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Where Would You Go for Help?

Perceptions of Social Services in Idaho

Merle J. Sargent *John E. Carlson*

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Merle J. Sargent is a research associate of agricultural economics and John E. Carlson is an associate professor of agricultural economics and rural sociologist, both in the Department of Agricultural Economics and Applied Statistics, University of Idaho, Moscow.

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Where Would You Go for Help?

Perceptions of Social Services in Idaho

Merle J. Sargent *John E. Carlson*

Introduction

This report addresses the questions of whether people know where to turn for help with various social problems, including mental illness, and the perceived usefulness of the various social services available in Idaho.

While most people know they are not immune to life's crises, they tend to avoid thinking about problems until they occur. Thus they are often poorly prepared to cope with situations when they arise, not knowing where to turn for help. In particular, many may be unaware of the range of services available from the State Health and Welfare Department. People may also feel there is so much stigma attached to public services that they will seek other more expensive help or no help at all. The purpose of this study is to ascertain which agencies are known to the residents of Idaho, the performance quality of those agencies, the role of experience in perceptions of social services and regional variations.

Historically, public agency programs providing assistance to the general population have been received reluctantly by the public. Several factors seem to account for this:

1. A lack of knowledge by the public about the services offered by agencies;
2. Misinformation about the nature of the programs;
3. Individual values, resisting services through public funded programs;
4. Inability on the part of the agency personnel to communicate adequately with the public;
5. Lack of adequately trained staff to provide services responsive to both the needs and values of the recipient of the service.

Possibly one of the most difficult barriers public agencies must overcome is the perception that the user of such services is less worthy of community respect than the nonuser. Welfare programs in particular have been limited by public attitudes that the needy are immoral, lazy, irresponsible, unintelligent, etc. Some types of aid may be viewed as more legitimate than other types. In a 1964 study, Alston and Dean (1972) found a number of attitudes unfavorable to welfare recipients and poverty in general. To the statement that "poverty results from lack of effort on the part of the individual", 33% of the sample agreed. With regard to how much money was being spent on welfare, Alston and Dean found 80% of the sample saying "too much or "about right". Those who felt poverty was due to lack of effort were most likely to feel too much was spent on welfare. When asked to estimate the extent of dishonest reasons for receipt of welfare, 78% said most or some recipients were dishonest. Responses were related to the view of the poor as lacking effort; 88% of those who said "lack of effort" also said most or some were dishonest. However, 66% of those who said poverty was due to circumstances also said most or some were dishonest.

Williamson (1975) feels that misconceptions about welfare recipients lead to welfare reform programs and proposals which are not workable. For example, when respondents to interviews in Boston in 1972 were asked to estimate what percent of welfare recipients are able-bodied unemployed males, the mean answer was 37%. The actual percentage according to a 1972 HEW report was less than 1%. When asked what percent of welfare recipients lie about their financial statements, repondents in the Williamson study had a mean answer of 41%. The actual incidence of fraud ranges from 4% to 7% by states according to an HEW report in 1969.

Similar conclusions were reached by Hahn (1975) in a review of Gallup public opinion polls from 1974 which found 42% of the respondents blaming lack of effort if persons were poor, 71% believing that many people getting welfare are not honest about their need and 85% agreeing that there are too many people on welfare who should be working.

Mental illness also carries a great deal of stigma. A study by Phillips (1963) indicates that the degree of stigma may be directly related to the source of whatever help is sought and thus community attitudes may influence the selection of the help agent more than does the competence of the agent. The Phillips research was conducted in New England. Interviewees selected from the general public were presented with five case abstracts, four "ill" and one "normal". The statement was added that either

1. No help was being sought,
2. Help was sought from a clergyman,
3. Help was sought from a physician,
4. Help was sought from a psychiatrist,
5. Subject has been in a mental hospital.

Every individual (of 300) saw five combinations of behavior and help source. A social distance scale was used to measure the depth of the rejection.

Results from the Phillips study were that the individual is increasingly rejected as he is described as seeking "no help" through the list to "has been in a mental hospital". However, behavior played a strong part in rejection with the "paranoid schizophrenic" case consistently furthest away on the social distance scale regardless of the help sought. Even the "normal" individual was increasingly rejected as his help sought attachment went from "no help" to clergyman, physician, psychiatrist and finally to mental hospital, although the rejection was less for the "normal" than for the disturbed case abstracts.

The largest increase in rejection rate occurred when an individual saw a psychiatrist, with the second largest increase occurring when the individual was described as having been in a mental hospital. "No help sought" was the least rejected. Seeing a clergyman or physician was only slightly less acceptable than no help; the disproportionate rejection came when help was sought from specialists in mental health. The association between help source and rejection was maintained regardless of age, religion, education or social status of the respondent.

