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An analysis of the public relations program of the Fall River mental health clinic to show its attempts in reaching the public.

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BOSTON UNIVERSITY
School of Public Relations and Communications

Thesis

AN ANALYSIS OF THE PUBLIC RELATIONS PROGRAM
OF THE
FALL RIVER MENTAL HEALTH CLINIC TO SHOW ITS ATTEMPTS IN
REACHING THE PUBLIC AND TO SHOW HOW THIS CONTACT CAN BE
MADE MORE EFFECTIVE

By
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Submitted in partial fulfillment of the
requirements of the degree of
Master of Science
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>DESCRIPTION</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Definition of Mental Health</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>INTRODUCTION TO THE PROBLEM</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Statement of the Problem and the Importance of the Study</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>The Mental Health Field on the National and State Level</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Fall River, Massachusetts</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Bristol County Mental Health Clinics, Inc.</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>The Fall River Mental Health Clinic - A Community Effort to Meet a Community Problem</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>Organization of the Remainder of the Thesis</td>
<td>22</td>
</tr>
<tr>
<td>II</td>
<td>RESEARCH METHODS AND PROCEDURES</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Methods Used in Acquiring Background Material</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>The Respondents - Referred and Non-referred</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>The Stratified Random-Sample of the Non-referred Group</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>The Questionnaire Pre-test</td>
<td>28</td>
</tr>
<tr>
<td></td>
<td>The Design of the Questionnaire-Interview</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>Methods Used to Enlist the Cooperation of the Respondents</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Adjustments Made to Fit Actual Conditions</td>
<td>34</td>
</tr>
<tr>
<td>CHAPTER</td>
<td>PAGE</td>
<td></td>
</tr>
<tr>
<td>---------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>II (Cont'd) The Limitations of Social Research</td>
<td>35</td>
<td></td>
</tr>
<tr>
<td>The Role of the Individual in This Study</td>
<td>36</td>
<td></td>
</tr>
<tr>
<td>III FINDINGS AND EVALUATION OF FINDINGS ON UNDERSTANDING, ACCEPTANCE AND COOPERATION</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>The Term &quot;Mental Health&quot;</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>Respondents' Factual Knowledge, National and State Level - Public and Private</td>
<td>40</td>
<td></td>
</tr>
<tr>
<td>Respondents' Contacts in the Field of Mental Health</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>Knowledge of the Fall River Mental Health Clinic</td>
<td>49</td>
<td></td>
</tr>
<tr>
<td>Respondents' Realization of the Need for Mental Health Facilities</td>
<td>51</td>
<td></td>
</tr>
<tr>
<td>Respondents' Acceptance of the Clinic</td>
<td>53</td>
<td></td>
</tr>
<tr>
<td>Respondents' Recognition of and Personal Involvement in Mental Illnesses</td>
<td>57</td>
<td></td>
</tr>
<tr>
<td>Respondents' Use of the Clinic and Other Treatment Sources</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Referrals' Opinion of Clinic's Results</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Respondents' Specific Knowledge of Clinic</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Respondents' Knowledge of Media</td>
<td>78</td>
<td></td>
</tr>
<tr>
<td>Respondents' Opinion of Media</td>
<td>82</td>
<td></td>
</tr>
<tr>
<td>Respondents' Opinion of Public's Cooperation</td>
<td>87</td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER III (Cont'd)  Respondents' Contact With the Clinic
Further Information Obtained At Interviews
Other Pertinent Information

CHAPTER IV  SUMMARY OF FINDINGS, CONCLUSIONS, RECOMMENDATIONS, PUBLIC RELATIONS' SIGNIFICANCE OF THE PROBLEM AND SUGGESTIONS FOR FURTHER STUDY

Summary of Chapter Contents
Summary of Study's Purpose

I. SUMMARY OF FINDINGS AND CONCLUSIONS ON THE PROBLEM OF MENTAL ILL HEALTH AND ACTIVITIES IN THE FIELD

The Writer's Impression of the Clinical Field of Mental Health
Summary of Findings on the Bristol County Mental Health Clinics, Inc.
Summary of Findings on Fall River, Massachusetts

II. SUMMARY OF FINDINGS ON THE FALL RIVER MENTAL HEALTH CLINIC

A. Summary of Information Obtained from Clinical Records and Interviews with Members of the Board, Staff and Community People
   Findings on the Board of Directors
   Findings on the Staff
   Other Findings

B. Summary of Findings from the Questionnaire-Interview
<table>
<thead>
<tr>
<th>CHAPTER IV (Cont'd)</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition of Mental Health</td>
<td>120</td>
</tr>
<tr>
<td>Knowledge of the Mental Health Field</td>
<td>121</td>
</tr>
<tr>
<td>Knowledge of the Clinic's Existence</td>
<td>121</td>
</tr>
<tr>
<td>Reason for Clinic's Establishment</td>
<td>121</td>
</tr>
<tr>
<td>Acceptance of Clinic to Meet the Need</td>
<td>122</td>
</tr>
<tr>
<td>Respondents' Recognition of Personal Involvement</td>
<td>122</td>
</tr>
<tr>
<td>Respondents' Use of the Clinic and Other Treatment Sources</td>
<td>123</td>
</tr>
<tr>
<td>Information Received from Clinic and Respondents' Part in Treatment</td>
<td>123</td>
</tr>
<tr>
<td>Referrals' Opinion of Clinic's Results</td>
<td>124</td>
</tr>
<tr>
<td>Familial Use of Clinic</td>
<td>124</td>
</tr>
<tr>
<td>Respondents' Knowledge of the Fall River Mental Health Clinic</td>
<td>125</td>
</tr>
<tr>
<td>Respondents' Knowledge of Media</td>
<td>126</td>
</tr>
<tr>
<td>Respondents' Opinion of Media</td>
<td>126</td>
</tr>
<tr>
<td>Respondents' Opinion of Public Cooperation</td>
<td>127</td>
</tr>
<tr>
<td>Respondents' Contacts with the Clinic</td>
<td>127</td>
</tr>
<tr>
<td>C. Summary of Findings on the Hypothesis that Increased Knowledge and Understanding Means Increased Cooperation</td>
<td>128</td>
</tr>
<tr>
<td>CHAPTER</td>
<td>PAGE</td>
</tr>
<tr>
<td>---------</td>
<td>------</td>
</tr>
<tr>
<td>IV (Cont'd) Relationship of the Clinic's Communications to Knowledge and Understanding</td>
<td>129</td>
</tr>
<tr>
<td>CONCLUSIONS</td>
<td>131</td>
</tr>
<tr>
<td>RECOMMENDATIONS</td>
<td>132</td>
</tr>
<tr>
<td>THE PUBLIC RELATIONS' SIGNIFICANCE OF THE STUDY</td>
<td>138</td>
</tr>
<tr>
<td>SUGGESTIONS FOR FURTHER STUDY</td>
<td>139</td>
</tr>
<tr>
<td>BIBLIOGRAPHY</td>
<td>140</td>
</tr>
<tr>
<td>APPENDICES</td>
<td></td>
</tr>
<tr>
<td>Appendix A</td>
<td>144</td>
</tr>
<tr>
<td>Bristol County Mental Health Clinics, Inc. (Question and Answer Sheet)</td>
<td></td>
</tr>
<tr>
<td>Bristol County Mental Health Clinics, Inc. (Latest Copy of Question &amp; Answer Sheet)</td>
<td>145</td>
</tr>
<tr>
<td>Chart of Completed Bristol County Mental Health Clinics, Inc.</td>
<td>146</td>
</tr>
<tr>
<td>Appendix B</td>
<td>147</td>
</tr>
<tr>
<td>Bristol County Mental Health Clinics, Inc., Fall River (By Laws)</td>
<td></td>
</tr>
<tr>
<td>Appendix C</td>
<td>151</td>
</tr>
<tr>
<td>An Analysis of Media Used by Fall River Clinic</td>
<td></td>
</tr>
<tr>
<td>Appendix D</td>
<td>153</td>
</tr>
<tr>
<td>Open-end Questionnaire Interview</td>
<td></td>
</tr>
<tr>
<td>Appendix E</td>
<td>156</td>
</tr>
<tr>
<td>Information Obtained from Workshop on, &quot;The Place of Mental Health In Today's Community Health Programs&quot;</td>
<td></td>
</tr>
<tr>
<td>Appendix F</td>
<td>159</td>
</tr>
<tr>
<td>Constitution, Advisory Board, Prince George's County Mental Health Clinic</td>
<td></td>
</tr>
</tbody>
</table>
# TABLE OF CHARTS

<table>
<thead>
<tr>
<th>CHART</th>
<th>Description</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Definition of Mental Health</td>
<td>38</td>
</tr>
<tr>
<td>2a</td>
<td>Respondents' Knowledge of Federal and State Activities</td>
<td>43</td>
</tr>
<tr>
<td>2b</td>
<td>Respondents' Knowledge of National and State-Level Organizations</td>
<td>44</td>
</tr>
<tr>
<td>3</td>
<td>Contacts in the Field of Mental Health</td>
<td>47</td>
</tr>
<tr>
<td>4</td>
<td>Knowledge of Clinic's Existence</td>
<td>50</td>
</tr>
<tr>
<td>5</td>
<td>Reasons for Clinic's Establishment</td>
<td>52</td>
</tr>
<tr>
<td>6</td>
<td>Acceptance of Clinic's Services</td>
<td>55</td>
</tr>
<tr>
<td>7</td>
<td>Respondents' Recognition of Personal Involvement</td>
<td>58</td>
</tr>
<tr>
<td>8a</td>
<td>Respondents' Use of Clinic and Other Sources</td>
<td>61</td>
</tr>
<tr>
<td>8b</td>
<td>Information Received from Clinic and Respondents' Part in Treatment</td>
<td>62</td>
</tr>
<tr>
<td>9a</td>
<td>Complete Satisfaction With Clinic's Treatment</td>
<td>65</td>
</tr>
<tr>
<td>9b</td>
<td>Familial Use of Fall River Clinic</td>
<td>66</td>
</tr>
<tr>
<td>10a</td>
<td>Respondents' Knowledge of Fall River Clinic</td>
<td>73</td>
</tr>
<tr>
<td>10b</td>
<td>Respondents' Opinion of Staff Time</td>
<td>74</td>
</tr>
<tr>
<td>11</td>
<td>Respondents' Awareness of Mental Health Media</td>
<td>80</td>
</tr>
<tr>
<td>12</td>
<td>Respondents' Opinion of Amount and Type of Publicity</td>
<td>83</td>
</tr>
<tr>
<td>13</td>
<td>Respondents' Opinion of Public Cooperation with Clinic</td>
<td>89</td>
</tr>
<tr>
<td>14</td>
<td>Contact with the Clinic</td>
<td>95</td>
</tr>
<tr>
<td>CHART</td>
<td>PAGE</td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>------</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>99</td>
<td></td>
</tr>
</tbody>
</table>

**Interviewer's Opinion of Interviewee's Cooperation**
THE GOAL ** *

"Mental health enables the individual to pursue reasonable, purposeful goals, to use his capacities and talents fruitfully; to possess a sense of security, of belonging, of being respected; to know that he is liked, or loved and wanted; to have self-respect, self-reliance, and a sense of achievement; to have the capacity for new experience and new ideas. Mental health also means that an individual has learned to respect others, and to live with others, not only at home and in his own country, but in the world."

National Health Assembly¹
May 1948

CHAPTER I

INTRODUCTION TO THE PROBLEM

Statement of the Problem and the Importance of The Study:

Mental ill health is a huge and costly problem. It includes the institutionalized, who are for the most part total losses to society, the seriously maladjusted, so frequently involved in crime, drug addiction and alcoholism; and the so-called normal people, harrassed by minor worries, fears and uncertainties.

Though much is being done to combat these conditions, little or nothing has been accomplished in the evaluation of the public relations aspects of these services. Many people engaged in mental health work feel the need for such an undertaking.

This study has been devised therefore, for the purpose of examining the public relations' program of the Fall River Mental Health Clinic, and if results prove necessary, making recommendations for its expansion and improvement.

It is the writer's contention that the Clinic is not receiving sufficient cooperation from the people of Greater Fall River because of the ineffectiveness of its communications with the public; and that by using known public relations' techniques the Clinic's communications can be improved.

To test the validity of this hypothesis, it is necessary to discover:

a) People's knowledge and understanding of the Clinic's purposes and objectives,

b) The relationship between public understanding and the Clinic's communications, and

c) The relationship between this understanding and cooperation.

Knowledge of the Clinic's purposes, objectives, communications and publics is the initial step on which are based the other research methods and procedures.

In order to fully evaluate the findings and recommendations of this study, it is necessary to have a broad famil-

2 Communications (Media) includes face to face contact, speeches, letter, pamphlets, newspaper publicity, etc.
iarity with the developments in the mental health field, in addition to a detailed knowledge of the Clinic. Knowledge of the city of Fall River is also necessary, as no organization exists unaffected by the community in which it is placed.

The Mental Health Field on the National and State Level: Developments in this area may be divided roughly into three phases.

1. In the 1840's and 1850's Dorothy Dix wrote of conditions among the mentally ill. Sympathetic public opinion led to the improvement and expansion of institutional facilities. In the 1900's Clifford Beers told of several years experience as an inmate of mental institutions in, "The Mind That Found Itself," and was instrumental in restimulating public opinion and furthering improvements. As curative knowledge of mental conditions grew, custodial care gave way to treatment and interest in the institutional area was expanded to include people with mental problems, who were not as yet in need of being hospitalized. This resulted in:

2. The establishment of child guidance clinics in and around the 1920's. It was soon realized however, that treatment of adults, with whom the children came in contact, was also necessary. Thus, the clinical field was broadened.

This period saw the gradual replacement of the patient-psychiatrist relationship with the modern psychiatric team—the psychiatrist, the clinical psychologist and the psychiatric
social worker --- for screening, diagnosing, testing, treatment and follow-up care.

Phases one and two dealt with remedial work among the mentally ill, and as these areas could not be expected to solve the problem, mental health interests, within the past few years, have again expanded to find:

3. Methods by which the onset of mental diseases can be prevented. This means establishing principles which result in sound mental health and incorporating them into everyday life.

Because of the scarcity of trained mental health personnel, these principles can only be presented on a mass basis by adding other professional groups to the existing psychiatric team. These professional groups, composed of those who come in contact with large segments of the public in their daily work, are social workers, doctors, school teachers, public health personnel, the clergy, etc. These people must be made to realize the necessity for their personal involvement. With their help, mental ill health can be combatted; it is the only practical way to attack the vast problem.

In addition to the need for activating this important public, is the need for perfecting faster less expensive methods of psychiatric treatment, increasing the size and

number of institutions for training mental health personnel, attracting new people into the field, and carefully analyzing existing treatment and education centers to be certain that they are utilizing their limited facilities to the utmost advantage.

Mental ill health is a tremendous waste which could be prevented. The need for mental health (although it is called by various names) is recognized by many. They have the tools but do not always use them, or use them wisely. When this is realized, much can be accomplished.

The United States Government, recognizing the magnitude of the problem, established the National Institute of Mental Health under the National Mental Health Act of 1946. Through this Institute, the Federal Government is providing funds for research, training, expansion of public and private mental health facilities and educational work.4

The Massachusetts State Government has ear-marked increased funds for this area, recently appointed a commissioner of mental health, and is at present conducting a survey of mental health facilities and needs in cities and towns, with a view towards extending public health facilities.

One outstanding national organization in the field is the National Association for Mental Health, Inc., a non-profit

organization supported by the contributions of individuals, foundations, etc. The Association functions as an information and research center. Its work includes the preparation of statistical information, pamphlets, radio sketches, movies, etc., for public and professional consumption. It sponsors gatherings of people involved or interested in the field, is one of the organizations active in promoting research and clinical standards, and also works with and assists other related national organizations.5

In Massachusetts, the outstanding non-governmental organization is the Massachusetts Association for Mental Health, Inc. Its purpose is to promote better care of patients within institutions, the restoration and rehabilitation of the mentally handicapped and the fostering of mental health. Its activities include community guidance in the establishment of a clinic or a mental health association, maintaining a speakers' bureau, acting as a clearing house for information, preparing pamphlets, movies and other related media; educational work on the elementary and junior-high level, and the promotion of institutes, workshops and training centers.6

The Fall River Clinic exists because of the cumulative

5 Personal correspondence with the Executive Assistant of The National Mental Health Association, Inc.

6 The Massachusetts Association for Mental Health, Inc. (Pamphlet discussing purpose, community work, speakers, etc.)
work of individuals and organizations in the field of mental health. Continued existence (and expansion) depends on successfully understanding and meeting the needs of its community.

Fall River, Massachusetts: The Mental Health Clinic serves the people of Fall River and the towns of Somerset, Swansea, Assonet and Westport (population - roughly 135,651). This area is located in the south-eastern section of Bristol County, bordering on Rhode Island, and is in close proximity to the cities of Providence and Newport. The other cities, in a radius of 13 to 25 miles, are Taunton, New Bedford and Attleboro. Fall River, a port of entry of Bristol County, is 50 miles south-east of Boston and 194 miles north-east of New York City.

The city, off the direct storm path and fortunate in its mild climate, is supplied by unlimited and excellent water for industrial and domestic purposes and offers plentiful land areas for future development.

At the turn of the century the city of Fall River was the textile industry and the textile industry was Fall River. As we have learned from past experience, a city's health depends on a diversification of industry and because Fall River

7 Information about Fall River was obtained from the Fall River Chamber of Commerce, various books, pamphlets and papers, and informal talks with members of the community, dating over a period of years.

8 Predominant nationality extractions - English, Irish, French, Portuguese, Polish and Italian. 1940 population statistics Fall River: 21.29% foreign born; 48.12% male and 51.88% female.
was a one industry town the crash was bound to come.

The city was struck by its own individual depression long before the rest of the country. Fall River became a graveyard for dismantled mills and for ten years or more the depression held full sway. Unemployment was wide-spread, and by 1932, 25% of the population were receiving municipal aid. The city, on the verge of bankruptcy, was placed in the hands of a Finance Committee.

The people of Fall River have not recovered psychologically from these terrible times. It is evident in the lack of faith the majority has toward its city.

Fall River has been rebuilt, but many of its problems remain unsolved. Textile companies, currently 60% of the city's industry, in an effort to acquire cheap labor turned more and more towards women employees and today men have difficulty finding jobs.

Another unsolved problem is the prevailing sentiment that there is no opportunity for the educated young. A city cannot survive and prosper if its young people will not stay, and industry to have a firm basis for success, must live in healthy surroundings.

The New England textile industry, with a few exceptions, failed to profit by its mighty lesson and is at present fighting a last ditch battle with competition from the South.

It may or may not be too late to solve the textile
problem. Even so, it is well to keep in mind that a city's health depends not on one, but on a diversity of strong industry.

Efforts to bring in heavy industry to Fall River are hampered not only by the city's geographic area and state taxation, but by the fact that Fall River lacks the buildings to house such industry. Added to this is the city's poor reputation -- helped by the outspoken comments of its citizens.

Let's examine the health of this textile community.
1. 40% of the women are employed, men have difficulty finding jobs and are often reduced to taking care of the home and children, or, as in the case of many, both parents work and the home again suffers.
2. Sub-standard housing and illiteracy are high.
3. Most of the schools are old and poorly located.
4. The patriarchal code of a large percentage of the people has been broken, taking with it the necessary parental discipline.
5. The educated young leave the city to find positions.
6. The unemployment rate is high and the city is listed as a critical area.
7. The majority have no pride in their city.
8. Circumstances have made these people uncertain,

9 Percentage received from the head of Unemployment Compensation.
fearful, self-centered and therefore overly conservative and unwilling to accept new ideas.

Fall River serves as a prime example of industry operating without a long range view, basing its policy on immediate profits, failing to build strong communities.

The area's textile industry cannot run from past blundering --- problems cannot be solved by moving to a new community --- for selfish interests will be carried along and the best that can be hoped for, is a short lull before what may be the final storm.

The industrial plight of Fall River is not only the concern of the textile owners and workers --- it is the concern of every citizen. It is time for doctors, lawyers, bankers, retail stores and all those who would find it difficult if not impossible to locate elsewhere, to see their personal stake in the city's health.

There are, as in every community, far-sighted people who realize the need and act accordingly. The city's future depends on the expansion of this group.

Fall River is Bristol County's largest city. The County's other municipalities in order of their size, are New Bedford (Fall River's sister city), Taunton and Attleboro. Taunton and Attleboro are not textile cities. Their industry requires a higher skill and therefore pays better wages, which
in turn allows a larger percentage of the women to stay at home and concentrate their attention on the care of their families.

Bristol County Mental Health Clinics, Inc.: In 1948, state-supported mental health clinics were discontinued because of lack of funds and personnel. This left Bristol County and greater Fall River without the necessary clinical services to meet the problem of mental illness health in the area.

Through the efforts of a group of social workers, the lack of clinical facilities in Fall River and in Bristol County as a whole, was explored and acknowledged. It was discovered that the cost of comprehensive clinical services and the scarcity of trained personnel would hinder the separate cities ability to provide the services the need warranted. To meet the problem therefore, interested citizens of Fall River, New Bedford, Taunton and Attleboro, after preliminary preparation in their individual cities, met and formed in June of 1950, the Bristol County Mental Health Clinics, Inc. The community consultant from the Massachusetts Association for Mental Health, Inc., and the head of Taunton State Mental Hospital were helpful in providing guidance in this formation.

The purpose of this organization is three-fold; to provide:

1. Clinical services.

2. Community services, i.e. orientation and education of the citizens in mental health theories and practices.
3. The facilities for the training of professional people in the clinical field of mental health.\textsuperscript{10}

The initial plan called for two-thirds support by federal funds and one-third by private contributions. The private funds were to be pro-rated according to population figures (Fall River to provide $12,000.00). The funds were to be used for an administrative center in Fall River, composed of a psychiatric team plus a psychiatric nurse, and four local centers. Fall River and New Bedford were to have a full time psychiatrist and a psychiatric social worker, and Taunton and Attleboro, a full time psychiatrist and a part time social worker.\textsuperscript{11}

At present there are part time clinics operating in all four areas and the administrative center is yet to be established.

Fall River, due largely to the energy and enthusiasm of the Chairman of the Board and the people associated with him, forged ahead of the other clinics. With success's usual impatience of others who fail to measure up, the local organization until recently maintained a rather loose association

\textsuperscript{10} The Bristol County Mental Health Clinics, Inc. (Question and answer sheets, and chart), Appendix A, pp.144 to 146.

\textsuperscript{11} Under the Mental Health Act of 1946, the organization must be in operation in order to qualify for federal money and must be able to match every two dollars of federal money with one dollar of its own. This federal money is distributed to the organizations, through the individual states.
with the county organization. While still keeping its legal
name, it is known locally as the Fall River Mental Health
Clinic in order to provide a closer identification with the
community. Also, all of the funds collected in Greater Fall
River have been and are being used in Fall River.

The question to be asked here is whether the long range
view will be better served by Fall River's separation and con­
centration on its own expansion in the hope that the other
Clinics will follow, or whether concentrated effort should be
made by Fall River to spur the other Clinics on by means of a
close association?

The Fall River Mental Health Clinic - A Community Effort
to Meet A Community Problem: In May of 1950, the Fall River
Mental Health Clinic began operating on a part time basis, fin­
anced by proceeds from a tag day, fund drive and money voted
by the school committee for the psychological testing of ex­
ceptional public school children.

The Clinic's support was to come not only from these
sources but from federal funds and from fees (according to
ability to pay) charged to patients or agencies who referred
these patients.

The Clinic conducted its own fund drives in 1950 and
1951, has received several thousand dollars from the federal
government, the yearly grant from the school department, and

12 The Bristol County Mental Health Clinics, Inc., Fall River.
is now a member of the Community Fund, whose annual drives will
provide the money for the Clinic's continued operation.

