11) Would you be interested in doing so in the future?

☐ No ☐ Maybe ☐ Yes

☐ Yes ---> Please describe:

12. Are you familiar with any other mental health educational programs in your community?

☐ No

☐ Yes ---> Please describe:

13. What is the most important mental health service you think a local volunteer group, such as the Canadian Mental Health Association, could provide for your community? (check one only)

- ☐ rehabilitation
☐ information and education
☐ advocacy and lobbying government
☐ development of community resources
☐ other: _____

14. Would your organization be interested in working with the Canadian Mental Health Association to plan for mental health educational programs and resources?

☐ No
☐ Perhaps
☐ Yes

15. If PERHAPS or YES: In what capacity could your organization contribute to this planning process?

16. Name of your organization: _____

17. Your title or job position: _____

18. We would appreciate any further comments or opinions you would like to make concerning mental health and mental illness.