Phillips also instituted a control for experience with emotional problems. Respondents not acquainted with anyone seeking help or only with a help-seeking friend responded as those previously reported. However when the problem experience was with a relative, those hypothetical cases not seeking help were rejected more than those seeking help from a clergyman, physician or psychiatrist, and almost as much as those using a mental hospital. Consulting a clergyman was also more rejected than seeing a physician. Those with experience may consider the clergyman as not technically competent in mental illness problems but believe that the physician should be able to handle the emotional problems of his patients. Even though psychiatrists and mental hospitals are likely to be the most competent, they still carried the most stigma even among those whose experience included a help-seeking relative.

Phillips hypothesized that a relevant factor in perceptions of help-seeking might be the extent to which the respondent felt people should be self-reliant. He found that those who were strongest on the norm of self-reliance showed a consistent increase in rejection as help sought went from no help to mental hospital. Those not adhering to a self-reliance norm were less rejecting than the self-reliant for categories of help sought from physician, psychiatrist and mental hospital but more rejecting than the self-reliant to no help being sought or help sought from a clergyman.

Objectives and Methodology

The objectives of this study were to assess the attitudes and knowledge of the public toward services available for help with social or mental health problems, particularly those services provided by the Idaho Department of Health and Welfare. Specifically, the focus was on the following:

1. What agencies are best known to respondents and how good a job are they seen as doing? How do perceptions vary by social background characteristics?
2. How many respondents have personal experience (close friend or relative) with social services and how does such experience affect their evaluation of services?
3. Are there regional differences in perceptions of social services?

Interviews were conducted by telephone in September and October, 1975, with a random sample of 892 residents of Idaho, selected from telephone books and chosen in direct proportion to the population of the various Department of Health and Welfare regions. Of the 666 persons actually contacted, 486 usable questionnaires were obtained, resulting in a response rate of 73% (Table 1).

The interviewer was instructed to begin with this statement:

> We are conducting a survey throughout Idaho to find out how people feel about social and mental health problems in Idaho. By social problems we mean people's ability to take care of themselves and those for whom they are responsible in a healthy environment. Mental health deals with a person's emotional ability to get along in the world.

The interview was in no way limited to mental health problems, yet most respondents replied primarily in terms of mental illness.

Table 1. Summary of sample responses and reasons for no response.

Total sample		892
Disconnected	79	
No answer*	147	
Total not available	226	
Actual contacts		666
Reasons for not completing questionnaire		
Refused	134	
Business phone	4	
Other	42	
Usable questionnaires		486
Response rate		73%

*After 3 calls.

Findings

Attitudes Toward and Knowledge Of Social and Mental Health Services

An initial question was asked to assess how respondents felt about social adjustment and mental health problems. Over three-fourths of the respondents view problems as major (Table 2). Females were slightly more likely than males to say problems were major. Other social background variables (age, education, income, occupation and religion) were tested but were apparently not significant.

Table 2. Attitudes toward severity of social adjustment and mental health problems.

	Major problem	Minor problem
N =	355	92
%	78.2%	21.8%
Sex:[1] Female	81.1%	18.9%
Male	72.6%	27.4%

[1]Chi Square $P < .05$

Individuals were then asked to list up to three agencies or organizations available in their community to deal with social or mental health problems. About 61% listed at least one agency, 29% listed two agencies and only 13% listed a third agency. The persistence of the different interviewers may have influenced the results somewhat; nevertheless 190 people (39% of the sample) could not name even one local organization.

The State Department of Health and Welfare was the best known agency — although not always specifically by that name — in most communities (Table 3). Hospitals, including either mental hospitals or regular hositals, mental health associations and other state or county institutions followed. The oldest age group (over 65) named Department of Health and Welfare most often while the youngest age group (under 26) named hospitals first. Respondents in white collar occupations most frequently named mental health associations as the best known agency. Respondents in blue collar occupations were more likely to name Department of Health and Welfare.

Of interest was the basis of knowledge about the organization that respondents listed as best known (Table

Table 3. Organization or agency best known in community.