The combined moneys met approximately half the fund goal
in 1950 and two-thirds of the goal in 1951. The 1952 Red
Feather Drive came within ten thousand dollars of the goal
set and the Clinic was notified that it would receive all
but 5% of the money requested.

Although the Clinic was not set up as a charity organi-
ization, it does have a certain percentage of charity patients
and at present some community agencies are getting free ser-
vice because of their limited budgets.

The Clinic has no specific policy governing the fee sys-
tem or the charitable work. There also has been some confusion
when several social agencies are handling the same patient, as
to who should pay the clinical charges.

The Clinic's policy, based on the broad statements set up
by the county organization, is governed by a board of directors
and appointed officers. These people are:

"To handle and control financial and organizational
matters that are the responsibility of the FALL
RIVER DISTRICT and disseminating information to
aid in the carrying out of the objectives of the
Bristol County Mental Health Clinic."

Through standing committees on:

1. Finance, Legal and Ways and Means.
2. Membership and Hospitality.
3. Staff.
4. Publicity.
5. Information and Educational.
And such committees as from time to time need be established."\textsuperscript{13}

The Clinic's purpose is to provide Fall River and its surrounding towns, with mental health services in the clinical, educational and training areas.

A psychiatric team provides screening, diagnosing, psychological testing (and treatment only if other treatment sources are unavailable) for any adult or child who does not have ready access to other psychiatric facilities. The patients are referred by doctors, social workers, clergy, courts, etc. The former practice of accepting self-referrals has been discontinued because the Clinic has found it more satisfactory to work through a professional source.

When patients are sent to the Clinic, the diagnosis or test results are sent back to the referral sources, who then decide whether to send the patient, if findings prove necessary, to a state or private mental hospital (if the person is beyond clinical care), to a private psychiatrist (if the patient can afford the expense), or back to the Clinic. The Clinic prefers to have as much treatment done on the outside as possible, in order to concentrate on the screening, diagnosing and testing areas.

Every effort is made by the Clinic to secure the cooperation of the people involved, whether they be the patients, their relations or the referral sources. The Clinic staff strives to

\textsuperscript{13} By-Laws, Bristol County Mental Health Clinics, Inc. Fall River, p.1, Appendix B, pp.147 to 150
involve the relatives and referrals personally in the diagnosis and treatment of the individual patient, by bringing them in on consultations, by guiding them in their dealings with the patient and future patients, and by teaching them their limitations in cases where professional help is essential.

By using these means the psychiatric orientation of this important segment of the public is furthered.

This involvement of the referral source and others has been hampered by the fact that the Clinic was operating until September of 1951 without the full psychiatric team and then by the fact that team work was difficult, if not impossible, because the psychiatrist (from Boston),¹⁴ the psychologist (from Taunton State), and the psychiatric social worker (who comes originally from Boston, has worked in the middle west, is now living in Taunton and spending his time between the four Clinics), came to the Clinic on separate days.

This team work is now in practice.

So far, no specific patient-intake policy has been formulated. As in other areas, efforts are being made to correct this situation. Recently completed is a standardized patient-information sheet to be sent in by the referral sources. This was necessary because information furnished by many of the referral agencies was not sufficient for mental health purposes.

¹⁴ The psychiatrist from Boston has recently resigned because of additional duties in the Boston area and has been replaced by a psychiatrist in private practice in New Bedford.
This standardization of patient information will enable the psychiatric social worker, whose duty it is to screen these individuals, to spend badly needed time on other necessary clinical work.

One area that needs attention is the manner of recording clinical statistics. The Clinic's present statistical records are inadequate. For example, the records show that the patient intake has jumped from 192 in 1950 to 431 in the first nine months of 1951. They do not show among other things, the number of visits by individual patients, whether these patients continued their contact with the Clinic and whether results were successful or unsuccessful. There is no concrete information to show whether a lack of cooperation exists and if so, whether this is in minor or major proportions.

The Clinic has just appointed a full time psychiatric social worker (this service until recently supplied only one and a half days a week) and an increase from one day's attendance by the psychiatrist to two days. The Clinic's difficulty in securing such services is a reflection of the acute personnel shortage in the entire mental health field.

No change in the amount of time allowed for psychological testing (one-half day a week) is planned at present.

The Clinic is presided over five days a week by a secre-

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15 The original psychiatric social worker is continuing his association with the Clinic one and one-half days a week.
tary, who is an intelligent person and well able to get along with the individuals concerned. Unfortunately, though lacking psychiatric training, she has been required to do a certain amount of follow-up work, and talk with referral sources who wish to send patients to the Clinic, or who wish to check on the patients' progress or their own role in treatment. This necessity is removed by the acquisition of the full time psychiatric social worker.

The secretary is also hampered in getting a complete picture of the Clinic prior to her employment, because of a lack of detailed clinical records.

Added to the very important educational work with people involved in the referral of patients, are the methods used to acquaint the general public with the needs, purposes and goals of mental health activities in Greater Fall River. These methods include a public meeting held before the first fund drive, newspaper publicity, ads, tag days, several radio programs; letters, folders, etc., sent to industry, labor, retail establishments and to private citizens during the fund drives; yearly banquets for the volunteer collectors and the fulfillment of speaking engagements by the staff and members of the Board of Directors. The Massachusetts Association for Mental Health, Inc., has also been able to fill some of the requests for speakers.
The major means of clinical publicity, aside from personal contact, has been local newspaper publicity. The Clinic received 181.5 column inches of publicity during the March 24 to June 22, 1950 campaign. National mental health copy, totaling 133 column inches, was also featured during this period in connection with National Mental Health Week. Additional publicity was received from an article in July of 1950. The Clinic received 72 column inches in the campaign period of January 23 to February 16, 1951.

In addition to this publicity in the daily paper, a suburban weekly carried several short articles during the 1950 and 1951 campaigns.

During the Red Feather Drive held in 1952, the Mental Health Clinic was the recipient of one article and had its name mentioned in all community chest publicity. Because of the addition of the Clinic, the Red Feather slogan was "Ten for Ten."

The Clinic's publicity for the most part, has been limited to the periods of the fund drives and even then has not been too extensive.17

Most of the speaking engagements have been made by the lay-people associated with the Clinic and then in connection

16 Fall River has one daily newspaper, several weeklies in addition to two radio stations.

17 Refer to Appendix C, pp. 151 to 152, for analysis of the Clinic's media.
with the fund drive. The Clinic has been unable to meet all requests for speakers because of the part time staff and the fact that it has no speakers' bureau.

To date, no specific attempts have been made to determine the Clinic's public education policy.

The third purpose of the Fall River Mental Health Clinic is to provide clinical training for professional people in the field of mental health, in order to help them become community-oriented and give them the opportunity to work with mentally ill people who are not institutional cases.

In this category, the Clinic has had one psychiatric social work student from the Boston College School of Social Work, who spent three days a week at the Clinic during the period of September, 1950 to June of 1951 and who used the Clinic as a case study to complete requirements for her master's degree.18

The aforementioned officers and board of directors, whose duty it is to handle and control "The Bristol County Mental Health Clinic, Inc., Fall River," are a diversified group of citizens. They include in their membership, people engaged in social work, industry, banking, religion, education, medicine, etc.19 Only two are familiar with the mental health field ---


19 The person in charge of the Board of Health was invited to join, but was unable to do so.
one a doctor, the other a nurse who is a graduate of a private psychiatric hospital and engaged in school nursing.

They are, on the whole, an active intelligent group deserving the thanks of the community. They are also busy people who can give only partial attention to the Clinic, who are not engaged in the psychiatric field and who are therefore more or less isolated from the problem and successes of the clinical area throughout the United States. The only routine outside contact that the Clinic has, aside from the county organizations, is a monthly newsletter from the Massachusetts Association for Mental Health, Inc.

In order for these people to serve the Clinic well, it is necessary for them to be versed in the broad aspects of mental health and the specific aspects of their own community.

No specific policy has been set up to familiarize the Clinic's lay-people in mental health and community relations. They are even isolated from their own staff (and this staff from the community), for no professional member of the Clinic has been able to attend more than two or three meetings. Fortunately, several of the Officers and Members of the Board have referred patients and therefore have a better knowledge of the problems affecting the Clinic.

The Clinic has been established through the efforts of citizens and because of lack of time, funds and experience, has more or less grown from day to day without a detailed
written policy --- a situation dangerous to the organization's survival and growth.

This absence of policy is felt and efforts are being made, at the present writing, to fill the gap. A paid administrator is badly needed --- a far-sighted, community-wise social worker is the logical person for this position at the present time.

The Clinic, as most organizations, is the victim of a certain amount of antagonism, misunderstanding and inertia. It has the nominal endorsement of the Fall River Medical Society but the Public Health Department has not officially acknowledged the Clinic, although it is using its services. This department's cooperation, as well as the active cooperation of the Medical Society, is essential for the Clinic's success. If, as is likely in the not too distant future, the Fall River Public Health Services are expanded to include mental health and private psychiatrists establish residence, cooperation between the Clinic and these groups is necessary to remove duplication of effort.

There is room for a comprehensive public health department, a greatly expanded Clinic and many private psychiatrists before sufficient personnel will be on hand to make a sizable dent in the vast mental ill health problem that is Greater Fall River's.

Organization of the Remainder of the Thesis: With this foregoing information as a background, an open-end question-
naire interview has been devised and administered to those who have most contact with the Clinic (other than members of the organization). The people chosen were the referral sources.

Their knowledge and understanding in relation to the media used by the Clinic has been compared with the results received from administering the same questionnaire to a stratified random sample of a universe of similar professional people in the Greater Fall River Area. These people were chosen because they had not referred patients, but because of their occupations could be expected to do so.

These two groups were then examined to discover the relationship between understanding and cooperation. Chapter II deals with a detailed explanation of the research methods used. Chapter III is composed of an analysis and evaluation of the questionnaire results. This chapter also discusses information obtained from personal correspondence with various organizations, clinics and individuals in the field of mental health. Chapter IV is concerned with a summary of the findings, recommendations, the public relations significance of the study and suggestions for further study.
CHAPTER II
RESEARCH METHODS AND PROCEDURES

Methods Used in Acquiring Background Material: Knowledge of the mental health field and of organizations on the national and state level (both governmental and private) was acquired through library research, personal correspondence and newspaper publicity.

In addition to these methods, informal interviews were held with a member of The Massachusetts Association for Mental Health, Inc., and various people employed by the Commonwealth of Massachusetts. The writer was also fortunate in attending a workshop sponsored by The Massachusetts Central Health Council and The Massachusetts Association for Mental Health, Inc., at which members of both state and private organizations discussed current clinical mental health problems and possible methods for their solution.

Information pertaining to the city of Fall River and its surrounding towns and cities was obtained through library research and by interviewing strategic people in the community, such as members of the school department, the city planner, and heads of the Fall River branch of the Massachusetts Division of Unemployment Compensation, the P-T-A Council, a teacher's organization, the Public Health Department, and the Chamber of Commerce. Also, the writer was born in Fall River and has spent much of her life in the community.
An understanding of the Bristol County Mental Health Clinics, Inc. and the Fall River Mental Health Clinic was acquired by talking with the Clinic's personnel (officers, board members and staff) and by examining available records. Knowledge of Greater Fall River organizations and individuals contacted by the Clinic was also acquired.

With information obtained from the above methods and open-end questionnaire-interview was devised and the people to whom it would be administered were selected.

The Respondents - Referred and Non-Referred: To determine the success of the Clinic's public relations, the people contacted by the Clinic had to be known and then questioned as to their knowledge, understanding, acceptance and cooperation.

It would have been impossible to get a complete listing of all the people contacted by the Clinic through its fund drive. It was decided therefore, to administer the open-end questionnaire to the group who had shown a definite measurable amount of cooperation with the Clinic. The people chosen were the referral group.

Within this group, the extent of individual cooperation could be compared with the amount of individual understanding to determine any significant relationship. The relationship between acceptance and cooperation could be shown as well.

The individuals or organizations who had referred patients to the Clinic were those who dealt with large segments of the
community in their daily work. The group was made up of nine doctors, ten social agencies (city, state and private) two school departments, one school of nursing, one law-enforcement officer, one banker, one clergyman and four self-referrals.

As the writer is not a trained psychologist it was felt that harm might be done by attempting to interview the self-referrals. These people were therefore eliminated, leaving a total of twenty-five referral sources. Of these twenty-five, five were officers or members of the Clinic's Board. During the time of the interviews two more from this group were elected to the board of directors.

The question now was, why had these people referred patients, when (in view of the known magnitude of mental ill health in Greater Fall River) other doctors, clergy, social agencies, etc., had not? Was it because the non-referral group were unaware of their personal involvement in positive mental health; were they able to handle mental problems themselves, or did they perhaps have access to other treatment sources? What part did ignorance, mis-information or antagonism play in this non-utilization of the Clinic? What was the relationship between this lack of cooperation and their understanding and acceptance of the Clinic's services? How did their understanding and acceptance compare with that of the referral group?

In order to answer these questions, a group of people was
needed who were similar to those making up the referral group. They were obtained by taking a stratified random sample\textsuperscript{1} from a complete list of Greater Fall River doctors, lawyers, ministers, priests, rabbis, hospitals, social agencies and organizations, and manufacturing and retail organizations that had personnel departments.\textsuperscript{2}

**The Stratified Random Sample of the Non-referral Group:**

A cross-checked list of these individuals and organizations, totaling 417, was procured and the names were listed alphabetically in their respective groups, doctors - a, b, c, d, etc., lawyers - a, b, c, etc. These groups were then placed in order of their size --- the doctors, the largest group, first, the lawyers, the next largest group, second, etc., down to the smallest, and therefore the last group, which happened to be retail stores. The universe\textsuperscript{3} was then assigned numbers from 1 to 417, the first doctor being Number 1, the last retail store Number 417.

The sample size decided upon was 25. By dividing 25 into

\textsuperscript{1} Sampling theory holds that by choosing names in a specific random manner from an entire group, interview results can be obtained that are representative of the results which would be produced if the total group were interviewed. For our purposes the smallest sample which would still be representative was selected. The method used in choosing the sample is only one of several.

\textsuperscript{2} 125 doctors, 101 lawyers, 92 priests, 49 ministers, 29 social organizations and agencies, 6 hospitals, 5 manufacturing companies, 5 rabbis, 3 school departments, 2 department stores.

\textsuperscript{3} Total group.
the total group every seventeenth name would go to make up the sample but in order to increase the random selection, a further step was taken. Eighteen identical slips of paper were numbered 1 to 17, folded cross-wise and placed in a container. The papers were thoroughly mixed and one was drawn. The slip chosen was number 14. Thus, the first name in the sample was Number 21, the second Number 38, etc., until 25 names had been obtained.

The sample was composed of eight doctors, six lawyers, eight clergymen (Roman Catholic Priests and Protestant Ministers), one hospital, one school department and one social organization. Collectively they are representative of the universe. They are not however, sufficient in number to be representative of their respective groups when separated into occupational categories. For example, the results received from the one social agency included in the sample cannot be taken as representative of the twenty-nine agencies and organizations in the universe. Therefore, in Chapter III which deals with the results of the questionnaire-interview, their answers will have weight only as individuals within the non-referred group.

The Questionnaire Pre-test: A tentative questionnaire was drawn up and pre-tested in interviews with an educator, a

4 The people in charge of these three organizations were selected for the interviews.
doctor and a clergyman. Wording was changed, questions were shortened and the order of the questions rearranged as a result of these interviews. For example, Question Number 8 which asks for a definition of mental health had, in the original draft, been placed first. It was found to be a very difficult question and therefore, was transferred to its present position.

The Design of the Questionnaire Interview: The questionnaire is composed of twenty-seven factual and opinion questions. Each of these questions has been assigned to a broad category.

1. **Question No.8.** The connotation placed on the term "mental health."

2. **Questions No.1,2,3,19.** Knowledge of the mental health field. Specific knowledge of organizations both public and private on the national and state level and their activities; the respondent's contact with these organizations and the part the Clinic played in this contact.

3. **Question No.4.** Knowledge of Clinic's existence.

4. **Questions No.6,9,10,11.** Specific knowledge of the Clinic; when established, services to the community, means of support and the amount of time the Clinic is able to give to patients each week.

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5. Refer to Appendix D for Questionnaire Interview. pp.153 to 155.
5. **Questions No.5,7.** Awareness of the need for mental health services in Fall River; opinion as to whether the Clinic is meeting the needs.

6. **Questions No.12,13,14.** Realization of personal involvement in mental health; active participation; utilization of the Clinic's services or other psychiatric services.

7. **Questions No.15,16.** Satisfaction with the services the Clinic has offered them; the Clinic's fulfillment of their needs.

8. **Questions No.17,18.** Initial contact with the Clinic; involvement other than as referral source.

9. **Questions No.20,21,22,23,24,25.** Awareness of media used.

10. **Questions No.26,27.** Opinion of type and amount of publicity the Clinic uses; opinion as the effectiveness of this media as far as the general public is concerned; opinion of the general public's cooperation with the Clinic.

When the last interview was completed the referral sources and the non-referral sources were separated into their respective groups and each individual within these groups was given a code number. The individual's answers, identified by the

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6 D-1R identifies the first doctor in the referral group; SP-3NR identifies the third social worker from a private social agency who has not referred a patient to the Clinic.
code, were then placed under the established headings.

As it would prove difficult to analyze 46 answers to 27 questions, it was necessary to find a way by which these answers could be reduced to a workable size. Therefore, specific categories into which these answers could be placed were established. For example, the categories set up for Question No. 7, "Do you think there is a more effective way of providing mental health services for the community?" were:

<table>
<thead>
<tr>
<th></th>
<th>R.</th>
<th>N-r.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied with the Status-quo or satisfied but feel the need for expansion (D-1, SP-1, SP-3, etc.)</td>
<td>14</td>
<td>0</td>
</tr>
<tr>
<td>Clinic a good try but don't know for sure (Sc-4NR, etc.)</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Private psychiatrist only</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Clinic plus private psychiatrist</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Federal, state or city supported clinics or psychiatrists</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Don't know enough to say</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Other: If everyone were healthy and happy we wouldn't need a clinic</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Before the individual's answer was placed in a category, his entire questionnaire was examined thoroughly (especially the opinion questions) to be sure that the correct category had been assigned.

7 The individual's categorized answer is identified by means of his code number.
When all the answers had been categorized they were then analyzed carefully to discover the relationship between understanding and the Clinic's media and the relationship between understanding and cooperation. Individual differences within the groups, as well as the differences between the groups, were used to discover the above.

Methods Used to Enlist the Cooperation of the Respondents:
Each respondent was called by telephone, told the interviewer's name, address and school and asked if they would be kind enough to answer some questions in connection with a thesis on the public relations aspects of mental health activities in the Greater Fall River area.

It was emphasized that they had not been called as mental health experts but as representative citizens and leaders in the community. They were also told that their names would not be used in any way and that the information obtained would be held in confidence. They were informed that fifty people were being interviewed and that the results would be compiled to provide the necessary data for part of the study.

Members of the referral group were told that the writer was interviewing all the people who had referred patients to the Clinic, that the writer was in no way connected with the Clinic but that the Clinic had permitted itself to be used as the thesis subject.

The Mental Health Clinic was not mentioned to the non-
referral group as it was likely that some of these people might not know of its existence. They were however, given a brief outline of the methods used in choosing them.

It was felt that a truer picture of the attitudes of both groups could be obtained by giving them a feeling of being submerged in the total group.

The number of appointments scheduled for each day was based on the profession and area placement of the individual. The amount of time lost in waiting for the respondent to be free, was also considered. For example, many of the doctors interviewed do not make appointments for office visits. Office hours are at specified times each day and the rule followed is, first come first served. As a result the interviewer had to wait until the patients were seen. Also several appointments had to be re-scheduled because of emergency calls. Although every effort was made to secure a compact time schedule, it was four weeks before the last interview was completed.

At the time of the interview, in order to establish rapport and enlist full cooperation, additional information desired by the respondent, as to the purposes and methods of study, was given. During the administration of the questionnaire, non-directive questions such as, "Could you be more specific on this point?" or "As you were saying?", were used to clarify and bring into focus the answers received. At the completion of the questionnaire, informal questions were asked
in order to acquire a more complete picture of the respondents' beliefs and attitudes.

The interviews, ranging from twenty minutes to two hours, averaged approximately one hour.

Adjustments Made to Fit Actual Conditions: Interviews were held with all but four. One doctor in the referral group was hospitalized after a major operation. Another member of this group was eliminated after repeated tries had failed to contact him. It was found impossible to interview two clergy-men in the non-referral group. One was seriously ill and the other begged to be excused as he was packing to leave the next day after a residency of fourteen years in this area.

One doctor in the referral group claimed he had never sent a patient to the Clinic. His statement conflicts with the Clinic's records. This person is partially engaged in psychiatric work and appeared to be antagonistic to the Clinic.

In the non-referred group three doctors and one educator claimed to have referred patients. One doctor had done so through a social agency and had no further contact with the Clinic. Another had instructed his nurse to call the Clinic. This referral was not listed in the Clinic's records, nor had he heard from them. The third doctor and the educator, on checking with the psychiatric social worker, were identified as referral sources and therefore were transferred to the referral group.
This left twenty-one or 84% in the non-referral group. The subtraction of 4 individuals from the total sample however, does not appreciably affect the sample's representation of the universe.

The Limitations of Social Research: In analyzing the public relations of the Fall River Clinic and testing the hypothesis that increased understanding brings increased cooperation, we are dealing with objective and subjective material. Objective data, such as the respondent's knowledge of the length of time the Clinic has been operating, the services offered, etc., can be measured accurately. Measurement of opinions is more difficult.

Though every effort was made to secure the utmost cooperation, it is possible that information and/or opinions were suppressed by some of the respondents because of the fear that the writer was working at the behest of the Clinic, and that the information they gave would somehow be used against them. To combat this, the number of opinion questions was increased, and the individual's entire questionnaire was examined thoroughly to insure the utmost possible accuracy of interpretation, taking into consideration human limitations.

This study cannot prove the hypothesis that increased understanding brings increased cooperation because it has not been set up as a completely controlled experiment.

Two groups were chosen, one who had specifically cooper-
ated and a like group who had not. This like group was chosen on a very broad basis — that of having similar professions to the people who had cooperated. Certain factors were measured, such as knowledge of and contacts with the mental health field, knowledge of the Clinic, awareness of the need for mental health services, etc., to determine reasons for cooperation or non-cooperation. It is probable that other unmeasured factors also have a bearing on the actions of the participants. It can be seen therefore, why the hypothesis cannot be proved. The information discovered however, can present a clear indication that the statement is true.

The Role of the Individual in This Study: Because of the enormity of the task, it was found impossible to treat individuals answers in great detail. Therefore, the information obtained from each interviewee has been highlighted only when such information appeared particularly pertinent to the overall purpose of the study.

Though most of the answers have been grouped into categories, (for purpose of anonymity) the reader wishing a more detailed cross-check will find this work facilitated by the code numbers assigned to all respondents.
CHAPTER III
FINDINGS AND EVALUATION OF FINDINGS ON UNDERSTANDING, ACCEPTANCE AND COOPERATION

The Term "Mental Health": "Mental Health" has been given a positive definition by the National Health Assembly. Organizations and individuals in this field stress this positive meaning and much has been done to clear away the ignorance and fear surrounding the term.

Question No. 8, "Could you give me a broad definition of the term "mental health?" was asked to discover the amount of negative thinking existing in the group of respondents. It was felt that the connotation placed on the term could favorably or unfavorably influence the person's approach to the entire subject of mental health and therefore, to the Fall River Mental Health Clinic.

Chart No. 1 records the results received, identifying the individuals by their code numbers.

Key to Chart
Categories assigned to definitions:
Positive - The well adjusted individual.
Neutral - The attitude towards life, whether it be normal or abnormal.
Negative - Diseased condition; insanity.

