Public Relations in Mental Health Programs

HAROLD P. HALPERT, M.A., M.P.H.

THE CURRENT TREND toward basing mental health facilities close to where people live and work, and the increased emphasis on viewing mental illness in terms of social malfunction, have heightened professional awareness of the importance of community attitudes about mental illness, the mentally ill person, and those who treat him. Favorable attitudes alone may not produce desired behavior nor always indicate that the facts are properly understood. They do provide a receptive climate for the newer treatment techniques and a base on which to build better understanding and concrete support of modern mental health programs.

Publicly declared or civic attitudes toward mental illness have changed considerably in the past 50 years; especially in the past 15. The average person nowadays is more apt to conceptualize psychosis in terms of an illness or at least to say that he does. He is also more apt to say that mental illness may be treated with some success, even if he does not really believe it. Few people today reject the mentally ill outright, and many express favorable attitudes toward psychiatry and the other mental health professions although a large percentage of the population still do not seek needed psychiatric help for themselves or their relatives except as a "last ditch" measure.

Despite these shortcomings, the culture is now in a state of transition with regard to mental illness. Changes in attitudes that people express publicly generally precede changes in felt attitudes and attitudes on which their actions are predicated. A key goal of present-day mental health program planning and administration must be to capitalize on the gains made thus far and to develop specific public relations objectives around which to mobilize, direct, and activate these germinal favorable attitudes.

Mr. Halpert is consultant on communications, Social Psychiatry Section, Community Research and Services Branch, National Institute of Mental Health, Bethesda, Md. *The paper is based on an address given at the 41st annual meeting of the American Orthopsychiatric Association, Chicago, Mar. 21, 1964.*

Identifying Key Audiences

An organization can be said to have a successful public relations program when it has identified, informed, and motivated in its interest all those persons who can make a significant contribution to the success of its avowed mission (*1*). Identification of significant publics needs to be carried out in sufficient detail so that specific educational and motivational programs can be developed. In general, such programs must be aimed at three overall objectives.

1. To insure financial support.
2. To insure what might be called psychological support, so that the newer community-based treatment and rehabilitation programs will not be hampered by negative reactions to the location of a needed facility in a given neighborhood or to reception of the convalescent mental patient in home, club, church, and industry.
3. To insure acceptance and use of the new types of facilities so that the goals of early treatment can be achieved. If the new community mental health centers are used principally as "last ditch" resources, will they be, or can they be, more than city-based versions of the outmoded public mental hospital?

Similarly, it is possible arbitrarily to enumerate several general categories of target audiences to which a mental health agency's public

relations activities should be directed (*2*). There is, to start with, the supporting public. Unless the relevant political authorities, legislative bodies, and other supporting groups fully understand the goals and rationale of the mental health program, it will be difficult to compete for support with other socially useful and financially needy programs. Taxpayers and voters who, in their less active role as citizens, are sometimes referred to as members of the general public are, of course, a very important part of the supporting public. So are the local opinion molders, the people who make up the community power structure.

In this connection, it is important to remember that the mass communications media are a key segment of the power structure. It has become fashionable in some circles to denigrate the importance of the press, radio, and television in influencing people's opinions and to place sole stress on person-to-person communications. Because they address themselves to the general public, it is easy to overlook the fact that the mass media influence opinions of the people who influence the opinions of others. The more influential members of a community, it has been observed, are considerably more exposed to the formal media of communications and tend to act as mediators, reinforcing the effect of the communications (*3*). Setting the mass media apart from the complex of elements and individuals that make up the power structure of a community is an artificial dichotomy, and one that can hamstring efforts to inform the public.

A second extremely important public is what might be termed the "operating" public. Mental health services involve the practice of highly specialized disciplines and the application of complex concepts. Their success depends on the mutual understanding and cooperation of a wide variety of groups and individuals. We are all painfully aware that even the limited psychiatric knowledge currently available is not being used to optimum advantage. This is not caused entirely by lack of funds or professional manpower. Researcher and program administrator often fail to communicate so that research findings, particularly in the area of social psychiatry, are not being put to use as rapidly as they might be. The researcher tends to feel that the administrator does not know how to ask appropriate questions and does not understand the methodology of scientific investigation; the program administrator tends to feel that the researcher does not look for the practical answers he needs.

Resistance to change is a serious obstacle to effective utilization of new knowledge and, in this respect, the mental health agency's own employees are perhaps the most important target group for its public relations program. If the mental health agency is to accomplish its mission, all of the people who work for it, from top clinical staff to maintenance personnel, must have a lively understanding of, and sympathy for, its goals and methods of operation.