		Health and welfare	Hospitals (reg. and mental)	Other	Mental health association	Other state and county inst.	Religious organization	Schools (state and public)	Private-Psych., psychol., doctor
Best known in community:	N	47	35	29	26	25	17	16	9
	%	23.0	17.2	14.2	12.7	12.3	8.3	7.8	4.4
Best known, by age groups:[1]		% in each age group							
Under 26		17.8	31.1	11.1	8.9	6.7	4.4	20.0	0
26-40		24.6	18.8	4.3	8.7	20.3	4.3	14.5	4.3
40-65		17.6	13.7	7.8	21.6	9.8	17.6	8.8	2.0
over 65		34.2	0	10.5	13.2	7.9	7.9	13.2	13.2
Best known, by occupation groups:[2]		% in each occupation group							
White collar		19.4	7.5	7.5	26.9	17.9	7.5	10.4	3.0
Blue collar		34.2	18.4	5.3	0	10.5	5.3	21.1	5.3

[1]Chi Square $P < .01$
[2]Chi Square $P < .001$

Table 4. Source of knowledge about best known agency.

	All agencies N	All agencies %	Health and welfare	Hospitals (reg. and mental)	Other	Mental health association	Other state and county inst.	Religious origin	Schools (state and public)	Private-psych., psychol., doctor
Source of knowledge about best known agency:[1]	N	%	N							
Common knowledge or schools	36	18.7	10	11	6	2	2	2	2	1
Place of employment	30	15.5	2	3	2	4	5	11	3	0
Family member with personal contact	33	17.1	10	3	4	6	4	0	5	1
Reading newspaper or magazine	29	15.0	11	5	3	3	4	0	3	0
Friends	21	10.9	5	5	1	3	4	1	2	0
Advertising-lectures	16	8.3	1	2	6	2	3	0	1	1
Radio or TV news	16	8.3	3	4	4	3	1	0	0	1
Other	12	6.2	5	2	1	2	1	1	0	0
Total naming each agency			47	35	27	25	24	15	16	4

[1]Chi Square $P < .01$

4). Most people indicated that their knowledge was essentially common knowledge or that they had heard of the agency through schools. A substantial number also indicated that they had learned of the agency through place of employment, family contacts or reading newspapers and magazines. When separated by agencies there were some statistically significant differences in the sources of knowledge of the best known agency. Those naming the Department of Health and Welfare as best known gave "reading newspapers or magazines" most frequently, followed by "common knowledge" and "family member with personal contact". Those naming hospitals as best known most frequently mentioned "common knowledge". "Place of employment" was named most often as the source of knowledge about help available from religious organizations.

Most respondents felt that the agency best known in their community was doing a good or excellent job (Table 5). Only 15% indicated that the agency was doing a poor or very poor job of providing services. Differences by agency were not statistically significant.

Reasons which respondents gave for indicating the particular quality of "best known" agency are summarized in Table 6. About 45% gave personal observations, opinion or knowledge of the agency as the basis for their indication of quality. Another 21% based their opinion on personal knowledge of assistance given to friends, themselves or relatives. For those who indicated a poor job was being done, 19% thought the facility could do better and that poor performance was usually due to lack of funding or personnel. Reasons for performance evaluations apparently did not vary by agency listed as best know.

When asked "How much more should be done in your community...," about 70% of the respondents indicated that a lot more should be done (Table 7). Another 28% felt that what was being done at present was sufficient and only 2% felt their community should do less than at present. Responses apparently did not vary by social background characteristics.

About 28% of the respondents indicated that more money, people and facilities were the main needs (Table 7). Another 25% felt that institutions need more public relations information, that they weren't getting the information to the people in need. Help for those with primarily drinking or drug type problems was given as a need by about 20% of the respondents.

Support for these additional services should come from the government or through taxation, most respondents said,

Table 5. Quality of job best known agency is doing.

	All agencies	Health and welfare	Hospitals (reg. and mental)	Other	Mental health association	Other state and county inst.	Religious organization	Schools (state and public)	Private-psych., psychol, doctor
Quality of job best known agency is doing:[1]	%	% of those naming each agency							
Excellent	25.0	20.5	29.6	26.9	31.3	35.0	18.8	16.7	0
Good	60.0	51.3	63.0	69.2	56.3	50.0	75.0	58.3	75.0
Poor	11.9	25.6	3.7	3.8	12.5	10.0	6.3	8.3	25.0
Very poor	3.1	2.6	3.7	0	0	5.0	0	16.7	0

[1]Chi square not significant at .05

Table 6. Reasons for indicating quality of best known agency.