1 Refer to definition, p.1, Chapter I.
Key to Chart No. 1 (continued)

Refusal - Too difficult to define; impossible to define; outside my field.

CHART NO. 1
DEFINITION OF MENTAL HEALTH

<table>
<thead>
<tr>
<th>Category</th>
<th>Referred</th>
<th>No.</th>
<th>%</th>
<th>Non-referred</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>D-4-5-6,</td>
<td>11</td>
<td>44%</td>
<td>D-2-3-6-7,</td>
<td>10</td>
<td>48%</td>
</tr>
<tr>
<td></td>
<td>SP-3-4,</td>
<td></td>
<td></td>
<td>L-1-3-5,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SS-3,</td>
<td></td>
<td></td>
<td>C-2-6,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SC-1,</td>
<td></td>
<td></td>
<td>H-1,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sc-1-2-3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C-1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neutral</td>
<td>D-7,</td>
<td>3</td>
<td>12%</td>
<td>L-2,</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>SP-1,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sc-4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative</td>
<td>D-1-2-3-8,</td>
<td>10</td>
<td>40%</td>
<td>D-4,</td>
<td>3</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>SP-2-5,</td>
<td></td>
<td></td>
<td>L-6,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SS-1-4,</td>
<td></td>
<td></td>
<td>C-4,</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LE-1,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B-1,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refusal</td>
<td>SS-2</td>
<td>1</td>
<td>4%</td>
<td>D-1-5,</td>
<td>7</td>
<td>33%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>L-1-3-5,</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>SP-1,</td>
<td></td>
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Total Group: Positive - 46%, Neutral - 9%, Negative - 28%, Refusal - 17%. 
Evaluation of Chart No. 1: Less than half the number in each group assigned a positive connotation to the term. By combining the positive and neutral answers (those definitions showing positive cognizance in whole or in part), the percentage for the non-referral group was 53% and that for the referral group, 56%. Of the referral group, 40% answered in the negative, in comparison to 14% of the non-referral group. However, only 4% of the referrals refused to define the term, as against 33% of the other group. The high percentage of refusal difference between the groups, seems to point to the referral group's greater awareness of mental health, even though 40% attach a negative connotation to the term. Four non-referrals who refused to define the term indicated that they thought mental health was outside their field.

The negative definition for the entire group totaled 28% plus (taking into consideration the refusals, 17% of the total answers). As the respondents are an educated group, it is safe to assume that the percentage of negative thinking would be higher for the general public.

Several of the interviewed suggested that there would perhaps be more cooperation with the Clinic if the word "mental" was deleted from its name.

The results seem to indicate that there is a need for emphasizing the role of the individual in building mental health, and that there is a need to make the public realize that "men-
"mental" doesn't mean disease.

Respondents' Factual Knowledge, National and State Level - Public and Private: Much is being done in the field of mental health by private and governmental organizations on the national and state level.

Questions Nos. 1, 2 and 3 were asked to determine the respondents' knowledge and contacts in this area, for it was felt that the referral group's greater knowledge and understanding of, and contact with these organizations, might play a significant part in the cooperation shown the Clinic. The information obtained from the respondents' answers to Questions Nos. 1 and 2 is shown in Charts 2a and b.

Key to Charts

Question No. 1, "Do you happen to know if the Federal or the Massachusetts State Government is doing anything in the field of mental health?"

Categories Determined By The Respondents' Answers:

Federal
A. Federal hospital for the mentally sick.
B. Federal aid to clinics and states.
C. Research.
D. Mental Health Act.
E. Institute for Mental Health.
F. Extension of work in preventative field.
G. Education.

State
A. State clinics.
B. Department of Mental Health.
C. New mental health program.
D. Appointment of Mental Health Commissioner.
E. Extension of state services.
F. Community programs of state hospitals.
G. School work - testing.
H. Courts - testing and psychiatric service.
I. State doctor helpful in the formation of the Fall River Mental Health Clinic.

Identification of the respondents' answers is by means of an * under the appropriate category.

Groups' Score:

Federal

Referred: 7 points x 25 respondents = possible group total - 185 points.

Non-referred: 7 points x 21 respondents = possible group total - 147 points.

State

Referred: 9 points x 25 respondents = possible group total - 225 points.

Non-referred: 9 points x 21 respondents = possible group total - 189 points.

Question No. 2, "Do you know of any private, non-profit mental health organizations on the national or Massachusetts State level."

Categories Determined By The Respondents' Answers:

National Level

A. National Association for Mental Health, Inc.
B. Sponsors research.
C. Sponsors educational programs, and
D. Institutes.
E. Magazines and other literature.
F. Institute for Pastoral Care.

State Level

A. Massachusetts Mental Health Association, Inc.
B. Films and literature.
C. Massachusetts Mental Health Association helped in
the organization of Fall River Clinic.

D. Education.
E. Private hospitals and clinics.
F. Boston University sponsored workshops.

Groups' Score:

National Level

Referred: 6 points x 25 respondents = possible group total - 150 points.

Non-referred: 6 points x 21 respondents = possible groups total - 126 points.

State Level

Referred: 6 points x 25 respondents = possible group total - 150 points.

Non-referred: 6 points x 21 respondents = possible group total - 126 points.
CHART NO. 2a

RESPONDENTS' KNOWLEDGE OF FEDERAL AND STATE ACTIVITIES

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CHART NO. 2B

RESPONDENTS’ KNOWLEDGE OF NATIONAL AND STATE LEVEL ORGANIZATIONS

<table>
<thead>
<tr>
<th>N.L. Ref. (25)</th>
<th>A B C D E F</th>
<th>SL. A B C D E F</th>
</tr>
</thead>
<tbody>
<tr>
<td>D-1</td>
<td></td>
<td></td>
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<tr>
<td>D-2</td>
<td></td>
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<tr>
<td>D-3</td>
<td></td>
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<tr>
<td>D-4</td>
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<tr>
<td>D-5</td>
<td>*</td>
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<tr>
<td>D-6</td>
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<tr>
<td>D-7</td>
<td>*</td>
<td>*</td>
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<tr>
<td>D-8</td>
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<td>*</td>
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<tr>
<td>SP-1</td>
<td></td>
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</tr>
<tr>
<td>SP-2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SP-3</td>
<td>* * *</td>
<td>* * * *</td>
</tr>
<tr>
<td>SP-4</td>
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<td>SP-5</td>
<td>* * * *</td>
<td></td>
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<tr>
<td>SS-1</td>
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<td>SS-2</td>
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<tr>
<td>SS-3</td>
<td>*</td>
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<tr>
<td>SS-4</td>
<td></td>
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<tr>
<td>SC-1</td>
<td></td>
<td></td>
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<tr>
<td>SC-2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SC-3</td>
<td>* * *</td>
<td></td>
</tr>
<tr>
<td>SC-4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LE-1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B-1</td>
<td>Group Points - 11</td>
<td>Group Points - 16</td>
</tr>
<tr>
<td>C-1</td>
<td>Group Score - 7%</td>
<td>Group Score - 11%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>N-Ref. (21)</th>
<th>A B C D E F</th>
</tr>
</thead>
<tbody>
<tr>
<td>D-1</td>
<td>*</td>
</tr>
<tr>
<td>D-2</td>
<td>*</td>
</tr>
<tr>
<td>D-3</td>
<td></td>
</tr>
<tr>
<td>D-4</td>
<td></td>
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<tr>
<td>D-5</td>
<td></td>
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<tr>
<td>D-6</td>
<td></td>
</tr>
<tr>
<td>D-7</td>
<td></td>
</tr>
<tr>
<td>L-1</td>
<td>*</td>
</tr>
<tr>
<td>L-2</td>
<td></td>
</tr>
<tr>
<td>L-3</td>
<td></td>
</tr>
<tr>
<td>L-4</td>
<td></td>
</tr>
<tr>
<td>L-5</td>
<td></td>
</tr>
<tr>
<td>L-6</td>
<td>Group Points - 4</td>
</tr>
<tr>
<td>C-1</td>
<td>Group Score - 3%</td>
</tr>
<tr>
<td>C-2</td>
<td></td>
</tr>
<tr>
<td>C-3</td>
<td></td>
</tr>
<tr>
<td>C-4</td>
<td></td>
</tr>
<tr>
<td>C-5</td>
<td></td>
</tr>
<tr>
<td>C-6</td>
<td>*</td>
</tr>
<tr>
<td>H-1</td>
<td></td>
</tr>
<tr>
<td>SP-1</td>
<td>*</td>
</tr>
</tbody>
</table>
Evaluation of Chart No. 2a: Although the total groups' knowledge of governmental activities is low, the referrals scored more than double the non-referrals in knowledge of federal and state activities. (Referrals: 13% for federal and 16% for state; Non-referrals: 5% for federal and 7% for state.) It was found that 48% of the referred group and 71% of the non-referred group had no information in the federal area; that 52% of the latter group had no knowledge of state activities.

It is interesting to note that both groups showed greater knowledge of state projects, possibly because twelve of the referrals and three of the non-referrals are state and city employees.

In the area of governmental mental health, the two important points not mentioned were federal training grants and the pilot mental health clinic in Bethesda, Maryland.

Evaluation of Chart No. 2b: Knowledge of private, national and state-level organizations was found to be lower than knowledge of governmental activities, although here again the referral group received a much higher percentage score. (Referrals: 7% and 11%; Non-referrals: 3% and .8% for national and state-level, respectively.) Eighty-four percent of the referrals and 81% of the non-referrals had no knowledge on the national-level (the referral groups' knowledge was higher however), and 60% of the referrals and 95% of the
non-referrals had no information pertaining to the state-level.

Within the referred group, knowledge of the state-level was held by more people (nine) than knowledge of the national level (four), pointing to a closer association with private organizations in Massachusetts. Many important points were not mentioned by either group, as can be seen by a comparison of the Categories on page 40, 41 and 42 and the discussion of activities in this area, on pages five and six, Chapter I.

It is interesting to note the difference between knowledge of governmental and private organizations.

The results from Charts Nos. 2a and b, show that knowledge is poor, indicating a need for education. However, as the referrals outranked the non-referrals in knowledge, the hypothesis that increased understanding means increased cooperation has at least not been disproved.

Respondents' Contacts In The Field of Mental Health:

Question No. 3, "Do you have any contacts with these organizations that you have mentioned?", was asked to see if the group who had the most contacts in the mental health field, were the ones who had cooperated with the Clinic. Chart No. 3, records the results.
## CHART NO. 3
CONTACTS IN THE FIELD OF MENTAL HEALTH

<table>
<thead>
<tr>
<th>Category</th>
<th>Referred</th>
<th>No. %</th>
<th>Non-referred</th>
<th>No. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Organi-</td>
<td>SP-3-4,</td>
<td>3 12%</td>
<td>0</td>
<td>0 0%</td>
</tr>
<tr>
<td>zations mentioned in Chap.1</td>
<td>Sc-4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>D-8,</td>
<td>3 12%</td>
<td>0</td>
<td>0 0%</td>
</tr>
<tr>
<td>Guidance Clinics</td>
<td>SS-3,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sc-1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. State or Private Hospitals</td>
<td>D-1-3-6-7,</td>
<td>5 20%</td>
<td>D-4,</td>
<td>4 19%</td>
</tr>
<tr>
<td></td>
<td>Sc-3.</td>
<td></td>
<td>L-3-5,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>C-3.</td>
<td></td>
</tr>
<tr>
<td>4. Literature</td>
<td>0</td>
<td>0 0%</td>
<td>D-6,</td>
<td>2 10%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>H-1.</td>
<td></td>
</tr>
<tr>
<td>5. None</td>
<td>D-2-4-5,</td>
<td>14 56%</td>
<td>D-1-2-3-5-7,</td>
<td>15 71%</td>
</tr>
<tr>
<td></td>
<td>SP-1-2-5,</td>
<td></td>
<td>L-1-2-4-6,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SS-1-2-4,</td>
<td></td>
<td>C-1-2-4-5-6,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>LE-1,</td>
<td></td>
<td>SP-1.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>SC-1,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sc-2,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B-1,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>C-1.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Answer recorded as given. This person is known to have contacts in M.H., at least with state hospitals.

Total 25 100% 21 100%

Total Group: Organizations mentioned in Chapter I - 7%, Guidance Clinics - 7%, State or Private Hospitals - 19%, Literature - 4%, None - 63%.
Evaluation of Chart No. 3: Less than half of the forty-six respondents (37%) had contacts in the field of mental health, other than the Fall River Clinic; the referrals (44%) ranking 15% higher than the non-referrals (29%).

In checking the type of contact, it was found that with the exception of the first group (organizations mentioned in Chapter I), contact and knowledge did not seem to be closely related, as the knowledge rating on the whole, was higher in the no-contact group than in the groups who had contact with the various organizations.

SP-4-3 and Sc-4 ranked respectively, 1, 2 and 4 in knowledge of governmental organizations and 1, 2 and 3 in knowledge of national and state-level organizations.

As a group, the referrals (who have shown the most cooperation), had the greatest number of contacts. As individuals, 56% of the referral group had no contact but still had cooperated with the Clinic.

Both private and governmental organizations have influenced the Fall River Clinic. The Massachusetts Mental Health Association, Inc., in its role of community consultant, was helpful in its formation and the federal government's pilot mental health clinic in Bethesda, Maryland, served as its model. The federal government has also contributed several thousand dollars toward the Clinic's support.

2 Refer to Chart No.1, p.38.
Question No. 19, "Did this Clinic play any part in your initial contact with the mental health organizations that you have mentioned?", asked to discover whether interest in the Clinic was instrumental in introducing the individual to the mental health field, received a negative answer from all respondents.

Knowledge of the Fall River Mental Health Clinic:
Question No. 4, "Do you happen to know if there is a mental health organization in Fall River (and if yes) could you tell me just what kind of organization this is?", received the answers recorded in Chart No. 4.
### CHART NO. 4

**KNOWLEDGE OF CLINIC'S EXISTENCE**

**Referral Group:** Yes - 100%.

**Non-referral Group:**

<table>
<thead>
<tr>
<th>Description</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Definite statement as to existence of Clinic. D-1-2-6-7, L-2-3, C-6, H-1, SP-1</td>
<td>9</td>
<td>43%</td>
</tr>
<tr>
<td>2. Knowledge of the organization but showed definite mis-information concerning it. D-4.</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>3. Knew of such an organization but didn't know anything about it. One of these mentioned that it was a mental health clinic. D-3-5, L-1, L-4.</td>
<td>4</td>
<td>19%</td>
</tr>
<tr>
<td>4. Thought there was some such organization. L-6, C-2.</td>
<td>2</td>
<td>10%</td>
</tr>
<tr>
<td>5. No knowledge of a mental health organization. L-9, C-1-3-4-5.</td>
<td>5</td>
<td>24%</td>
</tr>
</tbody>
</table>

* No knowledge in general mental health field.

**Total Group:** Definite knowledge - 74%, Vague knowledge - 15%, No knowledge - 11%.

---

3 To facilitate charting, these people will be carried throughout the study and listed under: Don't know, etc.
Evaluation of Chart No. 4: In the non-referred group, five people (24%) had no knowledge of the Clinic, and seven people (33%) had vague knowledge of the Clinic (i.e., they thought there was some such organization, or they knew of its existence but said they didn't know anything about it, or (as in one case) showed definite mis-information. One of the individuals in this group is a director of an organization whose paid executive serves on the Clinic's Board.

Only nine (43%) of the non-referral group definitely stated that there was a mental health clinic in Fall River.

Realization of the Need for Mental Health Facilities: Question No. 5 was asked to determine the respondents' realization of the need for mental health services. "In your opinion, why was this organization established?" The answers are shown in Chart No. 5.
## CHART NO. 5
### REASON FOR CLINIC'S ESTABLISHMENT

<table>
<thead>
<tr>
<th>Category</th>
<th>Ref. No.</th>
<th>%</th>
<th>Non-ref. No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Great need for clinical services.</td>
<td>23</td>
<td>92%</td>
<td>11</td>
<td>52%</td>
</tr>
<tr>
<td>Mental illness is a huge problem and the area was lacking in M.H.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>facilities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred: D-1-2-3-4-6-7-8, SP-1 to 5, SS-1 to 4, SC-1, SC-1 to 4,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E-1, C-1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-referred: D-1-2-3-4-7, L-1-2-3-5, C-2-6.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Don't know.</td>
<td>1</td>
<td>4%</td>
<td>9</td>
<td>43%</td>
</tr>
<tr>
<td>Referred: LE-1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-referred: D-5-6, L-4-5, C-1-3-4-5, SP-1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Don't know. There is no reason why it should be a private agency.</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Non-referred: H-1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Don't know. Someone thought there was a need.</td>
<td>1</td>
<td>4%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Referred: D-5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100%</td>
<td>21</td>
<td>100%</td>
</tr>
</tbody>
</table>

Total Group: Belief in need - 74%, Don't know - 22%, Don't know, showing antagonism - 4%.
Evaluation of Chart No. 5: Ninety-two percent of the referral group recognized that the Clinic was established because of the great need for mental health facilities in the area; two (8%) didn't know why the Clinic was established, one saying it was probably set up because someone thought there was a need.

In the non-referral group, 52% realized the need, 43% didn't have enough knowledge to say and one (5%) said he didn't know why the organization was established and that there was no reason why it should be a private agency.

Seventy-four percent of the total group were aware of the reason for the Clinic's institution and 22% were not. Of the remaining 4%, one, who appears to be aware of the need, seems to prefer no mental health facilities rather than have them under private auspices. The other seems to think there are adequate mental health services in the community and that the Clinic is superfluous.

Respondents' Acceptance of the Clinic: Aside from the two doctors engaged in private practice and a recently appointed consulting psychiatrist at one of the hospitals, there are no mental health facilities in Fall River (with the exception of the Clinic).

Question No. 7, "Do you think there is a more effective way of providing mental health services for the community?", was asked to discover the respondents' acceptance of the Fall
River Clinic, for it was wondered if the cooperation shown by a certain number of the interviewed would continue if other facilities become available.

It was also wondered what the non-referrals felt to be the most effective means of combatting the problem, because though they hadn't cooperated, they can be expected to do so. Chart No. 6 records the results received.
# ACCEPTANCE OF CLINIC'S SERVICES

<table>
<thead>
<tr>
<th>Category</th>
<th>Ref. No.</th>
<th>%</th>
<th>Non-ref. No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Satisfied with status quo or satisfied but feel the need for expansion. Referred: D-1-3-7, SP-1 to 4, SS-3-4, LE-1, Sc-1-2, B-1, C-1.</td>
<td>14</td>
<td>56%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>2. Clinic plus private psychiatrists. Referred: D-8. Non-referred: D-1.</td>
<td>1</td>
<td>4%</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>3. Clinic a good try but don't know for sure. (Referred:) D-2-5, SP-5, Sc-3-4. Non-referred: D-2-6, C-6.</td>
<td>5</td>
<td>20%</td>
<td>3</td>
<td>14%</td>
</tr>
<tr>
<td>4. Private psychiatrists only. Non-referred: D-7</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>5. Federal, state or city supported clinic or psychiatrist. Referred: D-6, SS-1, SC-1. Non-referred: D-4, L-1-6, H-1, SP-1.</td>
<td>3</td>
<td>12%</td>
<td>5</td>
<td>24%</td>
</tr>
<tr>
<td>6. Don't know enough to say. Referred: D-4, SS-2. Non-referred: D-3-5, L-3-4-5, C-1-2-3-4-5.</td>
<td>2</td>
<td>8%</td>
<td>10</td>
<td>47%</td>
</tr>
<tr>
<td>7. Other: If everyone were healthy and happy, we wouldn't need a Clinic. Non-referred: L-2.</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>5%</td>
</tr>
</tbody>
</table>

**Totals** | 25 | 100% | 21 | 100%

**Group Totals:** Complete acceptance - 30%, In conjunction with other means - 4%, Partial acceptance - 17%, Against - 20%, Don't know enough to say - 26%, Other - 2%.
Evaluation of Chart No. 6: Fifty-six percent of the referral group accept the Clinic, or an expanded Clinic, as the best means of supplying community mental health services. None of the non-referrals answered in this category. One member of each group feels it would be better to have a psychiatrist, or psychiatrists in private practice in conjunction with the Clinic. In view of the answers given to Question No. 7, the Clinic can count on the support of 34% of the total group if it continues to expand and improve its services.

The Clinic must prove itself to the next group, for they feel that the Clinic is a good try but are not sure that it is the best way to meet the problem. These people make up 17% of the total group (20% of the referral group and 14% of the non-referral group).

The Clinic has failed to reach 28% of the 46 respondents, as 8% of the referrals and 52% of the non-referrals haven't sufficient information to answer this question.

In Categories 4 and 5, there are 12% of the referrals and 29% of the non-referrals (20% of the total), who feel that there is a better way than a privately supported mental health clinic. It is interesting to note that, though there are twelve referrals and only three non-referrals employed by the government, the non-referral group scored 12% higher in Category No. 5.

The results seem to show the need for greater effort by
the Clinic, in securing expanded community acceptance. It appears that it must still prove to the people of Greater Fall River, that its existence is essential in combatting the problem of mental ill health.

The Respondents' Recognition of and Personal Involvement in Mental Illnesses: Although an individual may recognize the problem of mental ill health, realize the need for combatting it, and even accept the Clinic as the best means of doing so, he may still fail to see his part in the matter, or perceiving, fail to become involved.

The answers to Question No. 12, "In the past two years, have you, in your professional capacity, met anyone who seemed to need mental health treatment?"[^1] and Question No. 13, "Did you advise them directly or indirectly to submit themselves for diagnosis or treatment? (a) If no, would you tell me why? (b) If yes, did they take your (or --'s) advise? (c) If no to (b), Do you have any idea why they didn't take your (or --'s) advise?", asked to discover the respondent's recognition of mental ill health and their awareness of the need for personal involvement, may be found in Chart No. 7.

Question No. 13 (b), also included in Chart No. 7, was asked to gain some idea of the reaction of the person to whom the advise was given.

[^1]: All respondents who answered no, had no knowledge of anyone who had referred a patient to the Fall River Clinic.
<table>
<thead>
<tr>
<th>Category</th>
<th>Ref. No.</th>
<th>Ref. %</th>
<th>Non-ref. No.</th>
<th>Non-ref. %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Recognition of Mental Ill-health.</td>
<td>25</td>
<td>100%</td>
<td>12</td>
<td>57%</td>
</tr>
<tr>
<td>Referred: All.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-referred: D-1-5-6-7,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L-1-2-6, C-2-4-5-6, H-1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One (L-4), said he was not in a position to judge.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Awareness of necessity for personal involvement, (i.e., advised person to submit to diagnosis or treatment).</td>
<td>25</td>
<td>100%</td>
<td>11</td>
<td>53%</td>
</tr>
<tr>
<td>Referred: All.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-referred: D-1-5-6-7,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L-2-6, C-2-4-5-6, H-1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One (L-1), although recognizing ill health, felt it was beyond the scope of his job.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* C-5, indirectly.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Person's acceptance of advise.</td>
<td>25</td>
<td>100%</td>
<td>10</td>
<td>48%</td>
</tr>
<tr>
<td>Referred: All.**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-referred: D-1-5-6-7,</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>L-2-6, C-2-4-5-6, H-1.***</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualifications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>** With resistance - D-1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25% of advised - D-6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes - SP-2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Majority - SC-2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*** Some - D-1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most - D-7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don't know - C-5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Reason given for qualifications - People refuse through fear and ignorance.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Evaluation of Chart No. 7: The non-referrals as a group, scored low in recognition and personal involvement, in contrast to the perfect score of the referral group. A little more than half (57%) said they had met people who needed psychiatric treatment. One, of the remaining 43% who answered no to this question, said that he didn't feel that he was in a position to judge. It is likely that more of this group have the same feeling. Fifty-three percent of the non-referrals (one indirectly) advised the person, or persons, to seek psychiatric advise. One of the non-referrals, although he recognized an ill individual, did not suggest that this person seek help because he thought that such advise was not in his line-of-duty. It is probable that more of this thinking would be found if the non-referral group were larger.