The operating public also includes the many outside groups and organizations with which the mental health program must work. Clear communication of objectives and procedures is a prerequisite to needed cooperation from schools, courts, welfare and family agencies, physicians, and other individuals and institutions that participate directly or indirectly in providing mental health services.

A third target of mental health public relations might be termed the "receiving" public. Recipients and potential recipients of services and their families need to know when, how, and where to seek help. Radical changes in the patterns of providing psychiatric treatment may alter the general reluctance to seek such care. There is some evidence, albeit empirical, that more stigma attaches to the mentally ill treated in public mental hospitals than in private hospitals, and to inpatients than to outpatients. Perhaps, when we no longer need to be ashamed of how we treat the mentally ill, the sense of shame can be detached from mental illness and left behind with outmoded methods of treatment. But this will not happen unless the newer and improved methods of treatment are interpreted adequately and used intelligently. At a 1963 meeting with the Surgeon General, Public Health Service, the Commissioners of State mental health agencies urged the development of more effective methods of motivating people to take advantage of available mental health information, facilities, and services.

The fourth category of publics, the amorphous general public, can be subdivided into special interest groups through which public

relations can approach and motivate specific individuals. These groups include the civic, service, and volunteer organizations which are such an influential part of the American scene, the mental health associations, the PTA's, the Jaycee's, the women's groups, fraternal organizations, church and various denominational groups, and a host of others. These are the "in-groups" for most of middle-class America, determining people's values and the things they are willing to support. Professional associations in the mental health disciplines, medicine, education, law, and a number of other fields are obviously key audiences—as are industry and labor. Mental health programs and their goals need to be interpreted to the rotary clubs, chambers of commerce, and labor unions. Each mental health agency can develop for itself a list of the special target groups which are in a position to make a significant contribution to its avowed mission.

Analyzing Audience Attitudes

The content of the public relations and public education activities directed to each of these audiences needs to be developed on the basis of its special frames of reference and special interests. Before we can persuade people in a way that will lead them to take desired action, we must take into account their attitudes, interests, prior background, and experience. Considerable attention is being given therefore to assays of public opinions and attitudes and to the implications of their findings for mental health public relations.

Most of the studies made during the past 10 to 15 years indicate that the higher the educational and occupational level of the respondent, the closer his attitudes are likely to be to what mental health professionals consider desirable, that is, attitudes consonant with the goals of modern mental health programs (*4*). This finding indicates the need to address special mental health educational efforts toward people in the lower socioeconomic groups. They are less likely than the more prosperous to seek psychiatric help before the situation becomes desperate. Hollingshead's study of factors associated with the prevalence of mental illness revealed that proportionately more poor people end up as chronic patients in the back wards of the large public hospitals (*5*).

Unfortunately, these people are not "joiners" in the middle-class sense, and it is hard to find convenient target groups through which to reach them. Yet, if we are to realize the promise of the new community mental health centers and transform the public mental hospitals as we hope to, these are precisely the people who must be reached. Mental and emotional disorders compound their social problems and reduce the effectiveness of their already limited resources. Better public health control programs for mental illness among the poorer and less well-educated segments of the population can be an essential weapon in any war against poverty.

Several surveys—including those made in Trenton, N.J., in 1948; in Louisville, Ky., in 1950; in the State of New Jersey, in 1954; and in Baltimore, Md., in 1960—indicate that younger people have more enlightened opinions about mental illness. This is probably a result of the greater emphasis on mental health and psychology in school curriculums during recent years (*4*). The broad national analysis of popular thinking about mental illness, conducted by the National Opinion Research Center in 1950, revealed a high correlation between exposure to information about mental illness, whether through books, lectures, or mass media and "correctness" of opinions as suggested by professional standards (*6*, *7*). At every educational level, people who derived information from a greater number and variety of information sources were more knowledgeable than their educational peers. High school graduates with greater exposure to information sources showed more understanding of mental illness than did college graduates with low exposure. These findings suggest the need for continuing comprehensive programs of mental health education addressed to all levels of the population and designed to reach the same individuals many times and in many different ways.

Audience Motivation

There is question, however, about what the content of such educational efforts should be. Mere intellectual understanding of a problem does not necessarily result in desired action.