	All agencies N	All agencies %	Health and welfare	Hospitals (reg. and mental)	Other	Mental health association	Other state and county inst.	Religious origin	Schools (state and public)	Private-psych., psychol., doctor
Reasons for indicating quality of best known agency:[1]	N	%	N							
Personal observations, opinion or knowledge	65	45.1	16	10	11	6	8	6	7	1
Personal knowledge of assistance to friends, self or relative	30	20.8	5	5	6	5	5	2	2	0
Facility could do better, often due to lack of funding and personnel	27	18.8	6	5	4	3	4	2	1	2
Heard or read good things	6	4.2	1	2	2	0	0	0	1	0
From friends	9	6.3	1	1	1	1	0	4	1	0
People who don't need it get it	6	4.2	5	1	0	0	0	0	0	0
Other	1	0.7	1	0	0	0	0	0	0	0
Total naming each agency			35	24	24	15	17	14	12	3

[1]Chi square not significant at .05

with community support primarily through donations, churches, etc. (Table 7). In general, any type of taxation was felt to be primarily the responsibility of the state or a combination of state and federal government with minimal support being generated at the local level other than donations. A number of people felt that a combined effort of taxes and donations should be the basis for supporting these services. There was no apparent relationship between needed improvements and the approved source of funds for added services.

The Role of Personal Experience In Perceptions of Social Services

Personal experience as a factor in perceptions of social services was of interest for this study. In this sample, 213 reported that a friend or relative had had a social or emotional problem and 241 reported no experience (Table 8).

Of those who reported that a close friend or relative — or conceivably the respondent himself — had had a personal social or emotional problem, 85% thought social adjustment and mental health problems generally are among the biggest problems faced by people today. Only 72% of those without personal experiences judged general social adjustment and mental health problems to be major.

Experienced respondents were most likely to name Department of Health and Welfare as the best known agency in their community while the inexperienced were more likely to name hospitals (regular or mental) (Table 8). Regardless of the experience of the respondent there were no differences in the quality of the job the best known was evaluated to be doing.

Personal experience also affected opinions on how much more should be done in the community, with 75% of the experienced saying "a lot more" compared to only 65% of the inexperienced (Table 8). There were no statistically

Table 7. How much more should be done, what should be done and how should it be supported?

	N	%
How much more should be done in your community?		
A lot more	287	69.8
About the same as now	115	28.0
Less than at present	9	2.2
What should be done in your community?		
More money, personnel and facilities	83	28.1
Public relations	73	24.7
Help drinking or drug problems	58	19.7
Counseling, volunteers	32	10.8
Improve services	21	7.1
Work incentives	14	4.7
Help mentally retarded	8	2.7
Better education	8	2.7
How should added service be supported?		
Taxes, unspecified	79	23.7
Community, donations	75	22.5
State	43	12.9
Taxes and donations	39	11.7
Combination of govt. levels	34	10.2
Other	31	9.3
County or local	18	5.4
Federal	15	4.5

Table 8. The role of personal experience in perception of social services.

	Experience N = 213	No experience N = 241
	% of those responding in each category	
General problems major[1]	85.4	71.8
General problems minor[1]	14.6	28.2
Best known in community[1]		
Health and welfare	26.8	17.3
Mental health assn.	17.9	4.9
Other state and county	17.1	4.9
Other	13.8	14.8
Hospitals	9.8	28.4
State schools	6.5	9.9
Religious	5.7	12.3
Psychologists	2.4	7.4
What kind of job[3]		
Excellent	25.8	22.9
Good	59.1	63.9
Poor	12.9	8.4
Very poor	2.3	4.8
How much more should be done?[2]		
A lot more	75.6	64.5
About the same	22.8	32.7
Less than at present	1.5	2.8
What should be done?[3]		
Public relations	31.3	25.0
Money and help	25.4	28.7
Better education	20.9	13.0
Counseling	9.0	13.0
Improve service	6.0	8.3
Work incentives	4.5	3.6
Help mentally retarded	1.5	4.6
Help for drinking problems	1.5	1.9
Where would you go for help?[2]		
Doctor	52.1	46.1
Religious counselor	16.0	24.1
Mental health facility	11.3	3.4
Psychiatrist	8.0	9.9
Health and welfare	4.2	3.4
Family or friend	3.3	6.5
Other	3.3	3.4
Professional counselor	1.9	3.0

[1]Chi Square $P < .001$
[2]Chi Square $P < .05$
[3]Chi Square not significant at .05

significant differences between the experienced and nonexperienced on the question of what should be done and how it should be supported.

Asked where the individual personally would go for help should the need arise, 52% for those with personal experience and 46% for those without personal experience named doctor or private physician (Table 8). The experienced were a little less likely to seek help from a psychiatrist, a religious counselor, a professional counselor or from a family member or friend and a little more likely to go to a mental health facility or the Department of Health and Welfare. These findings are similar to those from the Phillips study cited earlier.

In addition to experience with a friend or relative's problem, the type and quality of that personal experience was relevant to attitudes about social services. Regardless of where the friend sought help, the response was generally that he was helped (Table 9). However the reasons for reporting how much the friend was helped varied by the source of help (Table 10). While "some improvements visible" was reported most frequently for all agencies, it was reported less for religious sources than for other sources, based on the number reporting help sought from each source. "No progress" and "inadequate treatment" were reported relatively most frequently for psychiatrists.