When asked if the persons had taken their advise, 48% of the non-referrals answered in the affirmative. The individual who had referred indirectly didn't know, which indicates that he wasn't deeply involved in the matter.

Of the total group, six people (13%), said that not all of the people followed the advise given because of fear and ignorance.

The results from Question No. 12 and No. 13, suggest the need for educating and activating a large percentage of the non-referral group and therefore, the need for educating and activating the professional group they represent.
The findings also reemphasize the importance of a well informed general public.

**Respondents' Use of the Clinic and Other Treatment Sources:** Questions No. 12 and No. 13, dealt with the respondents' recognition of mental problems and their realization of the need for personal participation in the solution. Question No. 14, "If they accepted your advise, where did you send them? (a) (If not to the Clinic) Would you mind telling me why you didn't send them to the Fall River Mental Health Clinic? (b) (If to the Clinic) Did you receive information pertaining to the diagnosis or did you take part in the treatment of the patient?" deals with the respondents' utilization of the Clinic and other sources. As the Clinic strives to involve the referral source personally in the diagnosis and treatment, Question No. 14, was also asked, to discover the Clinic's success in carrying out this objective. Charts Nos. 8a and b record the answers.
<table>
<thead>
<tr>
<th>Category</th>
<th>Ref. No.</th>
<th>Ref. %</th>
<th>Non-ref. No.</th>
<th>Non-ref. %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sent To Fall River Clinic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred: All except D-5 who claims he didn't refer, although the Clinic lists him as having done so.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-referred: D-6-7. The Clinic has no record of these referrals.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sent To Other Sources And Why?</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Private psychiatrists and state or private mental hospitals because they were private patients or beyond clinical care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred: D-3-4-6, SP-1-2-3, SC-1, Sc-1-4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-referred: D-1-5-6-7, G-2-4-6, H-1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. State when services are available.</td>
<td>1</td>
<td>4%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Referred: SS-1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Treated them myself.</td>
<td>1</td>
<td>4%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Referred: D-5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Used religious groups.</td>
<td>0</td>
<td>0%</td>
<td>2</td>
<td>10%</td>
</tr>
<tr>
<td>Non-referred: L-2-6.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>11</td>
<td>44%</td>
<td>10</td>
<td>48%</td>
</tr>
</tbody>
</table>
### Chart No. 8b

**Information Received from Clinic and Respondents' Part in Treatment**

<table>
<thead>
<tr>
<th>Category</th>
<th>Info. Received</th>
<th>Type</th>
<th>Category</th>
<th>Info. Received</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td><strong>A.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Receipt of Information</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>From the Clinic</td>
<td>23</td>
<td>92%</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Referred: All except</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LE-1 and D-5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Received letter,</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>advise, report.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred: D-1-2-3-4-7-8, SP-1-2-3-4-5, SS-1-2, Sc-1-2-3-4, B-1.</td>
<td>18</td>
<td>72%</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>2. Contacted the Clinic for report.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referred: D-6, SS-3-4, SC-1, C-1.</td>
<td>5</td>
<td>20%</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>23</td>
<td>92%</td>
<td>0</td>
<td>0%</td>
<td>23</td>
</tr>
<tr>
<td><strong>B.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part in Treatment</td>
<td>1</td>
<td>4%</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Referred: SP-4. Has been to one</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>conference. This person stated that</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the Clinic had been unable to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>have conferences before, because of</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the shortage of personnel.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>1</td>
<td>4%</td>
<td>0</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>
Evaluation of Charts Nos. 8a and b: Ten members of the referral group (40%) have used other psychiatric facilities besides the Fall River Clinic. One member of this group claimed that he never sent anyone to the Clinic as he treats them himself. Two non-referrals said they had referred people but had never received any information. One of these showed definitely that he thought the Clinic was remiss. The Clinic has no record of these referrals. It is understandable how such a mistake could be made, due to change-over in, and the shortage of Clinical personnel. Unfortunately, such a mistake can cause harm to the organization through the poor feeling that results.

Five referrals (20%) had to contact the Clinic for information about the people they had referred. It was discovered that two of these people felt it would be better to have governmental control of community mental health services (Chart No. 6, page 55). The failure of the Clinic to contact them might play some part in this feeling. The other three in this group however, appeared to feel that the Clinic offered the best means of combatting the area's ill health. One member of the referred didn't call the Clinic but received the information through the "grapevine." This person also supported the Clinic as the best means of supplying community mental health facilities.

Only one person (at the time of the interviews) had been
called in for a conference.

It appears that the Clinic must increase its efforts to "involve the referral source in the diagnosis and treatment of the patient."

Referrals' Opinion of Clinic's Results: Question No. 14, was concerned with the respondents' utilization of the Clinic, his receipt of information and his involvement in the Clinic's handling of the patient. The next logical step is to discover his satisfaction with the Clinic's results. Therefore, Question No. 15, "Were you satisfied with the Clinic's results regarding the patient?", was asked, and Question No. 16, "If someone in your family had an emotional problem that necessitated treatment, would you send them to the Fall River Clinic?", was also asked in order to get a further indication of the respondents' opinion of the Clinic.

The answers received, are to be found in Charts No. 9a and No. 9b.
### CHART NO. 9a

#### COMPLETE SATISFACTION WITH CLINIC'S TREATMENT

<table>
<thead>
<tr>
<th>Category</th>
<th>Referred</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Yes.</td>
<td>D-1-2-8, SP-1-3-5, SS-1-2-4, Sc-1-2, B-1.</td>
<td>12</td>
<td>48%</td>
</tr>
<tr>
<td>2. Partially satisfied.</td>
<td>D-4, SP-2-4, Sc-3-4, C-1.</td>
<td>6</td>
<td>24%</td>
</tr>
<tr>
<td>Feel they don't go far enough or help the referral source in his understanding of the patient.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Don't know, received no information. Had to wait 2-3 weeks for information. Not satisfied.</td>
<td>D-3-6-7, SC-1, LE-1.</td>
<td>5</td>
<td>20%</td>
</tr>
<tr>
<td>4. Too soon to tell. Patient still being treated.</td>
<td>SS-3.</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>5. Didn't refer.</td>
<td>D-5.</td>
<td>1</td>
<td>4%</td>
</tr>
</tbody>
</table>

Totals 25 100%
<table>
<thead>
<tr>
<th>Category</th>
<th>(\text{Ref. No.} )</th>
<th>(\text{Ref. %} )</th>
<th>(\text{Non-ref. No.} )</th>
<th>(\text{Non-ref. %} )</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Yes.</td>
<td>7</td>
<td>28%</td>
<td>1</td>
<td>5%</td>
</tr>
<tr>
<td>Referred: D-1, SP-3-4, SS-1-2-4, LE-1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-referred: C-6.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Don't know. Would depend on severity and type of problem. Imagine they are as good as any. Would be guided by my family doctor. If I couldn't afford a private physician. Depends on who they were in family.</td>
<td>7</td>
<td>28%</td>
<td>2</td>
<td>10%</td>
</tr>
<tr>
<td>Referred: D-7, SP-1, SS-3, Sc-1-2-3, C-1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-referred: D-2, L-2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Rather not say - too personal. Probably not because of its local nature. Would want to keep it quiet.</td>
<td>2</td>
<td>8%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Referred: D-8, SP-2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. No, can afford private care.</td>
<td>5</td>
<td>20%</td>
<td>3</td>
<td>14%</td>
</tr>
<tr>
<td>Referred: D-2-4-5-6, B-1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-referred: D-4-6-7.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Am great believer in personalized service. Would like to see less dependence on government. No. Against generalized medicine. Public unit. People use it without discrimination or selection. Its use is for indigents. Wouldn't send my family to the General Hospital.*</td>
<td>3</td>
<td>16%</td>
<td>3</td>
<td>14%</td>
</tr>
<tr>
<td>Referred: D-3, SP-1, Sc-4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-referred: D-1-3-5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* The Gen. Hospital does not have a Class A rating, to say the least.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Chart No. 9b (continued)

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6. No, would send school children but not own family. Have own idea on conducting a mental health clinic.</td>
<td>0</td>
<td>0%</td>
<td>1</td>
</tr>
<tr>
<td>Non-referred: H-1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. No, services limited.</td>
<td>1</td>
<td>4%</td>
<td>0</td>
</tr>
<tr>
<td>Referred: SC-1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Don't know enough about it to say.</td>
<td>0</td>
<td>0%</td>
<td>11</td>
</tr>
<tr>
<td>Non-referred: L-1-3-4-5-6, C-1-2-3-4-5, SP-1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>25</td>
<td>100%</td>
<td>21</td>
</tr>
</tbody>
</table>

**Evaluation of Chart No. 9a:** Only 48% of the referrals were completely satisfied with the results obtained. Twenty-four percent evinced partial satisfaction, for they did not feel that the Clinic had helped them in their personal understanding of the patient. As one individual stated, "We would at least like to know enough, to be able to leave the individual as mentally healthy as when we met him."

Dissatisfaction was shown by 20% of the referred group, because they had not been informed of the patient's progress, had to wait too long for a report, hadn't received a thorough follow-up, or did not feel that the Clinic had been successful in the treatment undertaken. The Clinic is unable to cure every person who is accepted for treatment. Though this
seems an obvious statement, at least one of the respondents does not seem to fully understand it. It is also possible, that the person is using this as a means for cloaking some other reason for antagonism.

One individual said that he thought the referrals should be notified if the patient discontinues treatment.

Only two of the dissatisfied, were among the people who had to contact the Clinic for information. (Refer to Chart No. 8b, page 62).

Some of the respondents have used the Clinic only for psychological testing. With the possible exception of these, and the respondents who feel the need for help in their dealing with mentally ill people, it is rather probable that certain individuals within the referral group do not realize the importance of their personal involvement.

Results, from Charts No. 8b and No. 9a, show that the Clinic, at least at the time of the interviews, was not successfully carrying out one of its purposes, that of involving the so-necessary additions to the psychiatric team.

Evaluation of Chart No. 9b: Before examining the results from Question No. 15, it must be remembered that the respondents are members of professional groups, and are for the most part in a fairly high income bracket.

Only eight respondents (28% of the referrals and 5% of the non-referrals) said they would use the Clinic if the need
arose. Nine respondents (28% of the referrals and 10% of the non-referrals) were undecided. Two members of the referred group (8%) indicated that they would want to keep the knowledge from the public and therefore, would not use the Clinic's services.

Of the remaining 27 respondents (59% of the total group), eight (20% of the referrals and 14% of the non-referrals) wouldn't use the Clinic because they could afford private care. This, in itself, cannot be taken as an indication of opposition to the Clinic, but when this group's answers to Question No. 7 (Chart No. 6, page 55) and Question No. 14 (Chart No. 9a, page 65) were checked, it was discovered that these people were among those who were either unsold, or against the Clinic as the best means of supplying community mental health services, and that only one (in the referred group) was satisfied with the Clinic's results regarding the patient or patients he had referred.

Eight (20% of the referrals and 19% of the non-referrals) were opposed to the idea of personally using the Clinic. Six of these showed mis-information and one felt the Clinic was good enough for public school children but not for his family.

The results show that the referrals rank 41% higher in cooperation. They also rank 6% higher in the contemplated use of private means and 2% higher in misinformation, but more than half of the non-referrals (52%) were unable to answer
Question No. 15.

Categories 2, 3, 4, 5, 6, 7 and 8 add further weight to the fact that the Clinic must still prove itself to the people of Greater Fall River, and that it must make every effort to clear away existing ignorance and misinformation. It must also do its utmost to avoid practices which will increase existing antagonism and opposition.

Respondents' Specific Knowledge of the Clinic: We now have an understanding of the individual's connotation of mental health and his knowledge and contacts in the general mental health field. We also know (from Question No. 19) that the Fall River Clinic played no part in this knowledge. We know whether or not the respondent has knowledge of the Clinic's existence. We know whether or not he realizes the communities' need for mental health services and what he thinks is the best means for meeting this need. We've examined his recognition of personal involvement, his utilization of the Clinic, his part in and satisfaction with the treatment, and whether or not he would use the Clinic for his family if the need ever arose. It is now time to discover his specific knowledge of the organization under study.

Questions Nos. 6, 9, 10 and 11 were asked to determine this information. The results are presented in Charts Nos. 10a and 10b.
Key to Charts

Question No. 6, "Do you happen to know its specific services to the community?"

Question No. 9, "Do you happen to know how long the Fall River Clinic has been in operation?"

Question No. 10, "During this period, how has the Clinic gotten its funds?"

Question No. 11, "Who staffs the Clinic and do you happen to know the amount of time each week that this staff is able to give to the patients? (a) Do you think this is sufficient?" (Part(a) is treated in Chart No. 10b.)

Categories

<table>
<thead>
<tr>
<th>Services</th>
<th>A. Clinical.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B. Education of referrals.</td>
</tr>
<tr>
<td></td>
<td>C. Education of general public.</td>
</tr>
<tr>
<td>In</td>
<td>D. Training.</td>
</tr>
<tr>
<td>Operation</td>
<td>E. Accepted - 1 to 2 years.</td>
</tr>
<tr>
<td>Funds</td>
<td>F. Public School Department.</td>
</tr>
<tr>
<td></td>
<td>G. Federal Government.</td>
</tr>
<tr>
<td></td>
<td>H. Clinic fund drives.</td>
</tr>
<tr>
<td></td>
<td>I. Patient and agency fees.</td>
</tr>
<tr>
<td></td>
<td>J. Community Fund.</td>
</tr>
<tr>
<td>Staff &amp;</td>
<td>K. Secretary.</td>
</tr>
<tr>
<td>Staff Time</td>
<td>L. Full time.</td>
</tr>
<tr>
<td></td>
<td>M. Psychiatrist.</td>
</tr>
<tr>
<td></td>
<td>N. One day.</td>
</tr>
<tr>
<td></td>
<td>O. Psychiatric social worker.</td>
</tr>
<tr>
<td></td>
<td>P. One and one-half days.</td>
</tr>
<tr>
<td></td>
<td>Q. Psychologist.</td>
</tr>
<tr>
<td></td>
<td>R. One-half day.</td>
</tr>
</tbody>
</table>

Identification of the respondents' answers is by means of an * under the appropriate category.

Number of Categories - 18

Staff and staff time at the time of the interviews.
Number of Respondents

Referred: 25 x 18 = 450 possible group total.

Non-referred: 21 x 18 = 378 possible group total.
### Chart No. 10a

**Respondents' Knowledge of the Fall River Clinic**

<table>
<thead>
<tr>
<th>Ref.</th>
<th>(25)</th>
<th>Points</th>
</tr>
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**Non-ref. (21)**

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<td>Total</td>
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- By:** *73 group score = 61.6%**
<table>
<thead>
<tr>
<th>Category</th>
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<th>Total</th>
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<tbody>
<tr>
<td>1. Satisfy my needs. At present.</td>
<td>5 20%</td>
<td>0 0%</td>
<td>11%</td>
</tr>
<tr>
<td>Referred: D-1-3-4, SP-3, Sc-1.</td>
<td>16 64%</td>
<td>4 19%</td>
<td>44%</td>
</tr>
<tr>
<td>2. Not to meet the needs, need more staff time. Have to wait 2-3 weeks for report. Patients waiting to hear. No, long waiting list, think they are overworked. No, called often. Secretary unable to give me information. Not to cover the city of F.R. Don't know whether F.R. makes use of it. Physicians are not entirely at fault. Think greater cooperation would be secured if Clinic sent more information to doctors.</td>
<td>0 0%</td>
<td>1 5%</td>
<td>2%</td>
</tr>
<tr>
<td>Referred: D-6-7-8, SP-1-2-4-5, SS-1-3-4, SC-1, Sc-2-3-4, B-1, C-1.</td>
<td>Non-referred: D-7, L-2, C-6, H-1.</td>
<td></td>
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</tr>
<tr>
<td>3. Don't think the Clinic is going to be a success. It's an embryonic organization but the field of M.H. is too new.</td>
<td>4 16%</td>
<td>16 76%</td>
<td>43%</td>
</tr>
<tr>
<td>Non-referred: D-5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Don't know.</td>
<td>4 16%</td>
<td>16 76%</td>
<td>43%</td>
</tr>
<tr>
<td>Referred: D-2-5, SS-2, LE-1.</td>
<td>Non-referred: D-1-2-3-5-6, L-1-3-4-5-6, C-1-2-3-4-5, SP-1.</td>
<td></td>
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</tbody>
</table>
Evaluation of Charts Nos. 10a and 10b: Results show that knowledge of the Fall River Mental Health Clinic is poor. Less than half the referrals (11) mentioned ten or more of the total eighteen points. Of the non-referrals, 29% had no knowledge and the remaining fifteen placed with eight points or under. The referral group's score was 50% and the non-referral group's 16%.

These figures show the referral group's knowledge to be considerably higher than that of the non-referral group. The figures also show, that the Clinic has not been very successful in making itself known to those who have cooperated with it, or even in making itself known to those who are a part of it. The knowledge of several Directors was low.

It was discovered that the Clinic's purposes were not fully understood. Thirty-nine of the respondents knew of its clinical services but only five referrals mentioned its educational role (four - education of professional people and one - education of professional people and the general public).

The Clinic's purpose as a training center was completely overlooked.

Knowledge of its monetary support, its staff and (especially) staff time was also spotty.

Only 20% of the referrals felt that the staff time at the Clinic was sufficient. Of the 64% of the referrals and 19% of the non-referrals who felt the staff time should be in-
creased, two (both doctors) said, "Don't know whether Fall River makes use of the Clinic. The physicians are not entirely at fault. Think greater cooperation would be secured if the Clinic sent more information to doctors." This information is stressed here because it was volunteered in addition to the required answers to the questions. (Refer to Questions Nos. 1 through 11, Appendix D, page 153.)

Sixteen percent of the referrals and 76% of the non-referrals (43% of the total group) didn't know whether the staff time was sufficient. One non-referral said he didn't think the Clinic was going to be a success because the field of mental health was too new.

Considerable and rather dangerous mis-information exists among the respondents. Three of the respondents, one a member of the non-referral group, believes that the Clinic is a child guidance center. This is not the case, although a staff member has indicated that he is afraid the Clinic is developing into one. Three members of the referral group, one a director on the Clinic's Board, have confused the secretary with the psychiatric social worker.

The Clinic's secretary has had no psychiatric training, but at the time of the interviews was the only full time staff member. As she cannot possibly understand everything about the patients and therefore, cannot present the referral sources with all the information they might desire, this mis-identification can cause serious consequences to the Clinic's pro-
fessional standing.

In addition to the above, mis-information exists over the non-payment of fees by some of the referral agencies. There is also a rather widespread belief that the Clinic is a welfare agency.

The Clinic received several thousand dollars of federal money. This information was not written up in the local paper, although many of the write-ups mention partial federal support. One individual (a doctor), said in reference to federal funds, "If what they say in the paper is true, they would make you believe that they are self-supporting through community funds."

In reference to the question about the staff, one individual (also a doctor) said, "They are all outside people running the Clinic." It has been emphasized time and time again through the course of the study that Fall River is an overly conservative town. The Clinic however, has made no specific attempt to introduce its staff and their qualifications to the community. Another individual (a doctor) said, "Have never investigated the Clinic. To my knowledge the people on the committee know nothing about psychiatry. Think the committee is too much of a mutual admiration society, although I think they are primarily interested in the Clinic." This statement emphasizes the importance of choosing intelligent, active, community-representative people as Board members.
There is no room for dead wood or "professional joiners." The stakes are too important.

Respondents' Knowledge of Media: Questions Nos. 20 through 25, were asked to determine the respondents' awareness of the Clinic's communications, as well as their awareness of general mental health media. The results are presented in Chart No. 11.

Question No. 20, "Do you happen to know if there have been any write-ups or radio programs on mental health in general or the Fall River Clinic in particular? a) Where did you hear or see them?"

Question No. 21, "Do you recall when this publicity occurred during the year?"

Question No. 22, "Do you happen to know if there have been any public meetings sponsored by the Clinic or by a state-level agency? a) Did you attend?"

Question No. 23, "Do you happen to know if there have been any requests by clubs or other organizations, for speakers from the Clinic or the state-level agency? a) Did you attend?"

Question No. 24, "Have you ever received any publicity information directly from the Clinic?"

Key to Chart

7 Answers to Questions Nos. 22a and 23a are to be found in Chart No. 14, p. 95.
Categories Determined by the Respondents' Answers

A. Local newspapers - Clinic.
B. Local radio - Clinic.
C. Other newspapers.
D. Other radio.
E. Time occurring.
F. Public meeting.
G. Requests for speakers.
H. Receipt of direct publicity.
I. Other Clinic publicity.

Identification of the respondents' answers is by means of an * under the appropriate category. (*) means the individual spoke of Clinical and other mental health publicity.

Groups' Score:

Referred: 9 x 25 respondents = 225 - possible group total.

Non-referred: 9 x 21 respondents = 189 - possible group total.
# Chart No. 11

## Respondents' Awareness of Mental Health Media

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<th>Total Points</th>
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<td>4 = 99 = 44%</td>
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<td>C-1</td>
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</tbody>
</table>

| **Non-referred (21)** |   |   |   |   |   |   |   |   |   |             |
| D-1    | * | * | * |   |   |   |   |   |   | 3           |
| D-2    | * |   | * |   |   |   |   |   |   | 2           |
| D-3    | * |   | * |   |   |   |   |   |   | 2           |
| D-4    | * |   | * |   |   |   |   |   |   | 2           |
| D-5    |   | * |   |   |   |   |   |   |   | 0           |
| D-6    | * |   | * |   |   |   |   |   |   | 3           |
| D-7    |   |   | * |   |   |   |   |   |   | 2           |
| L-1    | * |   |   |   |   |   |   |   |   | 2           |
| L-2    | * | * | * | * | * |   |   |   |   | 5           |
| L-3    | * |   | * |   |   |   |   |   |   | 2           |
| L-4    | * |   | * |   | * |   |   |   |   | 4           |
| L-5    |   |   | * |   |   |   |   |   |   | 0           |
| L-6    |   |   | * |   |   |   |   |   |   | 2           |
| C-1    |   |   |   | * |   |   |   |   |   | 0           |
| C-2    |   |   |   | * |   |   |   |   |   | 1           |
| C-3    |   |   |   |   | * |   |   |   |   | 0           |
| C-4    |   |   |   |   |   | * |   |   |   | 0           |
| C-5    |   |   |   |   |   |   | * |   |   | 0           |
| C-6    |   | * | * | * | * |   |   |   |   | 3           |
| H-1    | * | * | * | * |   |   |   |   |   | 4 = 34 = 21% |
| SP-1   |   | * | * | * |   |   |   |   |   | 1           |

*Group Score*
**Additional Comments by Respondents**

A. Am not a constant reader of the local paper.
   Referred: Sc-1.

B. Don't listen to the local radio.
   Referred: SS-1, Sc-1, Sc-3, C-1.
   Non-referred: D-4-6, C-6.

   I would rather watch television than listen to the radio.
   Non-referred: L-2.

C. -----

D. -----

E. Time occurring

   No.  Mentioned
   2 - Specific instances.
   6 - At formation.
   14 - Start or during fund drives.
   4 - Periodic.

F. Didn't attend meeting because I believe that mental health is a sub-division of P.H.
   Non-referred: H-1.

G. We asked for a speaker but couldn't get one.
   Referred: Sc-3.

H. Direct Publicity

   No.  Mentioned
   6 - Circularized for funds. (Didn't read -L-4)
   1 - Asked about it.