The annals of health education contain many instances of educational efforts that boomeranged. An African chieftain who had been convinced that he should send his young tubercular children to a hospital several hundred miles away became very uncooperative when one of the visiting health team members suggested that the chief's oldest daughter was the source of infection; in his culture, diseases are transmitted by sorcerers and witches (*8*). In Saskatchewan, the Cummings (*9*) encountered great resistance when their educational efforts ran counter to traditional views about human behavior. The concept that there is a continuum between health and mental illness was threatening to the people in Prairietown. Nunnally's report (*10*) on the 6-year study conducted by the University of Illinois Institute of Communications Research stressed that the public wants information to help relieve the personal threat that mental illness poses for them. They want solutions, not anxiety.

These and other similar experiences emphasize the need for well-defined, concrete purposeful objectives in mental health education and public relations programs. What do people want to know? What do they need to know? A recent study, conducted in St. Paul by Jacqueline Bernard of Minnesota's mental health program, underlined the importance of discovering what the audience wants to know. Members of homemaker groups in rural areas and small towns for whom an educational program was being planned were asked what kinds of information the public should be given about mental illness. The homemakers most often requested answers to questions like: "How should the public treat the mentally ill?" "How should one behave toward a patient discharged from the mental hospital?" "What can we do for the mentally ill?"

When asked the same question, mental health professionals in the State agency said that they thought the public should know about etiology and symptoms of mental illness, prognosis, social and financial costs, and modern treatment methods and philosophies. The professionals are concerned with what they do for the mentally ill. The average citizen is concerned about his own contacts with the mentally ill.

The fact that people are interested in how they should behave toward specific mentally ill individuals is a promising sign. Experience with mental hospital volunteer groups has indicated that volunteers, who have direct contact with patients, are knowledgeable about mental illness and often are able to do the best public relations for the mentally ill. The importance of the personal element was stressed in an unpublished 1963 study on attitudes toward mental illness conducted by Marisa Zavalloni and Alexander R. Askenasy under the auspices of the World Federation for Mental Health. They found that if they formed their questions in personal terms—"Would you be willing to take a job alongside a mental patient?" "Would you be willing to hire a former patient?" "Would you be willing to work under a man who had been a patient in a mental hospital?"—they tended to get more tolerant and favorable response than if they asked impersonal questions like, "Should employers hire former mental patients?" The same study revealed that even those people who are most distrustful of the mentally ill do not differ very much from the most trustful in being willing to actively help a close friend or relative who had been a mental patient.

Findings such as these raise questions about the relationship between attitude change and behavior change and further highlight the need to define specific objectives for educational activities. Behavior change, in the form of direct contact with mental health programs may, in many instances, be the necessary prelude to attitude change. The rapid development of more and more community-based mental health treatment centers perhaps can, by contact and example, do more than anything else to alter prejudicial attitudes toward the mentally ill.

The proximity of these treatment centers may also help to overcome some of the reluctance people have toward seeking early help. In their survey conducted as part of the work of the Joint Commission on Mental Illness and Health, Gurin and associates found that the availability of more psychiatric resources is associated with a greater tendency to seek help from all kinds of mental health facilities (*11*). The effective transmission and interpretation of pertinent information about these resources is

essential to their optimum use and is a fundamental ingredient of a mental health public relations program.

Planned Public Relations

The number and variety of factors in effective public relations pose a great problem to the mental health program administrator. As director of the program, he is charged with primary responsibility for the agency's public relations. Most directors do not have the background and experience required for this function and rarely have the time to do the job properly. The skilled public information specialist, the title by which he is most often known, offers the mental health agency specialized communications skills and experience. He can help the agency plan, and can direct for it, a comprehensive public relations program designed to interpret the agency to, and enlist the active support of, its many publics. He performs a variety of information and education activities and maintains effective liaison with those individuals and groups whose support is vital to the success of the mental health program. The information specialist can help arrange visits to mental health facilities by key legislators and other influential citizens, develop exhibits for medical society meetings, prepare written materials and talks to groups about the services offered by the program, plan strategy for stimulating both labor and industry to provide more job opportunities for former mental patients, and perform a host of other essential tasks.

A serious weakness in many mental hospitals and other treatment facilities is the lack of clear and unequivocal communication of agency goals and objectives so that all levels of operating staff understand, are in sympathy with, and carry out the goals of the program director. The skilled public information specialist can help the mental health agency develop effective intra-agency communications. He can serve as mediator or linking agent among clinical, administrative, and research staff, helping to translate and interpret widely varying approaches in terms of their contribution to the total agency effort.

The public information specialist can lay the groundwork for intelligent public support of the mental health agency during crises through long-term public education which combines information about the scientific methodology underlying the mental health agency's practice and program with information about its contributions to the general well-being of the community. The best antidote to unfavorable publicity is the background of knowledge and support that the agency has built up in key groups and individuals, as well as in the community at large.