Did the source of help for the friend affect the potential choice of help in the eventuality of a personal problem? Those whose friend consulted a psychiatrist, doctor or mental health clinic still preferred to consult a doctor, at least as first contact (Table 11). The nine whose friends received help from a religious source preferred that source also for themselves.

Regional Differences in Perceptions

The state of Idaho is divided into seven administrative regions by the Department of Health and Welfare. These regions were the basis of the sample chosen for this study, therefore it is of interest to know if there were differences among the regions. The counties within each region are listed in Appendix Table 1. This report refers to each region by the largest city in it.

There were no statistically significant differences between regions of the state in the ability of the respondents to name two or more organizations for social or mental problems, no differences in the evaluation of the job the "best known" agency is doing, no differences in where the friend sought help or how much he was helped and no differences in opinions on what additionally should be done in their various communities. Data for these questions can be seen in Appendix Table 2. Areas where there were differences are discussed below.

Region I (Coeur d'Alene)

While a majority of residents of all regions thought general social and emotional problems were major, there were variations by regions. Only 70% of those in Region I said "major", less than most of the other regions. Department of Health and Welfare was the best known agency and people were most likely to hear about it as common knowledge, from schools or from a family member. Less than half (45.9%) said they had had personal experience with a social or mental problem. Most based their evaluation of the best known agency on personal opinion. In this region, 65.4% of respondents feel that a lot more should be done. This is somewhat less than in other regions except Region VII (Idaho Falls) where only 47% felt a lot more should be done. Support in Region I for added services was preferred as coming from taxes (unspecified) or community support and donations. Nearly half (48.2%) the respondents in Region I would seek help first from a doctor with the second largest choice (17.9%) a religious organization.

Table 9. Relationship, where did friend go for help and how much was he helped?[1]

Source of help[1]		Amount helped		
		A lot	A little	Not at all
	N	(% of those reporting each source)		
All sources	194	54.6	31.4	13.9
Psychiatrist or psychologist	67	46.3	31.3	22.4
Mental health agency	56	64.3	25.0	10.7
Doctor	26	53.8	42.3	3.8
City or state (no agency specified)	14	71.4	21.4	7.1
Private care	12	41.7	41.7	16.7
Other	11	63.6	36.4	0
Religious organization	8	37.5	37.5	25.0

[1]Chi square not significant at .05.

Table 10. Relationship, where did friend go for help and reason for saying how much he was helped?[1]

Source of help		Some improvement visible	No progress (Yet)	Agency can do just so much	Treatment inadequate
	N	% reporting help from each source			
All sources	188	58.0	17.0	7.0	8.5
Psychiatrist or psychologist	65	52.3	24.6	6.2	15.4
Mental health agency	53	66.0	9.4	11.3	5.7
Doctor	25	48.0	12.0	4.0	4.0
Private care	13	61.5	15.4	15.4	7.7
Religious organization	8	37.5	25.0	12.5	0

[1]Chi Square $P < .05$

Table 11. Relationship, where did friend go for help and where would you go for help?[1]

Help for friend		Choice for self			
		Psychiatrist	Doctor	Religious	Mental health agency
	N	(% naming each source of help for friend)			
All sources	201	8.5	51.7	15.4	11.4
Psychiatrist	68	14.7	47.1	19.1	8.8
Mental health agency	59	3.4	50.8	10.2	22.0
Doctor	28	10.7	75.0	7.1	0
Religious	9	11.1	0	77.8	0

[1]Chi Square $P < .001$.

Region II (Lewiston)

More than 86% of the respondents in Region II judged social and mental problems to be major concerns. The "best known" agency was scattered among a number of sources of help, as was the source information about the best known. Over half (54.7%) reported personal experience with a problem. Evaluation of the best known agency was based on personal opinion (43.5%) with the second most frequent reason being "assistance to self or friend" (17.4%). " A lot more should be done" was the reply of 73% of the respondents, with preference going to support by community or donations (39%) or taxes, unspecified (17%). Half would go to their doctor should they need help; another 20% would see a psychiatrist. Region II was the only region where psychiatrist was second choice.

Region III (Nampa-Caldwell)

"Major" was the reply of 80% of the respondents of Region III to the question on the severity of problems. The "best known" agency was largely divided between Health and Welfare, State schools and other. The largest source of information was newspaper or magazines (24% of the respondents) and the major reason given for evaluation of the best known was personal opinion (50%). Two-thirds of those interviewed in Region III felt a lot more should be done, mostly supported by taxes (unspecified) or by community and donations. First choice for personal help was a doctor (55%), followed by religious counseling (14%).