I. Other Clinical Publicity

   No.  Mentioned
   6 - Contact or word of mouth.
   2 - Tag day.
   1 - Churches.
   1 - Play.
   1 - Fund drive.
**General Remark**

No publicity to tell you what they are doing.  
Nothing to encourage you.  
Referred: SC-1.

**Evaluation of Chart No. 11:** The total groups' awareness of mental health media is low. More than half the referrals mentioned four or less points. All of the referrals however, knew of at least two methods of Clinical publicity, whereas 33% of the non-referrals were unaware of any media used by the Clinic or other sources. The remaining fourteen non-referrals ranged from one to five points in knowledge, with more than half the group (eight) scoring two points or less.

Chart No. 11, shows that the referral group ranks considerably higher in awareness of media. The results also indicate, that the media used has not been very successful in stimulating interest toward and increasing knowledge of the Fall River Clinic.

**Respondents' Opinion of Media:** In order to gain further information, it was necessary to discover the respondents' opinion of the media used. Therefore, Question No. 26 was asked. "How do you feel about the type and amount of publicity the Clinic uses? From your own experience, do you think it effectively keeps the Clinic before the minds of the general public?"

The results received are to be found in Chart No. 12.
CHART NO. 12
RESPONDENTS' OPINION OF AMOUNT AND TYPE OF PUBLICITY

<table>
<thead>
<tr>
<th>Category</th>
<th>Ref. No.</th>
<th>Ref. %</th>
<th>Non-ref. No.</th>
<th>Non-ref. %</th>
</tr>
</thead>
</table>
| 1.  
Think Clinic's publicity is good --- waiting list. Public hard to educate.  
Hard to say. Think it has, patients keep coming in and asking about it.  
Yes, suppose so. Yes, otherwise they couldn't have gotten results. Well as anything.  
Referred: D-2-4-5, SP-5, SS-2-3.  
Non-referred: D-2, L-3.          | 6        | 24%    | 2            | 10%        |
| 2.  
Think the work they do is the best publicity. Clinic limited by time and funds.  
Referred: SP-2-3, SC-1.          | 3        | 12%    | 0            | 0%         |
| 3.  
Amount not sufficient, type all-right.  
Referred: Sc-4.  
Non-referred: SP-1.              | 1        | 4%     | 1            | 5%         |
| 4.  
Most publicity is connected with fund drives. It stops the week drive ends. No periodic publicity.  
Referred: D-3.  
Non-referred: D-1, L-2.          | 1        | 4%     | 2            | 10%        |
| 5.  
Not enough, not effective. Hasn't reached me. Received no literature, doctors should be circularized regularly. Many doctors don't know there is a clinic. Takes own physician or social worker to tell people about it. Would do better by approaching the individual physician. Many of the general public don't know the Clinic exists. F.R. is a difficult place to get a new idea across. High % of | 14       | 56%    | 6            | 28%        |
Chart No. 12 (Continued)

5. (Continued)
illiterates. Nothing is effective as far as Fall River is concerned.
Referred: D-1-6-7-8, SP-1-4, SS-1-4, LE-1, Sc-1-2-3, B-1, C-1.
Non-referred: D-3-4-6-7, L-4, C-6.

6.
Don't know. Never thought about it.
1 5% 1 4%
General public more reluctant than doctors. People don't think about it unless they are personally involved.
Referred: D-6.
Non-referred: H-1.

7.
Don't know enough to answer.
0 0% 9 42%
Non-referred: D-5, L-1-5-6, C-1-2-3-4-5.

<table>
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<th>Non-referred</th>
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<tr>
<td>Favorable</td>
<td>6 24%</td>
<td>Favorable</td>
</tr>
<tr>
<td>Not favorable</td>
<td>18 72%</td>
<td>Not favorable</td>
</tr>
<tr>
<td>Half &amp; half</td>
<td>1 4%</td>
<td>Half &amp; half</td>
</tr>
<tr>
<td>Don't know</td>
<td>- -</td>
<td>Don't know</td>
</tr>
</tbody>
</table>

Evaluation of Chart No. 12: Twenty-four percent of the referrals and 10% of the non-referrals think the Clinic's publicity has been good or fairly good. They point to the fact that the Clinic was able to raise enough money to get started and continue to exist, and that there is a waiting list. One member said that when you mention mental health it means insanity to many people, and that the general public, for the most part, is only interested when in need. Another member of this group said that the Clinic shouldn't use
more publicity until it had more money. The writer has run across this type of thinking before. Several participants at the Mental Health Workshop in Boston expressed the same opinion.

Twelve percent of the referrals said that the Clinic's publicity is limited by a lack of time and funds. They thought the best publicity is the work done by the Clinic.

One member of each group (4% of the total) believes that the type of publicity is effective but the amount could be increased. Three respondents (4% of the referrals and 10% of the non-referrals) stated that most publicity is connected with the fund drive and that it stops the moment the drive ends. One member of this group also said that most people are afraid of mental health. This person was one of the individuals who refused to define the term.

Fifty-six percent of the referrals and 28% of the non-referrals think the amount of publicity the Clinic uses is not enough and that the type is not effective.

One doctor said that he thought the doctors should be circularized regularly. This person also said that he didn't read the local papers or listen to the local radio stations. Statistics indicate that from 40 to 50% of all physical disease is caused by worries, fears and frustrations. It seems that this person does not fully realize this and is therefore treating the symptoms and doing nothing to eradicate
the cause. It must be remembered that his patients live in Fall River and that evidence supports the fact that Fall River is not a mentally healthy city. Residence in the community does not necessarily mean understanding of it. This individual is only one of many who are so isolated.

Another individual thinks that the public will accept the Clinic more readily through the efforts of doctors and social workers. One doctor felt the Clinic was publicizing itself to the best of its ability but that it should do more, for he had to call the Clinic to find out about it. A social worker said that she thought most doctors didn't know the Clinic existed.

Three individuals (two referrals and one non-referral) think Fall River is a difficult place to bring in new ideas and that very few new ideas have come into the city in fifty years. They also mentioned the high percentage of illiteracy as causing a special problem as to effective means of publicity.

Other statements found in Category No. 5: "If I am an example, the public is woefully ignorant." "Doubt it, hasn't been in my mind. When I needed a psychiatrist I wasn't aware that such services existed." "They should re-examine the Clinic's title." (Another example of negative thought towards the term "mental health.") "I don't know about it because it hasn't been publicized enough. Think I know as much as I do because I am a physician." (His score for knowledge of the
Clinic - 7% out of a possible 100%.) "Most people haven't heard of the Clinic." "I know of it because of contacts."

In examining the total group answers in Category No. 5, four people (9%) mentioned the need for greater involvement of the doctors, three (6%) mentioned the difficulty of bringing new ideas into Fall River and two (4%) mentioned fear of the term mental health.

The individual in Category No. 6, said he didn't know about the Clinic's publicity for he had never thought about it. He felt that the general public is more reluctant than physicians and that people don't think about illnesses unless they have to.

Nine members of the non-referral group (42%) couldn't answer this question.

Total results: 17% think the Clinic's publicity is more or less good, 57% think it's not good (72% of the referral group), 4% think the type is all right but the amount should be increased and 22% don't know enough to answer.

The data obtained from Question No. 26, lends further authority to the writer's statement, "The media used has not been very successful in stimulating interest in and increasing knowledge of the Fall River Clinic."

Respondents' Opinion of Public's Cooperation: Question No. 27, "What is your opinion of the general public's cooperation with the Clinic?", was asked not only to discover
the respondents' opinion of general cooperation, but also to gain further understanding of what the respondents thought about the Clinic. Results to this question are recorded in Chart No. 13.
CHART NO. 13
RESPONDENTS’ OPINION OF PUBLIC COOPERATION WITH CLINIC

<table>
<thead>
<tr>
<th>Category</th>
<th>Referred No.</th>
<th>Referred %</th>
<th>Non-referred No.</th>
<th>Non-referred %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Fairly good or good cooperation. Quite responsive financially. Went over well with people who realize its importance. Referred: D-3-4-5, SP-2-3-5, SS-2-4. Non-referred: D-1-4, L-6.</td>
<td>8</td>
<td>32%</td>
<td>3</td>
<td>15%</td>
</tr>
<tr>
<td>2. Not good. Certain amount of reticence to consult a psychiatrist. Stigma associated with mental diseases. Unless they are personally involved, there is not much cooperation. Don’t think the average citizen knows it is in existence. The public doesn’t know enough about it. Cooperation is not good. Think they would cooperate if they could understand what for. Don’t think it is as good as it should be. This also includes other agencies. People don’t refer because they are waiting for the Clinic to show what it can do. Think the Clinic would get greater cooperation if they worked through doctors. Should strive for awareness of and confidence in services. Referred: D-1-7, SP-4, SS-1-3, SC-1, LE-1, Sc-1-2-3-4, B-1, C-1. Non-referred: D-6-7, L-2-3-4, C-6.</td>
<td>13</td>
<td>52%</td>
<td>6</td>
<td>28%</td>
</tr>
<tr>
<td>3. Don’t know. Cooperation with government agency would be</td>
<td>0</td>
<td>0%</td>
<td>1</td>
<td>5%</td>
</tr>
</tbody>
</table>
Chart No. 13 (Continued)

greater than with a private agency.
Non-referred: H-1.

<table>
<thead>
<tr>
<th>4.</th>
<th>Don't know.</th>
<th>16%</th>
<th>11</th>
<th>52%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred: D-2-6-8, SP-1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-referred: D-2-3-5, L-1-5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C-1-2-3-4-5, SP-1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Group: Good or fairly good - 23%, Poor - 42%, Don't know - 35%.

Evaluation of Chart No. 13: Thirty-two percent of the referrals and 5% of the non-referrals (23% of the total group) thought public cooperation was good or fairly good; 52% of the referrals and 28% of the non-referrals (42% of the total group) said that cooperation was poor. Of the remaining, one individual felt cooperation with a public agency would be better, and the other 16% of the referred and 52% of the non-referred (35% of the total group) didn't know.

In category No. 1, it was discovered that four people thought of cooperation in financial terms. It must be remembered than many people are more or less forced to contribute to a fund drive and that contributions do not necessarily signify cooperation. This stress on financial success was also discovered in the thinking of two other people, who felt that the public had not given enough money for the Clinic's support. Another person said, "Those who have contributed
have cooperated.", although he also mentioned public indifference.

Two new individuals (i.e. in addition to those who have already mentioned the importance of involving the doctors) answered, "Would think the Clinic would get greater cooperation if they worked through the doctors. If doctors were thoroughly aware of this Clinic and had confidence in its work, they would utilize its services, as there is no psychiatrist in the city." "I heard a doctor make a derogatory remark. There must be a much closer relationship developed between the physicians and the Clinic. More work needs to be done to get these people where they live."

Four individuals, all referrals, said, "Don't think cooperation is as good as it should be. This also included other agencies. I think people don't refer because of their opinion of what the Clinic can do." "Not having general contact, I can't say. I wonder whether parents know what the Clinic is. I make no attempt to explain and I have had antagonism. The parents cooperate with me but I don't know that they understand the Clinic." (This person is engaged in guidance work.) "The public needs a lot of educating, but think they would cooperate if they knew what for. The person I referred went because she felt obliged to."

These answers show that it isn't only the general public that needs educating.
Three people felt that cooperation was poor because the public could not identify themselves with mental illness and that they (the public) only became concerned when the illness was pronounced.

Of the remaining respondents, six felt cooperation was good or fairly good, twelve didn't know, one felt that people accept the Clinic as a service, one felt that the public didn't know enough about it and one said that it was hard to sell the idea because of the Fall River public's over-conservatism.

Two people (in addition to those who had already mentioned it) spoke of the public's fear and ignorance concerning all things "mental."

In addition to the one individual who thought that a government agency would secure greater cooperation, was one (a doctor) who said, "Many people need and want free care. If people really thought, they would favor socialized medicine. You can't get doctors unless you have money. Some people are in the poor house because they spent all their money on medicine." It must be remembered that these people come in contact with large segments of the public, and therefore, what they say is important.

The major categorical opinion (42%) is that there is room for improvement regarding the public's cooperation with the Clinic.

The Respondents' Contacts With the Clinic: All through
this study, we have been contrasting the knowledge of one group against the other and found that the group that has referred has consistently scored higher in knowledge and understanding. It was wondered what part the individual's initial contact played in this and what part the type and number of contacts had in increasing knowledge and cooperation.

Questions Nos. 17, 18, 22a, 23a and 24, were asked to discover this. Information regarding Clinic membership was also obtained and results are recorded in Chart No. 14.

Question No. 17, "Have you ever been asked to work with the Clinic in any way? a) Were you able to do so? b) If not, why not?"

Question No. 18, "Would you tell me how you first heard of the Fall River Clinic?"

Question No. 22a, "Did you attend any public meetings?"

Question No. 23a, "Did you attend any of these meetings at which there were speakers from the Clinic or the state-level agency?"

Question No. 24, "Have you ever received any publicity information directly from the Clinic?"

Key to Chart

Categories Assigned from Answers Received:

A - Member of Clinic.
B - Volunteer collector in fund drives.
C - Attended public or other meetings.
D - Receipt of direct publicity.
E - Asked to work with the Clinic in any way.
other than fund drive.
F - Able to do so.
G - Initial contact.

An * - Indicates positive answer.
Referred: 7 points x 25 respondents = 175 - possible group total.
Non-referred: 7 points x 21 respondents = 147 - possible group total.
## CONTACT WITH THE CLINIC

### Referred

<table>
<thead>
<tr>
<th>Code</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td>D-1(25)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Talked with a member.</td>
</tr>
<tr>
<td>D-2</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Don't remember.</td>
</tr>
<tr>
<td>D-3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Bd. of D. meeting at Taunton.</td>
</tr>
<tr>
<td>D-4</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Asked to join Clinic's Bd.</td>
</tr>
<tr>
<td>D-5</td>
<td></td>
<td></td>
<td></td>
<td>*</td>
<td>*</td>
<td></td>
<td>Newspaper.</td>
</tr>
<tr>
<td>D-6</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Notified at planning stage.</td>
</tr>
<tr>
<td>D-7</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td>Meet. in connection with F.D.</td>
</tr>
<tr>
<td>D-8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>*</td>
<td></td>
<td>Direct publicity and newsp.</td>
</tr>
<tr>
<td>SP-1</td>
<td></td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Grapevine and newsp. Also Contact with Clinic member.</td>
</tr>
<tr>
<td>SP-2</td>
<td></td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>Got enough publicity.</td>
</tr>
<tr>
<td>SP-3</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>Instrumental in starting.</td>
</tr>
<tr>
<td>SP-4</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>&quot; &quot;</td>
</tr>
<tr>
<td>SP-5</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>&quot; &quot;</td>
</tr>
<tr>
<td>SS-1</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Newspaper.</td>
</tr>
<tr>
<td>SS-2</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td>Took part in 1st pub. meeting.</td>
</tr>
<tr>
<td>SS-3</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td>Newspaper.</td>
</tr>
<tr>
<td>SS-4</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
<td>Instrumental in starting.</td>
</tr>
<tr>
<td>SC-1</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Junior Chamber of Commerce.</td>
</tr>
<tr>
<td>LE-1</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Newspaper.</td>
</tr>
<tr>
<td>SC-1</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>Took part in 1st meeting.</td>
</tr>
<tr>
<td>SC-2</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>&quot; &quot;</td>
</tr>
<tr>
<td>SC-3</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>Newspaper &amp; conversation with public health nurse.</td>
</tr>
<tr>
<td>SC-4</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>Newsp. Attended meeting.</td>
</tr>
<tr>
<td>B-1</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>In at establishment.</td>
</tr>
<tr>
<td>C-1</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>*</td>
<td>Saw campaign sign and inquired about it.</td>
</tr>
</tbody>
</table>

### Non-referred

<table>
<thead>
<tr>
<th>Code</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
</tr>
</thead>
<tbody>
<tr>
<td>D-1(21)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Newspaper.</td>
</tr>
<tr>
<td>D-3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Newspaper.</td>
</tr>
<tr>
<td>D-4</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Newspaper.</td>
</tr>
<tr>
<td>D-5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Person came in looking for Cl.</td>
</tr>
<tr>
<td>D-6</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Newsp. Solicited for funds.</td>
</tr>
<tr>
<td>D-7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cl. tried to rent office space in building.</td>
</tr>
<tr>
<td>L-1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Newspaper.</td>
</tr>
<tr>
<td>L-2</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Newsp. Participated in 1st F.D.</td>
</tr>
<tr>
<td>L-3</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Perhaps letter asking for contrib.</td>
</tr>
<tr>
<td>L-4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Knew people working on drive.</td>
</tr>
<tr>
<td>L-5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&quot; &quot;</td>
</tr>
<tr>
<td>L-6</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Was in on org. on Bd. of D. of other social agency.</td>
</tr>
<tr>
<td>C-1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&quot; &quot;</td>
</tr>
<tr>
<td>C-2</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Letter asking for contribution.</td>
</tr>
<tr>
<td>C-3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&quot; &quot;</td>
</tr>
<tr>
<td>C-4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&quot; &quot;</td>
</tr>
<tr>
<td>C-5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>&quot; &quot;</td>
</tr>
<tr>
<td>C-6</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Junior Chamber of Commerce.</td>
</tr>
<tr>
<td>H-1</td>
<td>*</td>
<td>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Don't remember.</td>
</tr>
<tr>
<td>SP-1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Newspaper</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>86=49%</th>
<th>29=13%</th>
<th>1 group score</th>
</tr>
</thead>
</table>

---

*Numbers in the table represent the frequency of each contact method.*
Evaluation of Chart No. 14: It can be easily seen that the referral group has had by far the largest number of contacts (36% more than the non-referrals) with the Fall River Mental Health Clinic.

When asked how they had first heard of the Clinic, seventeen members of the referrals (68%) said that their initial contact came through either, being instrumental in starting the Clinic, participating in or attending the first meeting, or personal contact with some Clinic member. Of the four (16%) who said their first contact came through the newspapers only, three received publicity asking them to attend the first meeting, which they did. The fourth member referred a court case to the Clinic.

Of the remaining four referrals, three said they had received notification at the planning stage and one (the only one out of the total twenty-five referrals) had seen the campaign signs at the time of the fund drive and had inquired about it.

Fifteen of the referrals (60%) had been asked to work with or for the Clinic, either in fund drives or as members. All but two had done so. One of these individuals said he was too busy, the other appeared to be antagonistic to the Clinic.

In comparison to the large amount of personal contact found in the referral group, only five non-referrals had this type of contact with the Clinic. One of these individuals had
attended a meeting at which a Clinic member spoke. This person indicated that the talk was not too satisfactory because the speaker failed to show the audience how they could participate in preventing mental ill health, and that the talk was mostly on the need for funds. Another of these non-referrals had been asked to become a member but had not done so. This person believes that the Clinic should be a governmental agency. The third individual said he knew some people who were working on the fund drive, the fourth that he had participated in the fund drive and the fifth that he was in on the organization of the Clinic. During the course of the Questionnaire-Interview, one referral volunteered the information that an attempt had been made to indoctrinate the fund drive collectors, but that the attempt had not been too successful. At this time the Clinic had the undivided attention of these volunteer collectors --- now, the fund raising duties have been taken over by the Community Chest.

Of the five non-referrals who were aware of receiving direct publicity, three mentioned that they had received letters asking for contributions. As these people are constantly solicited for fund, letters requesting donations are not the ideal introduction to the Clinic. Of the eleven remaining non-referrals, five had no contact what-so-ever, as they had no knowledge of the Clinic's existence, four read of the Clinic in the newspaper and two learned about it by chance.
It seems that the type and amount of Clinical contact has an important role in increasing understanding and cooperation.

Further Information Obtained at Interviews: It was wondered if the referral group had cooperated with the Clinic and the non-referral group had not, because the referrals were:

1. More community minded?
2. Lived in Fall River and were therefore closer to the center of activities and the Clinic?
3. Greater readers of the local paper?
4. More highly trained in the field of mental health?

It was found that:

1. 36% of the referred and 14% of the non-referred were active in the community. Though more referrals were active, the majority of both groups were not.
2. Seven members of the referrals (28%) and only one of the non-referrals (5%) lived in suburban areas.
3. All the non-references and all but one of the referrals were constant readers of the city paper.
4. In the referred group the:

   Doctors had very little training and what they did have stressed the acute forms of mental illness. (32% of referral group)

   Social Workers, SP-2-3-4-5, SS-1 and SC-1 had taken courses and attended institutes and workshops. SP-1 had extra courses in college. (28% of referral group)

   Clergyman had received pastoral training and also had done extra reading. (4% of referral group)

   School Personnel (Sc-2) had extensive training in the
Institutional area. (4% of referral group)
Others of group (eight) had no training. (32% of referral group)

In the non-referred group the:

Doctors had same as the referred of like occupation. (32% of non-referral group)

Clergymen had same as clergyman in referred group. (29% of non-referral group)

Others of group (eight) had no training. Six of these are lawyers. (38% of non-referral group)

With the exception of the referrals who have taken courses, attended institutes and/or workshops, and the person who had considerable study in the institutional area, both groups run fairly parallel in psychiatric training. SP-4-5 and Sc-2 are members of the Clinic's Board, as are SP-3, SS-4, Sc-1 and B-1 who have had no psychiatric training.

CHART NO. 15
INTERVIEWER'S OPINION OF INTERVIEWEE'S COOPERATION

<table>
<thead>
<tr>
<th>Category</th>
<th>Referred</th>
<th>No.</th>
<th>%</th>
<th>Non-referred</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Excellent</td>
<td>D-1-2-3-4-7-8, SP-3-4-5, SS-2-3-4, SC-1, Sc-1-2-3-4, LE-1, B-1, C-1.</td>
<td>20</td>
<td>80%</td>
<td>D-1-3-6-7, L-2-3-4-5-6, C-2-4-5-6, SP-1.</td>
<td>14</td>
<td>66%</td>
</tr>
<tr>
<td>2. Good</td>
<td>D-6, SP-1.**</td>
<td>2</td>
<td>8%</td>
<td>D-2-4-5, C-3, H-1.</td>
<td>5</td>
<td>24%</td>
</tr>
</tbody>
</table>
Chart No. 15 (Continued)

3.

Fair

D-5, ***
SP-2, )
SS-3, )****

<p>| | | | | |</p>
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<tbody>
<tr>
<td></td>
<td>3</td>
<td>12%</td>
<td>L-1.*****</td>
<td>1</td>
</tr>
</tbody>
</table>

4.

Poor

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<tbody>
<tr>
<td></td>
<td>0</td>
<td>0%</td>
<td>C-1.*****</td>
<td>1</td>
</tr>
</tbody>
</table>

* Appeared impatient with length of questionnaire.
** Seemed rather supercilious.
*** "Do you expect to get answers?"
**** Appeared to be holding back.
***** Lacked interest in the entire project.
****** Resented questions. Said he was only interested in own parishioners.

Opinion of Questionnaire: In order to gain further understanding of the interviewee's cooperation, the respondents were asked what they thought of the questionnaire, did they have any suggestions for improving it, etc. All except C-1 thought (or said) it was worded clearly and was not too prying. C-1 wasn't asked, as his opinion was evident.

Other Pertinent Information: The material discussed in this section was acquired, for the most part, through correspondence with individuals in the field of mental health. Its purpose is to present in brief, additional information of pertinent organizations and activities and provide the reader with knowledge of sources where further information may be procured.

Through the cooperation of the Massachusetts Association for Mental Health, Inc. the pamphlet "The Massachusetts

8 All pamphlets, etc., discussed in this section may be obtained at the Fall River Mental Health Clinic.
Association For Mental Health, Inc.," copies of the monthly "Newsletter" and access to the Mental Health Workshop, were obtained.

This workshop was held under the auspices of the Massachusetts Central Health Council and the Association for Mental Health, for the purpose of bringing together people in the private and governmental fields of mental health to explore, "The Place of Mental Health in Today's Community Health Programs." As it was an excellent and instructive conference, a summary of the important points discussed, as well as the results from the discussion, may be found in Appendix E, pages 156 to 158.