This kind of defense in depth will become more important as mental health services become an integral part of the local community. Community conflicts tend to center about issues and events which touch on important aspects of the lives of community members (*12*). The big public mental hospital located in the country and supported by State funds does not have much immediate significance for the average citizen, unless his town derives a good part of its income from that hospital. The mental health center, on the other hand, situated in the local community and supported at least in part by local funds, may be a more personal concern for most people. Bringing the mental health program close to home, with all its advantages, may generate heat and controversy and bring demands for crash projects in special areas which will interfere with the agency's attempt to build a well-rounded program. These reactions can result in lack of continuing support and disillusionment with trial-and-error programing. Aggressive and continuing public education is the best way to help forestall such problems.

Public relations for mental health programs is a long-term, day-by-day task, requiring intelligent support and cooperation from all levels of agency administration and staff and direction by a skilled public relations practitioner. He must interpret the agency to itself, to its supporters, to its users, to the mass media and the other elements of the power structure, and to all segments of the community. He is equally responsible for keeping the agency informed about how its various publics view it and the climate of opinion in which it must operate. He is no more image builder but a communicator, a linking agent who can help the mental pro-

gram and the public view each other more clearly and understand each other more thoroughly.

REFERENCES

(*1*) Pray, F. C.: Development institute. American College Public Relations Association, Washington, D.C., November 1961, vol. 1, p. 72.

(*2*) McPheeters, H. L.: Keynote address to the Conference of State Mental Health Information Officers, National Institute of Mental Health, Washington, D.C., March 1960.

(*3*) Klapper, J. T.: The effects of mass communication. Free Press, Glencoe, Ill., 1960, p. 32.

(*4*) Halpert, H. P.: Public opinions and attitudes about mental health. PHS Publication No. 1045, U.S. Government Printing Office, Washington, D.C., 1963.

(*5*) Hollingshead, A. B.: Factors associated with prevalence of mental illness. *In* Four basic aspects of preventive psychiatry: Report of the First Institute on Preventive Psychiatry, edited by R. H. Ojemann. State University of Iowa, 1957, pp. 29–50.

(*6*) Star, S. A.: The public's ideas about mental illness. Presented at the annual meeting of the National Association for Mental Health, Indianapolis, Ind., November 1955.

(*7*) Star, S. A.: The place of psychiatry in popular thinking. Presented at the annual meeting of the American Association for Public Opinion Research, Washington, D.C., May 1957.

(*8*) Cassel, J.: A comprehensive health program among South African Zulus. *In* Health, culture, and community, edited by B. D. Paul. Russell Sage Foundation, New York, 1955, pp. 15–40.

(*9*) Cumming, J., and Cumming, E.: Closed ranks. Harvard University Press, Cambridge, Mass., 1957.

(*10*) Nunnally, J. C., Jr.: Popular conceptions of mental health. Holt, Rinehart & Winston, Inc., New York, 1961.

(*11*) Gurin, G., Veroff, J., and Field, S.: Americans view their mental health. Basic Books, Inc., New York, 1960.

(*12*) Coleman, J. S.: Community conflict. Free Press, Glencoe, Ill., 1957.

MEDLARS To Be Decentralized

The National Library of Medicine has awarded a contract of $125,000 to the University of California at Los Angeles for a pilot study for decentralizing MEDLARS, the library's computer-based information storage and retrieval system.

MEDLARS (Medical Literature Analysis and Retrieval System) is an application of computer technology to the task of maintaining access to the world's scientific literature in the fields of medicine and related biological sciences. The library uses MEDLARS to produce the monthly *Index Medicus*, a comprehensive reference listing of journal articles. MEDLARS is also used to compile recurring bibliographies in more specialized subject areas and to conduct searches of the literature in answer to specific requests from scientists, practitioners, and educators.

The UCLA Biomedical Library, one of the largest medical libraries in the country, was chosen as the first of a proposed network of geographically dispersed MEDLARS search centers. Such a network would extend MEDLARS' retrieval capacity throughout the United States.

The National Library of Medicine will provide the UCLA Biomedical Library with duplicates of the MEDLARS magnetic tapes on which the literature references are stored. Each 12-inch reel of tape holds about 35,000 bibliographic citations. The California search center will reprogram the MEDLARS tapes in COBOL (Common Business Oriented Language) for use on a local computer.

From the UCLA pilot project, the National Library of Medicine will develop data and experience relating to computer reprograming and tape conversion, program maintenance problems, cost factors, user evaluation, and training requirements for searchers, systems analysts, programers, and administrative personnel required to operate remote MEDLARS centers.