Region IV (Boise)

Social and mental health problems were considered major by 81% of the respondents in Region IV. The best known agency was Mental Health Association (33%), the source of information was friend (23%) or newspaper (25%) and the basis for evaluation was personal opinion or assistance to self or friend. The most frequent reply was that a lot more should be done (79%) with state taxes (28%) the preferred method of financing, followed by community support or donations (21%). In this region, 61% would seek help first from their doctor, with 13% going first to a religious source.

Region V (Twin Falls)

Region V residents considered problems to be major (79%), knew Health and Welfare as source of help (26%), heard about it through place of employment (25%) and based their evaluation mostly on personal opinion but also on the statement that the facility needs more money and personnel (30%). The largest group of any region (80%) said a lot more should be done, with the preferred source of funds either unspecified taxes (28%) or community and donations (22%). Doctor was the choice for help for 58%, religious source for 11%.

Region VI (Pocatello)

Residents of Region VI gave the largest response to major problems (89%). The best kown was scattered among several agencies but whatever the selection for best known, the source of information was place of employment (24%) or common knowledge or schools (24%). Personal opinion was the basis for most of the evaluations of the job being done, but some also said the facility needs more money or personnel (24%). Most of those saying a lot more should be done (72%) thought the added service should be supported with unspecified taxes (44%) or a combination of taxes and donations (24%). About 46% would go first to a doctor, 22% to a religious source.

Region VII (Idaho Falls)

Region VII had the fewest respondents (65%) who felt problems were major. Hospitals, regular and mental, were the best known agency (35%). Most frequent sources of information were common knowledge or schools or radio-TV, the only region to name radio-TV a substantial number of times. The bases for evaluation were personal opinion or assistance to self or friend. Only 22% of the respondents reported experience with any social or mental problems, the least of any region. Also, only 47% said a lot more should be done, again the least of any region. Support was preferred as coming from "other" (not ascertainable) or from community or donations. The majority (53%) would seek religious counseling first.

Summary and Recommendations

Summary

The purpose of this study was to determine how much knowledge people have of where to turn for help with a social or mental problem, the perceived effectiveness of various agencies, the role of experience in perceptions and variations by regions of the state. The intent of the study was to include a full range of social services such as welfare and aid to the handicapped, the mentally retarded and the elderly in addition to mental health problems. However the majority of the respondents answered primarily in terms of mental illness and emotional adjustment.

Social and mental health problems were generally considered to be major, but over a third of those interviewed could not name even one local agency for dealing with such problems. The Department of Health and Welfare was most often identified, with the source of information most frequently common knowledge or schools. Regardless of the agency named as best known, respondents evaluated it as doing a good job, based most often on personal opinion or hearsay.

A majority felt a lot more should be done in their community to improve services, either better public relations or more money and personnel. Taxes (either unspecified or state) seemed to be an acceptable means of supporting additional services with some also preferring donations or a combination of donations and taxes.

Personal experience with a friend or relative's social or emotional problem made a difference in responses to many questions for the nearly-half of the sample with such experience. The experienced were more likely to say general adjustment problems are major, more likely to name Department of Health and Welfare as best known and were more likely to feel a lot more should be done in their community. Doctor was the first choice for help with a personal problem should one arise, regardless of experience;

however, the experienced were more likely than the inexperienced to go to a doctor or a mental health facility, less likely to consult a religious counselor.

Regardless of the source of help for their friend, the majority said he was helped a lot, the most frequent reason given that "some improvement was visible". "Some improvement" was ascribed least when the source of help was a religious counselor, most when help was from a mental health agency. The type and quality of help received by the friend evidently had little effect on the choice for potential first contact for a personal problem: the majority would still consult their personal physician.

There were also some variations by Health and Welfare regions. Region VI was most likely to consider problems major, Region VII least likely. Health and Welfare was the best known agency in Regions I and V, Mental Health Association in Region IV and hospitals in Region VII. Common knowledge or schools was given as source of information about the best known in Regions I, VI and VII. Also sources of information were newspapers (Regions III and IV) and place of employment (Regions V and VI).

Region IV respondents had the most experience with friend's problems, Region VII the least. Respondents in Region V were most likely to say a lot more should be done, Region VII least likely to so state. Taxes at some level of government seemed to be an acceptable means of supporting added services in most regions, but people in Region II expressed a greater preference for community support and donations while those in Region VII were more likely to specify "other". Region VII was also the only area where a majority of respondents would seek help first from a religious source rather than a physician.

Recommendations

Four general recommendations based on the results of this study are aimed at both the relevant agencies and others who may have an interest in better resources for those needing help with social or mental problems.