Mr. Edmund F. Bagley, Probation Officer of the Second District Court of Bristol, was helpful in securing information regarding the mental health activities of the Commonwealth of Massachusetts. Through his kindness, an article published in the Fall River Herald News, Thursday, November 15, 1951, entitled "New Mental Health Commissioner Outlines Comprehensive Program for Operation of State Institution," was secured. Mr. Bagley also sent a notice he had received regarding a statewide meeting of probation officers and district court judges, to be held in Boston on Thursday, November 29, 1951. The subjects to be discussed were, "Mental Health and the Law", 
by Dr. Jack R. Ewalt, newly appointed Commissioner, Massachusetts Department of Mental Health; "Alcoholism and Psychiatry," by Dr. Robert Fleming, Director of the Alcoholic Clinic, Peter Bent Brigham Hospital; and "The Advisability of Making Psychiatric Service Available to the District Courts," by Attorney Gerald A. Berlin and Major Abraham Kaye, M.D., Chief, Neuro-psychiatric Services, Murphy Army Hospital, Waltham, Massachusetts. The latter was a discussion of their survey of Mental Health facilities in Massachusetts, which was conducted at the request of the Massachusetts legislature.

It is important to mention here that the probation officers have themselves requested training in mental health theories and practices.

Through the cooperation of Miss Alberta Jacoby, Chief of the Publications and Reports Branch, National Institute of Mental Health, and Mr. Herbert L. Rooney, Chief Psychiatric Social Worker, Prince George's County Mental Health Clinic, much valuable information was received regarding the federal government's work in mental health. One of the government's important activities is the publication of pamphlets related to clinics and community mental health program. Among them is a classified, annotated listing of films, entitled "Motion Pictures for Mental Health Programs." This tells where the films may be obtained, and gives the running time, a synopsis and suggested audiences. The catalog stresses the fact that,
"a mental health film is an aid, not a program." Another catalog, now in revision, "Mental Health Pamphlets," is also obtainable.

Other particularly valuable pamphlets are "Pilot Mental Health Clinic," by Dr. Mabel Ross, Director of Prince Georges County Mental Health Clinic; "National Institute of Mental Health"; "A Health Department Stimulates Community Thinking for Mental Health," by Dr. David Frost, Health Officer and Miss Genevieve Anderson, Director of Public Health Nursing, Alameda, California. The latter pamphlet tells of Alameda's approach to a mental health program. Monthly meetings are held at which various professional people meet to discuss and interpret case studies. The purpose of this program is "to promote effective team work and create an awareness of mental health factors among all community case workers," because of the belief that "a mental health program cannot be established as a separate entity."

Highly recommended is the pamphlet, "Birth of a Community Mental Health Clinic," by Edward Davens, M.D. and Paul Lemkau, M.D., which outlines the essential prerequisites for a clinic's success through its initial steps in securing cooperation.

The constitution of this clinic (the Prince Georges County Mental Health Clinic) is of particular interest and as such had been included in part, in this study and may be found in Appendix F, pages 159 to 161.
Knowledge of the National Association for Mental Health, Inc., was acquired through correspondence with the Association's Executive Assistant, Miss Mary C. Bentley. Among the organization's current activities are the preparation of a pamphlet on the organization and function of psychiatric clinics and plans for the reporting of clinical statistics. The Association is working with the National Institute of Mental Health, the American Psychiatric Association and the National Association of Community Chests and Councils on the latter project.

Miss Bentley also sent a catalog entitled "Mental Health Publications and Audio-Visual Aids," which is a listing of all pamphlets and leaflets produced by the National Association; a brochure, "1909 to 1949," the organization's annual report of 1948 to 1949; a booklet "History, Purposes and Organizations of The American Association of Psychiatric Clinics for Children"; and a list of various clinics and mental health organizations throughout the country.

In answer to the query regarding clinical public relations' programs, Miss Bentley said that attempts to reach the public have been spotty. She believes that one of the main liaisons between the clinic and the community should be through the clinic's board, and that when the board is not fully representative of the community, it is hard for them to carry out this function. Also,

"Much of the good public relations comes out of
a case by case development, or careful interpretation to people who are interested, particularly the family doctor, teacher, etc."

Information about various organizations on the aforementioned list was secured through additional correspondence. Three organizations, whose programs seem particularly pertinent are the Guidance Center of New Rochelle, Westchester, New York, and Peoria, Illinois Mental Hygiene Clinic and Association.

Under the leadership of Miss Marjorie P. Ilgenfritz, Education Director, the Guidance Center of New Rochelle has established what they call, "The Council of Human Relations." This council is composed of a series of committees, whose purpose is to gather material for a bi-monthly bulletin, and carry on committee work. The committees, supervised by one paid worker, are:

1. Discussion Committee - to enroll interested parents and secure qualified leaders.
2. Dramatic Committee - to write and produce plays and skits showing every day occurrences that cause problem relationships.
3. Membership Committee - to expand membership.
4. Newspaper Publicity Committee.
5. Radio Committee - to take part in public service programs.
6. Interpretation Committee - (Speakers' Bureau)
7. Finance Committee.

The success of this program can be measured by the fact that increased allocations have come from three of the four community chests supporting the Clinic. 9

9 Correspondence with Miss Ilgenfritz.
The Westchester County Mental Hygiene Service is included here because it is an excellent example of government working in conjunction with private interests. Private citizens were instrumental in the establishment of the Division of Mental Hygiene, under the directorship of Dr. A.J. Kazan, in the County Department of Health. These same individuals have continued their Association with the Division as "The Westchester Mental Hygiene Association."\(^{10}\)

The Peoria Mental Hygiene Clinic is another example of government and citizen cooperation. Part of its funds come from the state, part from the federal government and part from the Peoria Community Chest.

The Peoria Mental Hygiene Society (the Clinic's advisory group) carries on a program, which they break down into:

1. Educational Program
2. Public Relations Program
3. Legislative Program
4. Care of Mental Patients
5. Peoria Mental Hygiene Clinic\(^{11}\)

Mr. Edward Linzer, Executive Secretary of the Clinic, who supplied the above information, is also the author of "A Community Organization Project in Mental Health." The purpose of this project was to "strengthen the relationship of the state hospital with the communities it serves," by helping the communities determine their individual needs and

\(^{10}\) Correspondence with Dr. Kazan.
\(^{11}\) It is the writer's belief that public relations is an integral part of every activity.
objectives. The brochure is valuable because it included a
thorough explanation of the reasons for the undertaking, the
methods used and the programs established in the various
communities.

Additional information of the mental health field was
obtained from copies of "The Mental Health Programs of the
Forty-Eight States (Summary and Recommendations)," and
"Human Relations in Public Health," acquired through the
office of Boston University's School of Medicine.

Boston University publishes, "There is Something We Can
Do About Mental Health." This is an excellent booklet,
offering interesting and easy reading for the general public.
It unfortunately, as its purpose is to stimulate careers
in mental health work, does not put enough emphasis on the
role of lay-people in supplementing the psychiatric team and
the clergyman.
CHAPTER IV

SUMMARY OF FINDINGS, CONCLUSIONS, RECOMMENDATIONS, PUBLIC RELATIONS' SIGNIFICANCE OF THE PROBLEM AND SUGGESTIONS FOR FURTHER STUDY

Summary of Chapter Contents: Chapter I presents information pertaining to the Mental Health Field, including historical developments, governmental and non-governmental organizations and activities, the Bristol County Mental Health Clinics, Inc., the Fall River Mental Health Clinic, and the City of Fall River and its surrounding area. Chapter II supplies a detailed account of the research methods used, the results of which make up Chapter III.

The present Chapter provides a summary of the findings, and the conclusions and recommendations based on this information. Chapter IV also includes the public relations' significance of the work and the recommendations for further study.

Summary of Study's Purpose: This study has a two-fold purpose:

A. To analyze the public relations' program of the Fall River Clinic in order to discover its strengths and weaknesses, and from the findings make recommendations for the program's improvement.

B. To test the hypothesis that increased knowledge and understanding means increased cooperation, by:
a) Discovering people's knowledge and understanding of the Clinic's purposes and objectives.

b) The relationship between understanding and the Clinic's communications, and

c) The relationship between this understanding and cooperation.

I. SUMMARY OF FINDINGS AND CONCLUSIONS ON THE PROBLEM OF MENTAL ILL HEALTH AND ACTIVITIES IN THE FIELD: Mental ill health is a problem of huge proportions. Efforts are being made to reduce the growing number of the mentally sick. Departments of Mental Health have been set up in the national and in certain state governments. Private organizations are also working in the field. The current mental health thinking is that it is easier to prevent than cure and therefore, methods are being studied where by prevention can be put into practice.

Emphasis is on --- more research in the study of the mind and in techniques for utilizing the findings, education of the general public and specific groups, more personnel through increased funds to colleges, universities and other organizations and through stimulation of interest in mental health careers.

The problems are many. Study of the mind is a relatively new science, comparable to the study of bacteriology at the time of Pasteur; personnel is scarce, training centers are limited, treatment centers are few and inadequate and public
education (so necessary for the preventative approach) is on a small scale in relation to the need. The problem is so large that the work being done is only scratching the surface.\(^1\)

The Writer's Impression of the Clinical Field of Mental Health: The Clinical field of mental health is uncoordinated, is lacking in detailed records, and organizations and individuals are isolated. Valuable information is not fully utilized because individual successes and problems are not made known for mutual help. For example, an organization, called by several the outstanding mental health organization in Massachusetts, was unable to furnish the writer with any data because they had nothing prepared.

Many people associated with the clinical mental health field have had no specific mental health training. In addition, individuals seem to be so bogged down with the immensity of the job, that they are hindered in their work by this negative approach. The word "mental" has a negative ring. There also seems to be a lack of community knowledge and a lack of knowing how to use community people.

On the whole, the foregoing is realized and attempts are being made to improve the situation.\(^2\)

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\(^1\) The Mental Health Field on the National and State-Level, Chapter I, pp.3 to 7.

\(^2\) Impression received from correspondence, conversations, attendance at workshop and "Summary of Workshop Outcomes and Results," Appendix E, pp.156 to 158.
Summary of Findings on the Bristol County Mental Health Clinics, Inc.: This organization is the result of the combined efforts of citizens of Fall River, New Bedford, Taunton and Attleboro to provide mental health services for their respective communities. It was organized on a county basis because it was felt that no individual city could afford the cost of comprehensive mental health services.

The Fall River Clinic has to date been the most successful, although Attleboro is expanding rapidly, with the result that the local organization maintained a rather loose association with the other cities. Recently however, there has been a re-emphasis of the necessity for closer communication and support. The wisdom of this can be readily seen after a careful examination of the position of the Fall River Clinic, in relation to its meeting the present and future needs of the area it serves.

Each city raises its own funds and as these moneys have been only sufficient to furnish part time services in the four cities, the planned center, to be established in Fall River, has not been set-up.3

Summary of Findings on Fall River, Massachusetts: Fall River's past history as a "cotton center" has not been ideal in fostering "mental health," and like other textile areas

3 Bristol County Mental Health Clinics, Inc., Chapter I, pp.11 to 12. Also, Appendix A. pp.144 to 146.
is presently the scene of widespread unemployment. The majority of its people are overly conservative; are dissatisfied with the city; its population is declining, men have difficulty getting jobs; there is a shortage of women for power-sewing machine positions although 40% of Fall River's women work, a situation dangerous to the stability of the home and the morale of the men; educated young people find few openings in Fall River and poor housing and illiteracy are high. In addition, the patriarchal code of many of the city's people has been abolished, taking with it the necessary parental discipline.

Because of this situation, mental health services are essential, but because of the over-conservatism of the people, any new organization regardless of its purpose, would find difficulty gaining public acceptance. Unfortunately the Clinic has to work doubly hard as it is a "mental" health organization.

The Clinic can only gain widespread acceptance by meeting the needs of the people of Fall River. To meet these needs it must know the city and its people. If the Clinic is to be successful in its preventative program, it must, in conjunction with other individuals and groups, find ways of removing or allaying the area's major problems.4

Together with Fall River's drive for new industry, two

4 Refer to Fall River, Massachusetts, Chapter 1, pp.7 to 11.
interesting projects are being undertaken.

One is the establishment of a course for men in the use of the power-sewing machine. The opportunity is being accepted with enthusiasm. At the time of this writing approximately seven hundred applications have been received. The fact that this work was formerly considered a woman's field has been tempered by the lack of job opportunities and the amount of money that can be earned by the type of piece work involved. It not only helps the manufacturers who have great difficulty filling the openings, but is a healthy situation and a reversal of the old practice of hiring women because of the unequal wage scale.

The other project is an emphasis on the expansion of industries established in Fall River, by helping them secure greater work loads, and by so doing enable them to increase the number of their employees.

It is the writer's belief that these two undertakings are very important to the mental health of the community, and as such should be the concern of the Mental Health Clinic.

II. SUMMARY OF FINDINGS ON THE FALL RIVER MENTAL HEALTH CLINIC:

A. Material Obtained from Clinical Records and Interviews with Members of the Board and Staff.

5 The Fall River Mental Health Clinic, Chapter I, pp.13 to 22, and Appendix B, pp.147 to 150.
B. The Clinic's Public Relations' Program from Findings Based on the Questionnaire-Interview.

C. An Examination of the Questionnaire-Interview Findings Regarding the Hypothesis - Increased Understanding Means Increased Cooperation.

The Fall River Mental Health Clinic is composed of a Board of Directors and a Staff, whose joint purpose is to provide comprehensive mental health services, in the clinical, educational and training areas, for the people of Greater Fall River.

a) Clinical --- Diagnosis, psychological testing and some treatment for people who have not ready access to other mental health sources and who are referred to the Clinic by professional people.

b) Educational --- Work with the referral sources in order to expand their usefulness as members of the psychiatric team, and with the general public in order to:

1. Remove the fear of mental illnesses and the negative concept of the term "mental."
2. Gain acceptance and support for the Clinic.
3. Spread mental health principles and increase their utilization in everyday living.

Training --- Practical experience for career people in the clinical area of less serious mental illnesses and in preventative practices.
A. SUMMARY OF INFORMATION OBTAINED FROM CLINICAL RECORDS
AND INTERVIEWS WITH MEMBERS OF THE BOARD, STAFF AND COMMUNITY

PEOPLE

The Fall River Mental Health Clinic is filling an important need and the people responsible for its founding are to be highly commended. These individuals have taken on a grave responsibility and will in turn be held accountable for the Clinic's success or failure.

The organization, supported for the most part by individual donations and belonging to all the people of Greater Fall River, must show a rising profit. The profit in this instance, is the utmost expansion of mental health through the economical use of time, funds and personnel. The need for mental health services is too great to allow for inefficiency.

The development of the Fall River Clinic has been hampered by a shortage of money, a gradual accumulation of personnel, changes in personnel and the fact that the "psychiatric team" is not on a full time basis; it has been additionally hampered because the Board of Directors is not overly familiar with the mental health field or public relations techniques.

Findings on the Board of Directors: No specific policy governs the choosing of members, which presents the danger of the Board not being fully representative of Greater Fall River.

Attendance at meetings is not required by law and as a
result certain members are rarely present.

No specific policy governs the education of the Board. These people, who spend most of their time elsewhere, can naturally give only partial attention to the Clinic. Unfortunately, the majority are isolated from the mental health field and from their own staff. No staff member has been able to attend more than one or two meetings, and the members (with the exception of two) have had little or no psychiatric training.

The Fall River Clinic receives the monthly "Newsletter" from the Massachusetts Association for Mental Health, Inc. It is doubtful, however, whether all of the Board (or Staff) have access to it. This is the Clinic's only routine outside contact, other than the Bristol County organization. Out-going reports to other mental health organizations are negligible.

There is no library at the Clinic, either for members, referrals or patients and their families.

The Clinic has no written history other than that contained in this study and the minutes-of-the-meeting do not provide a sufficient record of problems and achievements.

Findings on the Staff: The professional staff is composed of people who do not live in this area (with the possible exception of the new full-time social worker), but little effort has been made to introduce them and their qualifications to various groups in the city. This is dangerous, not only
because Fall River is overly conservative, but also because
the staff needs to understand Fall River and its problems.
The isolation of the staff from the Clinic's Board of Direct-
ors, does nothing to further this understanding.

Because of the shortage of staff-time, the Clinic's
secretary until recently was required to do follow-up work
on patients. Unfortunately, she has had no psychiatric
training.

Other Findings:
1. There is a waiting list for Clinical services.
2. The Clinic's record of referrals is incomplete, as
witnessed by the necessity for transferring people from the
random-sample to the referral group at the time of the
questionnaire-interview.
3. The Clinic's statistics are inadequate. They show
the number of patients seen by each staff member. They don't
show how many staff members saw the same patient, whether the
patient kept his appointments, or the number of visits by
each patient and the results of the visits --- all very
important information.
4. The Clinic charges fees on a sliding scale but there
is no specific policy regarding this fee system. Some re-
ferral agencies do not pay, although most social agencies
submit a yearly budget and the Clinic has been in operation
since 1950. Sometimes three or four social agencies handle
one patient. There is some concern regarding which of them should pay the Clinical fee.

5. The Clinic receives funds from:

The Fall River Public School Department for the psychological testing of exceptional school children. There is no appropriation for psychiatric diagnosis or treatment which is sometimes found necessary.

The Federal Government has given the Clinic one grant of several thousand dollars.

Private Fund Drives in 1950 and 1951 during which it obtained one-half and two-thirds of its goal, respectively.

The Fall River Community Fund Drive of 1952, from which it received all but 5% of the funds requested.

Fees charged to patients or referral sources.

6. No specific policy governs the Clinic’s committee system (except for the Finance, Legal Ways and Means Committee).

7. The Clinic has no specific policy regarding its educational work with referrals. It attempts to educate the referral sources by means of reports and conferences, but has been hampered in this undertaking by a shortage of time. A standard patient-referral sheet has just been completed which will help the referral provide the Clinic with the information necessary for mental health purposes. This undertaking was necessary because of the incomplete reports being sent in.
8. General public education has included one public meeting at the time of the Clinic's foundation, two radio programs, and speeches, mostly by lay-people in connection with the fund drives. The staff has been unable to fill all requests for speaking engagements.

The Clinic has sent out direct publicity in the form of question and answer sheets and several letters asking for funds. The major means of publicity has come through the newspapers. This publicity has been rather infrequent, mostly during and concerning the fund drives. The amount of publicity has steadily declined. The 1952 Community Fund Campaign gave the Clinic one write-up and listed it as a participating organization in all Red Feather publicity.

The Clinic's publicity has included information on the purpose, staff, number of patients seen, the referral sources, speaking engagements and the money necessary for its continued operation. There have been no case studies on the local Clinic.

In addition to the above, the Clinic has given two banquets for the volunteer collectors at the start of the Clinic's fund drives, has conducted two tag days and has received several full page ads during the campaigns. These ads included information about the Clinic and pictures of people endorsing its services. It seems that more thought could have been given to the choosing of these people, as representatives from some important groups were overlooked. It would
be interesting to discover how much the endorsers and the volunteer collectors know about the Clinic.

9. With the exception of one hospital, which has just appointed a consulting psychiatrist, and two doctors who are doing psychiatric work, the Fall River Mental Health Clinic is carrying the burden of the area's mental ill health.

Greater Fall River's school departments are doing little or nothing towards the education of their teachers and pupils. The same applies to the medical society, the banks, retail establishments and manufacturing companies. They appear to be waiting for the mental health organization to approach them. The public health department as yet has not incorporated mental health into its services, although projects are pending. It also has not officially endorsed the Clinic.

10. A social work student from Boston College spent several days a week at the Clinic during one school year and used the Clinic as her thesis subject. This is in line with the Clinic's training purpose.

B. SUMMARY OF FINDINGS FROM THE QUESTIONNAIRE-INTERVIEW

Definition of Mental Health: Less than half the group assigned a positive connotation to the term. Three of the referrals and one of the non-referrals mentioned both positive and negative aspects. Although ten referrals gave a negative definition, in contrast to three non-referrals, seven of the

6 Refer to Chapter III, pp.37 to 107, for detailed data.
non-referrals were unable to answer the question. Only one referral placed in this category. Four of the non-referrals who refused to define the term, said that mental health was outside their field and several, of the total group, suggested removing the word "mental" from the Clinic's title in order to insure greater public cooperation.

**Knowledge of the Mental Health Field:** Although total knowledge was low, the referrals scored more than double the non-referrals. The respondents showed greater knowledge of federal and state activities, possibly because fifteen are employed by governmental organizations.

**Contacts in the Mental Health Field:** The people who were in touch with the various organizations mentioned in Chapter I,\(^7\) were the individuals who possessed the most knowledge. Association with state mental institutions and the like did not seem to increase information. As more than half the referrals had no contacts, no significant relationship was discovered between general mental health contacts and cooperation with the Clinic.

**Knowledge of the Clinic's Existence:** Nine non-referrals definitely stated that there was a Clinic in Fall River, seven had vague knowledge of a mental health organization and the remaining five did not know that the Clinic existed.

**Reason for Clinic's Establishment:** Approximately two-

\(^7\) Refer to Chapter I, pp.5 to 7.
thirds of the total group said the Clinic has been established because of a great need for mental health services. This included twenty-three of the referrals and eleven of the non-referrals. One member of each group showed evidences of antagonism saying, "Don't know. Someone thought there was a need." and "Don't know, There is no reason why it should be a private agency." Ten respondents (nine non-referrals) said they didn't know why the Clinic had been established.

Acceptance of Clinic to Meet the Need: A little over half the referrals accept the Clinic or an expanded Clinic, with or without other means, as the best way of supplying the needed mental health services. Five referrals and three non-referrals think that the Clinic is a good try but don't know for sure. Five non-referrals and three referrals would prefer governmental control. In addition, one non-referral believes that private psychiatrists could best supply the needed services. Over half the non-referrals and two of the referral group don't know enough to say.

Respondents' Recognition of Personal Involvement: All of the referrals had recognized evidences of mental ill health, had suggested that the individuals seek treatment and had knowledge of whether or not the person had taken the advice. Four of the referrals qualified their affirmative answer by saying, with resistance, 25% of advised, sometimes, the majority; giving as the reason, fear and ignorance. A little more
than half the non-referrals were aware of having been in contact with mentally ill people. When asked if they had suggested that the person (or persons) seek help, all but one of these answered in the affirmative. This individual felt that it was outside the scope of his job. When asked if the people had accepted their advice, all but one said that they had (two qualifying this as in the referral group). The individual who didn't know had referred indirectly. One, of the remaining nine non-referrals who answered no to this question, said that he wasn't in a position to judge whether or not an individual is mentally ill.

Respondents' Use of the Clinic and Other Treatment Sources: One member of the referral group claimed he didn't send patients to the Clinic, although this organization lists him as having done so. Two members of the non-referral group said they had referred people but had received no information. One feels the Clinic was remiss. These people are not listed as referrals by the Clinic.

The respondents who used other mental health sources did so for reasons which do not appear to be antagonistic. The reasons were --- serious cases, private patients or ignorance of the Clinic.

Information Received from Clinic and Respondents' Part in Treatment: All but two of the referrals received information from the Clinic. Eighteen were sent a letter or re-
port or were called by a staff member. Five had to solicit the information. Two of this latter group appear to be antagonistic, preferring governmental control.

At the time of the interviews, only one person had been called in for a conference.

Referrals' Opinion of Clinic's Results: Twelve respondents were completely satisfied with the Clinic's results. These people do not seem to be aware of the need for closer contact with the Clinic in order to become a functioning part of the psychiatric team. Six referrals were only partially satisfied. These people felt that the Clinic was not helping them to broaden their understanding of the individuals they referred. Of the remaining referrals, five were dissatisfied because they, had received no information, had to wait too long for the report or did not feel the Clinic had helped the patient. One still had a patient under treatment.

Familial Use of Clinic: Over half the non-referrals did not possess enough information to answer the question. Seven referrals and one non-referral answered in the affirmative. Two of the non-referrals and seven of the referral group were undecided, giving a strong indication that they would prefer private psychiatrists. These people are not completely sold on the Clinic.

Two referrals showed their fear of mental illness in the
statements, "Rather not say --- too personal," and "Probably not. Would want to keep it quiet." Eight respondents (five referrals) said they could afford private care. On checking previous answers, it was discovered that these respondents were among those who were unsold on, or against the Clinic as the best means of supplying mental health services, and that only one referral was satisfied with the Clinic's results. This group is composed of seven doctors.

Four referrals and four non-referrals were against personal use of the Clinic, saying it was for indigents; that they were against generalized medicine and government control; that people went to it without discrimination or selection; that the services were limited, or that it was alright for school children but not for family use. Six of this group are doctors.

Respondents' Knowledge of the Fall River Mental Health Clinic: The Clinic has a three-fold purpose. The one known by the majority was its clinical role (fourteen of the non-referrals knew of this). Only a handful of referrals mentioned its educational sphere; no one mentioned the Clinic as a training center.

Nine members of the referral group volunteered misinformation. Three believed the Clinic to be a child guidance center, three have confused the secretary with the psychiatric social worker and three show misinformation regarding the
fee system.

Three people appeared to harbor antagonism, saying, "They are all outside people running the Clinic." "The Board of Directors has had no psychiatric training." "The Clinic didn't give sufficient publicity to the grant received from the federal government." In addition to the foregoing, two doctors feel that the Clinic should do more to secure the cooperation of the medical profession.

**Respondents' Knowledge of Media:** Total knowledge of media was found to be low, although the referrals possessed twice as much information as the other group. One-third of the non-referral group was unaware of any Clinical publicity. The type of media mentioned most by both groups was newspaper write-ups; the type least mentioned was personal contact.

**Respondents' Opinion of Media:** A little more than half the total group feel that the Clinic's media is not effective. Almost two-thirds of the referrals (18) voiced this opinion. Nine non-referrals had no opinion.

Four individuals think that the Clinic should direct more information to the doctors and three people spoke of the difficulty of gaining public acceptance for new ideas. These latter also mentioned the high percentage of illiteracy in Greater Fall River. Three other people spoke of the need for combatting the fear of the word mental.

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8 Refer to Chapter I, pp. 18 to 20.
Respondents' Opinion of Public Cooperation: The majority opinion is that public cooperation is not good. Of the eight respondents who think cooperation is good or fairly good, five thought of cooperation in financial terms. Fifteen respondents had no opinion, indicating that they were not aware of the matter.

The importance of involving the doctors was mentioned by two additional people. One respondent felt that the social agencies were not cooperating as they should. They seem to be sitting back waiting for the Clinic to prove itself. Another thinks people don't refer because of their opinion of what the Clinic can do. Others spoke of fear of mental illness, lack of identification and over-conservatism on the part of the public.

Two doctors feel that the public would cooperate with a governmental agency, that people want and need socialized medicine.

Lack of understanding of the importance of personal involvement in public education was indicated by two referrals who said, "The person I referred went because she felt obligated to." and "I make no attempt to explain and I have had antagonism."

Respondents' Contacts with the Clinic: The referrals had over one-third more contacts than the non-referral group
and all but five referrals had personal contact with the organization. Three of this latter group had received notification at the planning stage.

Seven members of the referral group are also on the Clinic's Board. These people were either instrumental in the Clinic's establishment or took part in the first public meeting. Another referral was asked to join but was unable to do so.

In contrast to the referrals, only five non-referrals had come in personal contact with Clinic members or people working on the fund drive and only two had been approached before the Clinic was set up. One of these had worked in the establishment but had not continued his association and the other had been asked to become a director. He did not join as he favors government control. Five people had no contact as they didn't know that the Clinic existed.

C. SUMMARY OF FINDINGS ON THE HYPOTHESIS, INCREASED KNOWLEDGE AND UNDERSTANDING MEANS INCREASED COOPERATION

Results from the Questionnaire-Interview show that the referrals, who had cooperated with the Fall River Clinic to a much greater extent then the non-referrals, ranked significantly higher in:

- knowledge of the general mental health field,
- knowledge of the Fall River Clinic and the Clinic's media,

Refer to Chapter III, pp. 37 to 100 for detailed data.
awareness of the need for mental health services in Greater Fall River, acceptance of the Clinic to meet the area's mental health needs, and understanding of the need for personal involvement.

Results also show that overall knowledge of the mental health field, the Clinic and the Clinic's media is low and that there is need for increasing, not only the respondents' acceptance of the Clinic, but their realization of the necessity for personal involvement in combatting mental ill health.

Relationship of the Clinic's Communications to Knowledge and Understanding: No significant difference was discovered between the groups as to, their activities in the community, residence, or readership of the local paper. Also, with the exception of the individuals who had taken courses and/or attended institutes or workshops and the school employee, who had considerable training in the area of serious mental illnesses, both groups closely paralleled each other in lack of mental health training.

Knowledge of the general mental health field has no doubt influenced the referral's approach to the Fall River Clinic, but as general mental health knowledge is very low (some of the referrals having none), it could not be taken as an outstanding reason for cooperation with the Clinic.
The referrals were found to have 15% more contacts with organizations in the mental health field. It is safe to assume that these contacts helped increase over-all knowledge, realization of the need for mental health services and the need for personal involvement. However, as over half the referral group had no mental health contacts (other than with the Fall River Clinic) these contacts cannot have played a very important part in the cooperation shown the Clinic.

It was thought that the referral group had perhaps cooperated because of greater need, possibly because they did not have access to other treatment sources, or because they dealt with a poorer class of people. Results show that the referrals, as a group, had greater access to other treatment sources. The second reason was eliminated because, as Fall River is a manufacturing city with a high unemployment rate, it seems rather far fetched to assume that the non-referrals, who were picked from a random sample of the entire professional group of Greater Fall River, would deal only with people who could afford private treatment, or with people who would only have need of institutional care.

Before establishing the Fall River Clinic, it was felt necessary to determine whether the professional people in the area would support such an organization. Therefore, a group of social workers sent out a questionnaire to social agencies and hospitals. The majority answered in the affirmative, thus
causing the ultimate foundation of the Clinic. This information is included here because seven members of the referral group, who are also members of the Clinic's Board, were either instrumental in sending out the questionnaire, or were among those who received it. However, as fifteen of the referrals do not fall into this category, it seems safe to assume that the Clinic's communications (from the time of establishment on) have been the important factor in increasing Clinical cooperation. Of the media used by the Clinic to date, the most effective was found to be personal contact, which appears (in this necessarily limited study) to be the differential between cooperation and non-cooperation.

CONCLUSIONS: Results from the Questionnaire-Interview support the hypothesis, "increased knowledge and understanding means increased cooperation."

Results also show that:

1. Mental ill health is a considerable problem in Greater Fall River.

2. The Clinic needs to be greatly expanded before it can meet the area's needs.

3. The Clinic is needlessly attempting to shoulder the burden of the community's ill health. People appear to realize the Clinic's responsibility to them. However, they do not realize their responsibility to the Clinic. The Clinic has failed to put sufficient stress on gaining the
acceptance and personal involvement of doctors, clergy and other important groups.

4. Over-all knowledge of the Clinic is poor and misinformation and antagonism exist. The Clinic has not geared its information for public understanding. To do so it must know its publics.

5. The Clinic has not been fully accepted by the public or even by some of the referrals. A majority of the general public does not know the Clinic exists.\(^\text{10}\)

6. The Clinic's limited facilities are not being utilized to their best advantage. The organization is hampered by a lack of detailed policy and clearly defined direction, which in turn is endangering its expansion and survival.

7. Inefficient utilization of existing lines of communication and established community groups has isolated the Clinic from the community and board members from the mental health field.

8. Improvement in the use of existing personnel, communications and community people will increase the Clinic's chance for continued success.

**RECOMMENDATIONS:**

1. The Bristol County Mental Health Clinics, Inc., Fall River, is composed of a Board of Directors and a Clinic Staff. The title as it presently stands is confusing and has caused

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10 Cultivating Community Relations in a Mental Health Program, by Herbert L. Rooney, may be obtained at the Clinic.
misinformation and antagonism. It is suggested therefore, that the Board be called "The Advisory Board of the Bristol County Mental Health Clinics; Inc., Fall River," in order to insure proper identification.

2. The Board Members' isolation from their staff and the mental health field, and the staff's isolation from the Board and the community, is a dangerous thing. It is recommended therefore that a staff member be appointed Executive Secretary of the Board, to serve as liaison between the two groups, and that this individual keep a detailed record of all proceedings in order to provide a complete record of Clinical history. It is also suggested, that the Board members be limited as to their number of absences from the monthly meetings and that, unless attendance requirements are fulfilled automatic dismissal follows. The Fall River Clinic needs as many active members as possible.

3. It is recommended that a specific list of qualifications be drawn up for new Board members, with particular care being given to their group leadership ability and the community placement of the group they represent. The Clinic belongs to the people of Greater Fall River, and as such, should be as fully representative as possible of the various nationalities, religious, occupations, etc. The Clinic must constantly aim at expanded community acceptance.

It is suggested that particular attention be given to
the Constitution of "The Advisory Board, Prince George's County Mental Health Clinic," particularly to the purposes and objectives of the Board, Article II, Section 1., membership of the Board, Article III, Section 1., and the duties of the Executive Secretary, Article III, Section 4.

4. It is recommended that at each Clinical Board meeting, a definite time be allotted for the education of the Board members in mental health principles and practices and the education of the staff in community knowledge. Staff members, other than the Executive Secretary should attend these meetings as often as possible.

In addition, a qualified instructor should be engaged for a series of mental health lectures, to be attended by Board members and representatives from important groups within the community. These individuals could then serve as a basis for a speakers' bureau, which in turn would make community education an easier task. The lack of such a bureau is apparent at the present time. All speakers should stress the positive meaning of the term "mental health," speaking of health as an integration of physical and mental health, and the importance of the individual's role in mental health practices. A definite need for this type of information was discovered at the time of the interviews.

5. The Clinic should send appointed representatives to

9 Refer to Appendix F, pp. 159 to 161.
all mental health workshops and institutes in the area, with these representatives bringing complete reports of the discussions back to the Clinic.

6. It is also recommended that the Executive Secretary (or an appointed Board member) and committee send out a detailed quarterly summary to The Massachusetts Association for Mental Health, Inc., as this organization acts as a clearing house for information. Two way communication is extremely important for the advancement of the entire field of mental health.

7. A committee should be established to provide a mental health library for the Board members, the staff and professional people in the community; this library to be cross-indexed and the basis of a comprehensive and up-to-date mental health library. Catalogs listing current mental health literature, movies and plays are available at the Clinic. Further information about mental health literature may be obtained at the mental health association in Boston and at various colleges and universities. Material that is particularly pertinent to specific community groups should be brought to their attention.

8. A complete listing of mental health courses should be secured from colleges in the area and the information channeled to the proper groups.

9. A council of case workers should be established for
the purpose of integrating and streamlining their now separate activities; the council to have practical mental health as its central theme. 10

10. It is further recommended that an active and interlocking committee system be established, with yearly objectives and means clearly defined; these committees to be a:

1. Speakers' Bureau.
2. Library group.
3. Theatre group to discover available mental health plays; to eventually write or adapt plays (integrating the subject into community situations); to act in these plays and to utilize other established community groups for their presentation. Each play should be followed by a discussion period led by a qualified individual.

4. Newspaper group to contact daily and weekly newspapers, plant and school publications, for the purpose of securing their interest in material for regular articles on the meaning of the term "mental health," the importance of individual participation and the integration of mental health into the everyday life of Greater Fall River. The articles should be geared to the type of publication. The Clinic's newspaper committee should work closely with the paper according to its needs.

5. Radio group to secure the cooperation of the radio stations for the purpose of obtaining space for year round spot announcements stressing the term "mental health," individual participation in and integration of mental health practices into the daily life. Well prepared (with the help of the radio station) mental health panels might be held several times a year --- perhaps with audience participation for added community interest. Mental Health Plays could also be used. The possibility of using the Providence and Boston television channels should be thoroughly examined.

6. Publicity campaign group to work with the Fall

10 An excellent pamphlet, "A Health Department Stimulates Community Thinking for Mental Health," by David Frost and Genevieve Anderson, may be obtained at the Clinic.
River Community Fund for the purpose of securing expanded publicity and better informed campaign collectors.

7. Contest group to plan contests for the selection of the healthiest family, school children, etc. This has been done successfully. More information can be obtained by contacting the Massachusetts Association for Mental Health, Inc.

8. Movie group to obtain information about current mental health films and to arrange for showings before various groups and in the theatres.

9. Newsletter group to send information routinely to the professional people of the community, whether referred or non-referred, in order to explain the Clinic's purpose, objectives and goals. Information should be presented about the Board of Directors and the Staff --- how they are chosen, their qualifications, the groups they represent, etc.,; the problem of limited time and funds, what the Clinic is doing about it and their role in this undertaking; the reasons for stressing the term "mental health,"; the Clinic's role in community problems, showing how mental ill health can be caused by these problems; how each and every community member is affected economically, socially and politically by the over-all health of the city. Increased individual cooperation will come through realization of the personal stake in a healthy city.

Each committee must be kept informed regarding the work of the other committees, so that the information obtained by one group can be used when it applies to the activities of the other groups. Committee isolation places limitations on ultimate success. The talents of the people making up the committees should be carefully judged and used to best advantage.

The entire program must be carefully planned and coordinated for greatest possible success. Cost of literature, paper, ink, etc., may perhaps be obtained from the association's
members, until this cost can be underwritten by the Fall River Community Fund. Such money should be provided, for these activities are an integral part of the Clinic’s services. Without them, the Clinic is not fulfilling its duty to the people of Greater Fall River.

All the foregoing must be based on clearly defined policy. The policy regarding the number of patients the Clinic can effectively help must be examined. Insufficient treatment time leads to poor results and dissatisfied referrals. Lack of a specific policy regarding fee systems, education, appointment of the Board, etc., also leads to confusion and antagonism. Poor recording of Clinical statistics and other data, adds its weight to the Clinic’s many problems. In addition, the policy once established must be carried through. If not the reasons should be carefully stated.

It is important to remember that the Fall River Mental Health Clinic is a new organization which needs to gain majority acceptance. To do so it must fulfill majority needs. In order to succeed, it must examine its strengths and weaknesses, then put forward a strong program geared for the present, with a clear view of the future. Far-sighted cooperation with community individuals and organizations will provide a firmer basis for success.

**THE PUBLIC RELATIONS’ SIGNIFICANCE OF THE STUDY:** This
study is pertinent to the field of Public Relations because the methods used can be applied to any organization interested in discovering its strengths and weaknesses, for the purpose of planning a program aimed at greater public knowledge, understanding and cooperation.

As this study progressed, it has become apparent that the fields of Mental Health and Public Relations are closely allied. Public Relations is interested in the application of the integrated social sciences for the betterment of man, realizing that such applied knowledge provides an atmosphere which will support and increase "mental health," thus creating a favorable economic, social and political atmosphere. The field of mental health is interested in the same goal but is lacking public relations' tools. By working together, their common goal will be more easily attained.

Suggestions for Further Study: It is suggested that the present findings and proposed program be examined after one year's time. After determining which recommendations have been carried out, a questionnaire-interview of referrals and non-referrals (selected from a new stratified random sample of the areas professional people) might be undertaken to study the effectiveness of the Clinic's activities.

The future study might also be designed to add further emphasis to the hypothesis, "increased knowledge and understanding means increased cooperation."
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Reprints


1. What is the Bristol County Mental Health Clinics, Inc.?  
It is a project to provide the 374,000 people in Bristol County with the best possible mental health services, including psychiatric clinic facilities. To be supported by direct contributions of the people and by grants from the State and Federal Mental Health Act, this project is organized to supplement already existing agencies which do not have as part of their function facilities for psychiatric diagnosis, treatment or consultation.

2. What kind of services will be offered?  
Since this is an all purpose clinic, the services fall into three general categories, Clinic Services, Community Services and a Training Center.

3. Will you tell us about the CLINICAL SERVICES?  
Any child or adult with an emotional problem will be offered services. The Clinics' project is organized to supplement already existing agencies which do not have as part of their function facilities for psychiatric diagnosis, treatment or consultation.

4. Will there be any special services offered by the Clinic?  
Yes. Cases may be referred by physicians or social agencies for diagnosis alone; or if desired, recommendations made and consultation with physicians or social agencies who wish to carry out treatment with their patients or clients. Of course treatment will be given at the Clinics if desired and "otherwise available to the individual in his community".

5. Will there be a psychologist attached to the Clinic?  
Most certainly since the psychologist is a part of the psychiatric team. He will also be ready to do psychological testing such as the projective tests, vocational and guidance test as well as the conventional intelligence testing.

6. What are the COMMUNITY SERVICES?  
Of primary importance will be the responsibility for educational work throughout the country. This will include the establishment of consultative relationships with other social agencies, with courts, schools, medical societies and religious groups with industry and labor and community groups and individuals who will act as referral sources to the Clinics. When requested help will be given to doctors, nurses, teachers, clergy, personnel directors and other professional persons toward the better understanding of the emotional problems of those who come to them for assistance.

7. Will the staff of the Clinic give talks or lectures?  
Yes. They will be ready to give courses, seminars or any other type of discussion groups which may be desired.

8. What do you mean by TRAINING CENTER and why is this a part of the Clinic's Services?  
Since one of the major goals of the Mental Health field is a shortage of personnel, the importance of Training Centers cannot be too strongly emphasized. The training is directed toward experience, with the less severe personality and emotional disturbances, which constitute the bulk of the training of psychiatrists, psychiatric social workers and psychologists who make up the psychiatric team. Also, being an accepted Training Center makes the Clinics eligible for U.S. Mental Health Fund training grants.

9. I understand there are only a few Training Centers in Massachusetts. Will the Clinics be acceptable for a Training Center?  
The Clinics' plan as set up has the approval of Dr. W. Everett Glass, Chairman of the Medical Advisory Committee on Training, Education and Research. If we are able to obtain the right psychiatrist to be "Director of the Training", the Committee will use the Clinics as a Training Center for residents in psychiatry. With the same proviso the three Boston Schools of Social Work would like to have agreements for their Social Work students. Such placements are now available in only a few Clinics and these must have a first class rating by the Training Committee.

10. Twice you have said "if no other services are available to an individual in his community". Will you explain why you have done so?  
This is quoted from the statement of Policy made by the Board of Directors of the Clinics. It is the intention of the Clinics' program to supplement rather than overlap the existing services in the county. The statement is broad enough to be broadened to meet the needs of the four areas wherein the available services vary. For example, in New Bedford there are four physicians practicing psychiatry; these must be considered as community assets and should be used when available for treatment. The Taunton and Fall River areas have a relatively small number of psychiatrists and the Clinics for treatment as well as diagnosis and consultation.

11. Why are the Bristol County Mental Health Clinics needed? Is this a new demand?  
No indeed! As early as late 1946 a survey was made by the Massachusetts Department of Work of various services available to people in Massachusetts. In early 1948 a Preparatory Commission for the International Congress on Mental Hygiene Meeting in London during August was held in New Bedford. It was their opinion that a definite need for psychiatric help in Well Baby Clinics was demonstrated from four conference statistics. In three Clinics 77 of 205 babies seen needed help as to habit forming — and in the fourth, 50% of the children showed some poor adjustment on the parent-child relationship. In early 1948 the results of a questionnaire sent out by the State Massachusetts American Association of Social Workers definitely indicated need for these services.

12. I understand that the Taunton Hospital Clinics were withdrawn in April 1948. Will the new Clinics differ in any way from those?  
The Clinics under Dr. Steineke were diagnostic clinics only and they were part time. The new services will consist of 205 full time local units, Attleboro, Taunton, New Bedford and Fall River. That in Fall River will be staffed by a full time psychiatric Social Worker and a full time psychiatrist and a full time clerk. Supervision is essential in all psychiatric clinics and will be given each of the local units by the Administrative and Supervisory Team which consists of the Director of Clinics and the Chief Social Worker and the Psychologist. The team is the most highly paid and could not be supported singly by any of the areas. By sharing its services all four areas will have obtained facilities to meet the basic requirements of their demonstrated needs.

13. You speak of "demonstrated needs". By this you mean the cases known to various agencies. Is there a valid way to estimate how many more people will use Clinic services at some time during their life?  
Yes, there are some very valid figures used by the United States Public Health Service which may be applied to the Bristol County area. For instance, did you know that according to these statistics "30-50 children (out of every 100 children in our schools) suffer at some time in their life from minor but crippling symptoms which will impair that degree of happiness and efficiency which they should have in life".

14. You have spoken of the shortage of personnel. Will it be possible to find enough trained people to staff the Clinics?  
I believe so. The broad base of the Bristol County Mental Health Clinics has much to offer personnel who desire community work and teaching as well as Clinic work, that is diagnosis and therapy. It is a true preventive program and the trend in psychiatry is toward prevention. The rate of pay for all staff is attractive. Also there is a gradual loosening of the supply of psychiatrists and social workers. Our standards are set high but we do not anticipate too much difficulty.

15. What will be the total cost to the County of these services?  
It is estimated at $52,000. This is covered in part by grants-in-aid and by training grants.

16. What is Fall River's share of this total amount?  
The budget is $12,000.

17. Who is responsible for raising this money?  
The various people in the four areas who are interested in the establishment of the Clinics have formed themselves in "Local Committees" of the Clinics. These four local Committees are represented by a Board of Directors which will consist of twenty-one members. Five members drawn from each local committee and Dr. W. Everett Glass, The Clinics are incorporated and money given to it is deductible.

18. Do we have a "Local Committee" in this area?  
Yes.
Appendix A (continued)

LATEST COPY OF PRECEDING QUESTION AND ANSWER SHEET.
7. You speak of "demonstrated needs." By this you mean the cases known to various agencies. Is there a valid way to estimate how many more people will use Clinic services at some time during their life?

Yes, there are some very valid figures used by the United States Public Health Services which may be applied to each area. For instance, did you know that according to these statistics "30-50 children out of every 100 children in our schools will suffer (at some time in their life) from minor but crippling symptoms which will impair that degree of happiness and efficiency which they should have in life." This does not include those who will be hospitalized for mental illness nor those who will commit delinquencies of major or minor importance.

10. You have spoken of the shortage of personnel. Will it be possible to find enough trained people to staff the Clinics?

I believe so. The broad base of the Bristol County Mental Health Clinics has much to offer personnel who desire community work and teaching as well as Clinic work that is diagnosis and therapy. It is a true preventive program and the trend in psychiatry is toward prevention. The rate of pay for all staff is attractive. Also there is a gradual lowering of the supply of psychiatrists and social workers. Our standards are set high but we do not anticipate too much difficulty.

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It is estimated at $52,000. This is covered in part by grants-in-aid and by training grants.

12. What is this area's share of this total amount?

The budget for each area is shown on the diagram on page 6.

13. Who is responsible for raising this money?

The various people in the four areas who are interested in the establishment of the Clinics have formed themselves in "Local Committees" of the Clinics. These four local Committees are represented by a Board of Directors which will consist of twenty-one members. Five members drawn from each local committee and Dr. W. Everett Glass. The Clinics are incorporated and money given to it is deductible.

14. How will the money be raised?

By contributions from any person who desires to give toward this service and by various projects in each area developed by the local committees to raise money.