1. More information needs to be disseminated about the range of and eligibility for available services and the place of contact for their services. Radio and television were seldom mentioned as sources of information; their greater use might be worth exploring.
2. Better public relations was one of the most often mentioned improvements needed even though the job being done was usually evaluated as excellent or good. Employees of the various agencies should be heartened by the fact that respondents recognized that more money, facilities and personnel are needed and that an agency can do just so much for an individual.
3. Efforts are needed to reduce the stigma attached to the more professionally trained agents such as psychiatrists, to mental health associations and to Health and Welfare facilities. Greater use of these agents would free physicians and ministers from some of the burden of duties they may be ill-prepared to handle.
4. If doctors and/or religious counselors are to continue to be the first contact for the majority of help-seekers, the question arises of how well prepared these professionals are to handle social and mental health problems. If the judgment is that they are not adequately trained, perhaps some of the appropriate agencies could offer supplemental training programs.

A number of recommendations come to mind for those considering a similar research effort, resulting both from experience with this project and the review of other projects.

1. Interviews would likely be more successful if conducted personally. It's easier to refuse a telephone caller than a face-to-face interaction.
2. In the coding of responses, we would recommend separating:
   (a) experience with a friend's problem from experience with a relative's problem;
   (b) a regular hospital from a mental hospital;
   (c) doctor from psychiatrist or psychologist.
3. If questions are asked on preferences for means to support services, the political orientation of the respondent should also be ascertained. The type of support (taxes, donations, patient fees) should be one question; the level of support (federal, state) should be a separate item.
4. There were not a lot of apparent variations by background characteristics in this study. It might be more useful to ascertain attitudinal correlates such as self-reliance.
5. If responses are desired to the full range of available social services rather than limited to mental health problems, those services should be specified in greater detail.
6. No determination of rural-urban differences could be made due to lack of information. Such differences may well have existed.

Appendix Table 1. Health and welfare regions and counties in each.

Region I (Coeur d'Alene)	Region IV (Boise)	Region VI (Pocatello)
Boundary	Valley	Bingham
Bonner	Boise	Power
Kootenai	Ada	Bannock
Benewah	Elmore	Oneida
Shoshone		Franklin
Region II (Lewiston)	**Region V** (Twin Falls)	Bear Lake
Latah	Camas	Caribou
Clearwater	Blaine	
Nez Perce	Gooding	**Region VII** (Idaho Falls)
Lewis	Lincoln	Lemhi
Idaho	Jerome	Custer
Region III (Nampa-Caldwell)	Minidoka	Butte
Adams	Twin Falls	Clark
Washington	Cassia	Jefferson
Payette		Bonneville
Gem		Madison
Canyon		Fremont
Owyhee		Teton

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Appendix Table 2. Influence of region on perceptions of social services.

	Regions						
	I	II	III	IV	V	VI	VII
Number of respondents in each region	**42**	**44**	**37**	**74**	**60**	**32**	**49**
	% of respondents in each region						
Are problems major?[1]	70.0	86.3	80.4	81.3	78.9	88.9	65.3
Name three organizations dealing with problems:							
One organization named[2]	68.3	64.7	63.0	67.0	61.8	83.3	52.0
Two organizations named[4]	30.0	45.1	23.9	30.7	22.4	47.2	28.0
Three organizations named[4]	11.7	19.6	2.2	21.9	9.2	25.0	12.0
Best known in community:[3]							
Health and welfare	50.0	16.7	22.2	20.5	25.7	11.8	8.1
Other state and county	13.6	16.7	5.6	7.7	17.1	17.6	10.8
Psychologists, doctors	9.1	0	5.6	0	5.7	5.9	0
Hospitals	0	20.8	5.6	17.9	14.3	17.6	35.1
Religious organizations	4.5	0	0	2.6	8.6	17.6	21.6
Other	13.6	29.2	22.2	2.6	17.1	17.6	13.5
Mental health assn.	4.5	4.2	16.7	33.3	8.6	11.8	8.1
State schools	4.5	12.5	22.2	15.4	2.9	0	2.7
How hear about best known:[2]							
Place of employment	11.4	16.1	12.0	9.6	25.0	24.0	17.9
Friend	5.7	12.9	16.0	23.1	4.2	0	2.6
Common knowledge or school	25.7	16.1	16.0	13.5	16.7	24.0	23.1
Family member	25.7	19.4	12.0	11.5	16.7	12.0	17.9
Newspaper	11.4	19.4	24.0	25.0	14.6	16.0	7.7
Radio-TV	2.9	0	8.0	1.9	10.4	0	20.5
Advertising, lectures	5.7	16.1	0	11.5	8.3	16.0	7.7
Other	11.4	0	12.0	3.8	4.2	8.0	2.6

Appendix Table 2 (Continued).