15. How can I get in touch with the Local Committee?

If you wish to ask questions about the services of the Clinic or have suggestions which would be helpful toward raising the necessary budget—or if you would like to make a contribution you can write to Bristol County Mental Health Clinics, Inc., at the following addresses:

**LOCAL COMMITTEES**

**ATTLEBORO area**—Committee in process of organization.

**FALL RIVER area**—P. O. Box 185, Fall River, Mass.

**NEW BEDFORD area**—P. O. Box 6, New Bedford, Mass.

**TAUNTON area**—P. O. Box 1205, Taunton, Mass.
1. What is the Bristol County Mental Health Clinics, Inc.?  
It is a project to provide the 374,000 people in Bristol County with comprehensive mental health services, including psychiatric services. The project is supported by direct contributions of the people and by grants from the National Mental Health Act Fund. The Clinics' project is organized to supplement existing agencies which do not have or have limited facilities for psychiatric diagnosis, treatment or consultation.

2. What kind of services will be offered?  
Since this is an all-purpose clinic, the services fall into three general categories: Clinic Services, Community Services and a Training Center.

3. Will you tell us about the CLINICAL SERVICES?  
Any child or adult with an emotional problem will be accepted by the Clinic for diagnosis. Treatment will be undertaken by the Clinic "only if not otherwise available to the individual in his community." Since this is a preventive program the effort will be toward reaching cases as early as possible in order to avoid the development of more serious conditions. The treatment program will be broad enough to include psychiatric case workers as well as the direct therapy offered by the psychiatrist.

3a. Will there be any special services offered by the Clinic?  
Yes. Cases may be referred by physicians or social agencies for diagnosis alone; or if desired, recommendations will be made and consultations held with physicians or social agencies who wish to carry out treatment with their patients or clients. Of course treatment will be given at the Clinics if desired and "not otherwise available to the individual in his community."

3b. Will there be a psychologist attached to the Clinic?  
Most certainly since the psychologist is a part of the psychiatric team. He will also be ready to do psychological testing such as the projective tests, vocational and guidance tests as well as the conventional intelligence testing.

4. What are the COMMUNITY SERVICES?  
Of primary importance will be the responsibility for educational work throughout the country. This will include the establishment of sound working relationships with other social agencies, with courts, schools, medical societies and religious groups, with industry and labor and with other community groups and individuals who will act as referral sources to the Clinics. When requested help will be given to doctors, nurses, teachers, clergy, personnel directors and other professional persons toward the better understanding of the emotional problems of those who come to them for assistance.

4a. Will the staff of the Clinic give talks or lectures?  
Yes. They will be ready to give courses, seminars or any other type of discussion groups which may be desired.

5. What do you mean by a TRAINING CENTER and why is this a part of the Clinic Services?  
Since one of the most urgent problems in the Mental Health field is a shortage of personnel, the importance of Training Centers cannot be too strongly emphasized. Psychiatric training is coming more and more to be directed toward experience with the less severe personality and emotional disturbances, which constitute the bulk of the problems which require psychiatric help. The Clinics' program will provide excellent opportunities for the training of psychiatrists, psychiatric social workers and psychologists who make up the psychiatric team. Also, being an accepted Training Center makes the Clinics eligible for U. S. Mental Health Fund training grants.

5a. I understand there are only a few Training Centers in Massachusetts. Why the Clinics be acceptable for a Training Center?  
The Clinics' plan as set up has the approval of Dr. William Malauam, Chairman of Commissioner Perkins' Committee on Training, Education and Research. If we are able to obtain the right psychiatric to be "Director of Clinics" the Committee will use the Clinics as a Training Center for residents in psychiatry. With the same proviso the three Boston Schools of Social Work would like to have placements for their Social Work students. Such placements are now available in only a few Clinics and there must have a first-class rating by the Training Committee.

6. Twice you have said "If no other services are available to an individual in his community." Will you explain why you have done so?  
This is quoted from the statement of Policy made by the Board of Directors of the Clinics. It is the intention of the Clinics' program to supplement rather than overlap the existing services in the county. The statement of Policy must be broadly stated to meet the needs of the four areas wherein the available services vary. For example, in New Bedford there are four physicians practicing psychiatry; these must be considered as community assets and should be used when available for treatment. The Taunton and Fall River areas have no psychiatric facilities and desire to use the Clinics for treatment as well as diagnosis and consultation.

7. Why are the Bristol County Mental Health Clinics needed? Is this a new demand?  
No indeed! As early as late 1846 a survey was made by the Massachusetts Conference of Social Work of various services available to people in Massachusetts. In early 1948 a Preparatory Commission for the International Mental Health Meeting in London during August was held in New Bedford. It was their opinion that a definite need for psychiatric help in Well Baby Clinics was demonstrated from four conference statistics. In three Clinics 70% of the cases were cases of help to habit forming—and in the fourth, 50% of the children showed some poor adjustment on the parent-child relationship.

In early 1949 a questionnaire was sent out by the S. E. New England Chapter A. A. S. W. to all agencies in the county who could be expected to use clinic services. The results of this questionnaire are broken down into area results as follows:

Fall River area: Seventeen of twenty agencies who returned the questionnaires felt the need for psychiatric services. There were three agencies who did not feel any need. Ninety-two referrals were made by nine agencies during the preceding twelve months. Had adequate services been available two hundred referrals would have been made by eleven agencies. Of the remaining six agencies who felt a need for services, five had no data and one would have referred to the Family Society or the local Welfare Bureau for follow-up with clinic services. It is known that at the present time many agencies and individuals desire to use the consultation services offered by the clinics.

New Bedford area: Fifteen agencies of 20 who returned the questionnaire felt the need for psychiatric clinic services. The question regarding the need for services was answered "No" by three groups who use their own doctors and the other only "so" came from an agency which did feel there was a use of clinic services found in their own function. Six agencies had made one hundred and sixty-two referrals during the previous twelve months and could have made two hundred and forty-nine referrals if services had been available. There are definite known individuals and agencies who could use the consultation services of the clinic.

Taunton area: Six agencies in this area received the questionnaire. Five of them felt the need for psychiatric clinic services. The seventh agency only used psychiatric services. Two hundred and sixty-one referrals would have been made by these agencies during the previous twelve months if services had been available. A seventh agency of this area would like to use the consultation services of the clinic to obtain a better understanding of their client's problems.

Attleboro area: Nine agencies were sent questionnaires. Seven felt the need of services. Of the two who gave "No" answers one has resources available and one is an agency most active in the organization of the Committee which is working toward the establishment of mental health services. Eight referrals were made during the previous twelve months by five of the agencies. Forty-three referrals would have been made during this period by eight agencies if services had been available.

8. I understand that the Taunton Hospital Clinics were withdrawn in April 1948. Will the new Clinics differ in any way from these?  
The Clinics under Dr. Stehleke were diagnostic clinics only, they were part-time. The new service will consist of four full-time teams for four full-time services. The new services will consist of two full-time staffs in Fall River and New Bedford. Taunton and Attleboro will be staffed by a full-time psychiatric social worker and a part-time psychiatric and clerical. Six training residents in psychiatry will be available at the new Clinics and will be given each of the local units by the Administrative and Supervisory Team which consists of the Director of Clinics and the Chief Social Worker and the Psychologist. This team is the most highly paid and could not be supported singly by any of the areas. By sharing its services all four areas will have obtained facilities to meet the basic requirements of their demonstrated needs.
Appendix A (continued)

A. FALL RIVER AREA
135,651 pop.
$12,000

ASSONET
SWANSEA
WESTPORT
SOMERSET
FALL RIVER

B. NEW BEDFORD AREA
123,562 pop.
$12,000

ACUSHNET
DARTMOUTH
FAIRHAVEN
FREETOWN
(except Assonet)
NEW BEDFORD

C. TAUNTON AREA
43,683 pop.
$6,000

BERKLEY
DIGTON
RAYNHAM
REHOBOTH
TAUNTON

D. ATTLEBORO AREA
44,068 pop.
$7,000

NORTH ATTLEBORO
EASTON
MANSFIELD
NORTON
SEEKONK
ATTLEBORO

County Board
↓
Administrative Center

PsY. Social Worker
PsY. Psychologist
PsY. Nurse
(all full time)

Local Centers
PsY. Social Worker
PsY. Psychiatrist
(full time)

Local Agencies

PsY. Social Worker
PsY. Psychiatrist
(full time)

Local Agencies

PsY. Social Worker
PsY. Psychiatrist
(half time)

Local Agencies
APPENDIX B

BRISTOL COUNTY MENTAL HEALTH CLINICS, INC.
FALL RIVER

By Laws

Article I

Name

The Name of the association shall be BRISTOL COUNTY, MENTAL HEALTH CLINICS, INC., FALL RIVER.

Article II

Purpose

To handle and control the financial and organizational matters that are the responsibilities of the FALL RIVER DISTRICT and of disseminating information to aid in the carrying out of the objectives of the Bristol County Mental Health Clinics.

Article III

Membership

The membership of this association shall be composed of the following:

1. The officers and the Board of Directors.
2. Any person may be elected to membership whom the Board of Directors determines so qualified.

Article IV

District

The FALL RIVER DISTRICT shall consist of Fall River, Assonet, Swansea, Westport and Somerset.

Article V

Officers, Mode of Election, Removal, Term of Office

Sec. 1. OFFICERS: The officers shall consist of a Board of Directors, a Chairman, Vice-chairman, Treasurer, Financial Secretary, Secretary and Clerk. The Board of Directors shall consist of Twenty-one (21) members and the officers.1

Sec. 2. ELECTION: The officers and directors shall be chosen by a nominating committee at a meeting in June, provided however that nominations may be accepted from the membership

1 The number of members has been recently increased.
Appendix B (continued)

at the annual meeting. All officers and directors shall be elected by ballot and he who receives a majority of votes shall be termed duly elected.

Sec. 3. VACANCY: In the event any office becomes vacant, the Board of Directors shall have the power to appoint to such office a member who is in good standing, to complete the unexpired term.

Sec. 4. REMOVAL FROM OFFICE: Any officer may be removed from his office by a 2/3 vote of the members, after formal complaint has been made of which the officer complained of has received notice.

Sec. 5. TERM OF OFFICE: The Directors shall serve for three years, providing however that out of the 21 directors originally elected, seven shall serve for one year, seven for two years and seven for three years.

Article V

Duties of Officers

Sec. 1. DUTIES OF CHAIRMAN: The chairman shall preside at all meetings of the association and the Board of Directors of which he shall be chairman. He shall, subject to confirmation by the Board of Directors, appoint such committees as are necessary to carry on the work of the association and shall have such other powers as are usually exercised by a chairman. He shall call all special meetings of the association and of the Board of Directors.

Sec. 2. DUTIES OF THE VICE-CHAIRMAN: Duties of the Vice-chairman shall be to preside in the absence of the Chairman at all meetings of the association and of the Board of Directors and shall execute all the duties of the Chairman in his absence.

Sec. 3. DUTIES OF THE TREASURER: The Treasurer shall receive at each meeting from the Financial Secretary all monies received by him since the last meeting and shall give him a written receipt therefore to such Secretary. The monies received by the Treasurer shall be deposited forthwith in such bank or depository as shall be designated by the Board of Directors. He shall keep an account of all monies received and paid out, specifying the source or object in each instance. He shall pay at the direction of the chairman all bills approved by the Board of Directors by check. He shall report to the association, when so requested, the
exact financial conditions of the association. The Treasurer shall be permitted to keep a petty cash account of not more than $10.00.

Sec. 4. DUTIES OF THE FINANCIAL SECRETARY: The Financial Secretary shall collect all monies due the association or accruing to the association through fund raising activities; he shall pay over to the Treasurer all monies received specifying the amounts and sources received and the Treasurer shall forthwith give him a receipt for the same.

Sec. 5. DUTIES OF THE SECRETARY: The Secretary shall keep a true and accurate record of the doings of the association and of the Board of Directors. He shall call the role of officers and read the minutes of meetings. He shall keep separate books for the same. He shall keep a role of the members, their ages, residences and occupations with the dates of their admission. He shall send all notices to members. He shall be present at all meetings and perform such other duties as the association may impose.

Sec. 6. DUTIES OF THE CLERK: The Clerk shall assist the Financial Secretary and the Secretary in the performance of their duties.

Sec. 7. DUTIES OF THE BOARD OF DIRECTORS: The Board of Directors shall have the entire control and management of the affairs of the association subject to the approval of the membership. They shall have control and custody of all property of the association, superintend the performance of all contracts, make recommendations to the association for the conduct of its business and perform all duties imposed upon them by the membership. They shall see that the financial records of the association shall be examined annually or at such other times as they may see necessary by a qualified auditor of accounts.

Article VII

Meetings

Sec. 1. ASSOCIATION MEETINGS: The annual meeting shall be held before the 30th day of June of each year at time and place to be designated by the Chairman. There shall be quarterly meetings held by the association, the time and place to be designated by the Chairman or the Board of Directors. Special meetings can be called by the Chairman or the Board of Directors.

QUORUM: Shall consist of at least seven members.

The Secretary shall send notices of the meetings of the Assoc-
Appendix B (continued)

Notice to all members at least seven days prior to the day of the meeting by mailing such notices.

Sec. 2. BOARD OF DIRECTORS MEETINGS: Meetings of the Board of Directors shall be held upon such notice and at such times and places as the Board of Directors may determine. Special meetings of the Board of Directors may be called by the Chairman or by the Board of Directors.

QUORUM: Shall consist of at least seven members.

Article VIII

Fiscal Year
The Fiscal Year shall close on the 15th day of June.

Article IX

Committees
The following committees shall be standing committees:
1. Finance, Legal and Ways and Means
2. Membership and Hospitality
3. Staff
4. Publicity
5. Information and Educational
6. Nominating
and such committees as from time to time need be established.

Article X

Amendments to By-Laws
These By-Laws may be amended, altered or repealed and new ones may be adopted by a majority vote of the members present at any regular or special meeting of the association called for that purpose, providing that the substance of the proposed amendments, alterations or repeals shall be plainly stated in the call for the meetings at which they are to be considered.
APPENDIX C

AN ANALYSIS OF THE MEDIA USED BY THE FALL RIVER CLINIC

1950 Campaign - March 24 to June 26

176.0 Column inches in Fall River Herald (Clinic)
5.5 Column inches in Spectator (Clinic)
133.0 Column inches in Fall River Herald (National articles)

Total 314.5 Column inches composed of:

18 articles - purpose, goals, staff, needs
5 national articles - case studies
2 mentions in newspaper articles

Other Publicity:

6 pictures
1 full page ad - pictures and endorsements
2 radio discussion programs
1 banquet at the beginning of campaign
1 public meeting, and
several speakers at various community organizations.

* One article which appeared on July 13, in the Fall River Herald is included in the total column inches.

1951 Campaign - January 23 to February 16

72 Column inches in Fall River Herald composed of:

8 articles - purpose, goals, staff, needs

Other Publicity:

3 pictures
1 full page ad - pictures, endorsements, purpose, goal, etc.
1 tag day
1 radio program - five minute speech
1 banquet, and
several speakers at various community organizations.

1952 - Member of Community Fund

10.5 Column inches, plus picture in Fall River Herald.
Mention of Clinic name in all Red Feather publicity.
Appendix C (Continued)

Since this time, several articles have appeared telling of the acquisition of the new psychiatric social worker and of the appearance of Clinic speakers before various groups.
APPENDIX D
OPEN-ENDED QUESTIONNAIRE INTERVIEW

(Probe fully on all questions.)

1. Do you happen to know if the Federal or the Massachusetts State Government is doing anything in the field of mental health?

2. Do you know of any private, non-profit mental health organizations on the National or Massachusetts State level?

3. Do you have any contacts with these organizations that you have mentioned?

4. Do you happen to know if there is a mental health organization in Fall River, (and) could you tell me just what kind of organization this is?

5. In your opinion, why was this organization established?

6. Do you happen to know its specific services to the community?

7. Do you think there is a more effective way of providing mental health services for the community?

8. Could you give me a broad definition of the term "mental health?"

9. Do you happen to know how long the Fall River Clinic has been in operation?

10. During this period, how has the Clinic gotten its funds? (a) Is this in connection with any other local agencies?

11. Do you happen to know the amount of time each week that the professional staff is able to give to patients? (a) Do you think this is sufficient?

12. In the past two years have you, in your professional capacity, met anyone who seemed to need mental health treatment? (a) (If no) Do you know anyone who has referred a patient to the Clinic? (b) (If yes to a) Do you happen to know if they were
Appendix D (continued)

satisfied with the Clinic's treatment of the patient?

13. Did you advise them directly or indirectly to submit themselves for diagnosis or treatment?
   (a) (If no) Would you tell me why?
   (b) (If yes) Did they take your (or ---'s) advice?
   (c) (If no to b) Do you have any idea why they didn't take your (or ---'s) advice?

14. If they accepted your (or ---'s) advice, where did you (or ---) send them?
   (a) (If not to the Clinic) Would you mind telling me why you (or ---) didn't send them to the Fall River Clinic?
   (b) (If to the Clinic) Did you (or ---) receive information pertaining to the diagnosis or did you (or ---) take part in the treatment of the patient?

15. Were you (or ---) satisfied with the Clinic's results regarding the patient?

16. If someone in your family had an emotional problem that necessitated treatment, would you send them to the Fall River Clinic?
   (a) Would you tell me frankly why you say this?

17. Have you ever been asked to work directly with the Clinic in its establishment or in any other way?
   (a) (If yes) Were you able to do so?

18. Would you tell me how you first heard of the Fall River Clinic?

19. (If yes to No. 3) Did this Clinic play any part in your initial contact with the mental health organizations that you have mentioned?

20. Do you happen to know if there have been any write-ups or radio programs on mental health in general or the Fall River Clinic in particular?
   (a) Where did you see or hear them?

21. Do you recall when this publicity occurred during the year?

22. Do you happen to know if there have been any public meetings sponsored by the Clinic or by a state level agency?
   (a) Did you attend?
Appendix D (Continued)

23. Do you know if there have been any requests by clubs or other organizations for speakers from the Clinic or the State level agency?
   (a) Did you attend?

24. Have you ever received any publicity information directly from the Clinic?

25. We have spoken of newspaper write-ups and radio programs, can you think of any other publicity the Clinic may have used?

26. How do you feel about the type and amount of publicity the Clinic uses? From your own experience do you think it effectively keeps the Clinic before the minds of the general public?

27. What is your opinion of the general public's cooperation with the Clinic?

Referred:  Non-referred:

Any psychiatric training:

Official position in F.R. Clinic:

Resident:

Read Herald:

Activities in community:

Opinion of Questionnaire:

Cooperation with interviewer:

Remarks:
APPENDIX E

INFORMATION OBTAINED FROM THE WORKSHOP ON, "THE PLACE OF MENTAL HEALTH IN TODAY'S COMMUNITY HEALTH PROGRAMS"

Selections from Speeches:

"Human health is the summation of an integral relationship. It cannot be separated into physical health and mental health."

Dr. William Malamud, Professor of Psychiatry, Boston University School of Medicine.

"Public Health is not just work done by the government. It also takes in social agencies, doctors, etc."

Dr. Hugh R. Leavell, Professor of Public Health Practice, Harvard School of Public Health.

"Mental health agencies should combine:

1. Prevention of disease
2. Treatment of disease
3. Community integration
4. Study and control of human causative factors.

"We need self-conscious modes of operation, joint teams sitting together, sharing skills and processing information, in order to be able to build the future. Knowledge must make possible the acquisition of more knowledge."

Dr. Erich Lindemann, Associate Professor of Mental Health, Harvard School of Public Health.

"Summary of Workshop Outcomes:"

A. The points which seem most prominent in the Work-

1 Dr. Lindemann is currently engaged in community mental health research in Wellesley, Massachusetts.
2 Report on "The Place of Mental Health in Today's Community Health Program," sponsored by The Massachusetts Association for Mental Health, Inc. and the Massachusetts Central Health Council.
Appendix E (continued)

shop proceedings and around which most discussion centered were:

1. Emphasize the positive, preventive aspects of mental health.
2. Interpret mental health to the community and get the "grass roots" support.
3. The method must be one of whole community education.
4. Mental health should be integrated into the total community health program.
5. The community should use its existing organizations to ascertain community needs and to develop an appropriate program.
6. The methods should be similar to the methods of public health.
7. Professional consultants (in mental health) should be employed for guidance of local programs.
8. Mental health leaders should be persuaded that educational procedures and discussion group work are good preventive methods.
9. Training in group leadership should be included among the aids to local programs.
10. There is need for leadership to stimulate, encourage and guide local community programs, and to serve as an informational clearing-house.

B. Results of the Workshop:

1. A permanent committee has been set up who "will try to develop a long-range program to arouse and carry on a concern for mental health within existing community programs."
2. A workshop to be held "in conjunction with the Massachusetts Public Health Conference at Amherst in June, 1952."
4. "Between mid-March and June, 1952, conduct a series of discussion group sessions to pursue further certain developments at the November Workshop."

3. Even here the term "mental health" is given a neutral meaning. This does not agree with the world definition. Refer to definition, Chapter I, p. 1.
4. Underlining is the writers.
5. Presented by Sub-committee: Mrs. Irene Malamud, Mrs. A.L. Twomey, Mr. J. Garton Needham.
Appendix E (continued)

The purpose of the discussion groups is to think through the problem, and discover means to develop a "unified community program."
APPENDIX F
CONSTITUTION
Advisory Board, Prince George's County Mental Health Clinic

ARTICLE I
NAME

Section 1. The name of this organization shall be the Advisory Board of the Prince George's County Mental Health Clinic, hereinafter referred to as the Board.

ARTICLE II
PURPOSE AND OBJECTIVES

Section 1. The purpose and objectives of this Board shall be:

To provide a vitally interested advisory group with wide community representation for the Prince George's County Mental Health Clinic.

To advise the Director of the Prince George's County Mental Health Clinic in matters of policy relating to community relations.

To assist in promoting active cooperation with the clinic of all community agencies having allied interests in planning the over-all mental health program of the county, and more specifically in carrying out, when indicated, plans for modification of the Clinic patient's environment.

To insure that the Clinic remains a truly community-wide enterprise and does not become unduly influenced by any special group.

Section 2. The purpose and objectives of the Prince George's County Mental Health Clinic shall be:

To provide an all-purpose community mental health clinic as a part of the public health services of the County Health Department.

To serve the community by providing out-patient treatment for personality and behavior disorders of patients not in need of hospitalization and, most significant, for patients in the early stage of illness when the prospect for cure is greatest.
Appendix F (continued)

To serve the schools in helping solve the varied mental and emotional problems of children especially in the areas of behavior disorders, mental retardation, and school attendance.

To serve the social agencies particularly in helping solve the emotional problems of children in broken or foster homes.

To serve the courts by providing consultation service at the request of the judge of the court.

To serve physicians by providing consultation service for patients presenting mental or emotional problems, if such consultation is not available from psychiatrists in private practice.

To serve the mental hospitals by helping provide prehospitalization service and by referring those in need of institutional care to the hospital; by helping provide supervision and follow-up treatment of boarded-out patients, and of provisional discharge of convalescent post-Hospitalized cases.

To provide mental health education including dissemination of information about mental health principles and practices, active-case finding programs, and the study and control of mental diseases from a public health standpoint. Understanding that the clinic cannot do this job alone, to coordinate its educational activities with those of the school, the health department and other community agencies.

ARTICLE III

MEMBERSHIP OF BOARD

Section 1. The Director of the clinic and 12 elected members shall constitute the Board. Six of the elected members shall represent the following: (1) County Medical Society; (2) County Department of Education; (3) Courts; (4) Community Chest; (5) Parent-teachers Associations; (6) County Health Department. The remaining six members shall be elected at large from other community groups especially interested in mental health as the churches, women's clubs, fraternal orders, university, and others.
ARTICLE IV

Section 4. The executive secretary to the Board shall be the Director of the Prince George's County Mental Health Clinic. He shall keep lists of members; notify the membership of meetings; take care of records and correspondence; perform all secretarial duties for the Board; and collaborate with the Chairman on preparing the agenda for meetings.