	Regions						
	% of respondents in each region						
	I	II	III	IV	V	VI	VII
What kind of job is best known agency doing?[4]							
Excellent or good	75.9	95.9	86.7	86.8	75.7	87.0	91.7
Reason for evaluating job being done by best known:[1]							
Personal opinion	59.3	43.5	50.0	38.9	45.9	44.0	46.7
Friends opinion	0	4.3	14.3	11.1	0	0	20.0
Assistance to self or friend	7.4	17.4	14.3	25.0	13.5	16.0	23.3
Heard or read about it	14.8	13.0	7.1	5.6	8.1	4.0	0
People get help who don't need it	14.8	4.3	0	0	0	8.0	0
Other	0	4.3	0	2.8	2.7	4.0	0
Facility needs more funding, personnel	3.7	13.0	14.3	16.7	29.7	24.0	10.0
Experience with friend's problem[3]	45.9	54.7	40.4	59.0	52.4	52.3	21.8
Where did friend go for help?[4]							
Pschiatrist, psychologist	33.3	51.9	20.0	37.5	29.3	45.5	20.0
Doctor	0	22.2	20.0	17.9	14.6	0	13.3
Private care	18.5	0	0	5.4	4.9	9.1	6.7
Religious	3.7	3.7	0	3.6	4.9	0	13.3
Mental health agency	25.9	18.5	53.3	25.0	34.1	31.8	33.3
Other	18.5	3.7	6.7	10.7	12.1	13.6	13.4
How much was friend helped?[4]							
A lot	54.2	36.0	50.0	61.1	61.9	59.1	50.0
A little	33.3	41.0	31.3	27.8	31.0	22.7	28.6
Not at all	12.5	20.0	18.8	11.1	7.1	18.2	21.4
How much more should be done?[2]							
A lot more	65.4	72.7	66.7	79.3	80.0	71.8	47.1
About the same	30.8	27.3	33.3	19.5	18.6	28.2	45.6
Less than at present	3.8	0	0	1.2	1.4	0	7.4
What should be done?[4]							
Public relations	25.7	56.5	30.8	25.9	28.6	17.9	13.6
Improve services	2.9	0	11.5	5.6	9.5	14.3	4.5
Counseling	11.4	13.0	11.5	5.6	9.5	14.3	13.6
More money	22.9	4.3	26.9	38.9	28.6	25.0	31.8
Incentive to work	8.6	4.3	0	5.6	7.1	0	4.5
Help mentally retarded	8.6	0	3.8	3.7	0	0	4.5
Better education	17.1	21.7	15.4	13.0	16.7	25.0	22.7
Help for drinking problems	2.9	0	0	1.9	0	3.6	4.5
How support improvements?[2]							
Taxes, unspecified	30.4	17.4	22.2	18.7	28.1	44.1	11.1
Federal	10.9	4.3	2.8	2.7	3.1	0	5.6
State	4.3	13.0	13.9	28.0	4.7	8.8	11.1
County or local	8.7	2.2	7.4	2.6	2.9	2.9	5.6

Appendix Table 2 (Continued).

	Regions						
	% of respondents in each region						
	I	II	III	IV	V	VI	VII
Some combination of government	8.7	8.7	11.1	8.0	11.0	9.2	11.2
Community, donations	23.9	39.1	19.4	21.3	21.9	11.8	22.2
Taxes and donations	6.5	10.9	8.3	6.7	18.8	23.5	0
Other	6.5	4.3	13.9	12.0	4.7	2.9	33.3
Where would you first go for help?[3]							
Doctor	48.2	50.0	54.5	60.8	57.9	46.3	17.6
Psychiatrist	3.6	19.6	6.8	10.3	5.3	9.8	10.3
Religious	17.9	10.9	13.6	13.4	10.5	22.0	52.9
Appropriate professional	5.4	9.1	0	1.0	3.9	0	4.4
Mental health facility	8.9	8.7	9.1	9.3	9.2	4.9	0
Health and welfare	7.1	0	9.1	3.1	5.3	2.4	0
Family or friend	5.4	8.7	2.3	1.0	1.3	7.3	13.2
Other	3.6	0	4.5	1.0	6.6	7.3	1.5

[1] Chi Square, $P < .05$
[2] Chi Square, $P < .01$
[3] Chi Square, $P < .001$
[4] Chi Square not significant at .05

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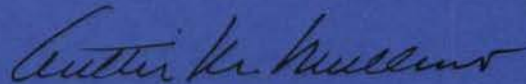

Auttis M. Mullins
Dean, College of Agriculture
University of Idaho

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