Arlington Mental Health Assessment and Intervention Plan

Developed for the City of Arlington Texas by the Arlington Mental Health Task Force: (Note: This is a fictitious report)

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Task Force Members
Nee Gotiator, MPA Management Consultants, Inc.
Hard Atwork Ph.D. Arlington Branch, Family Services
Firan Brimstone, BVD Arlington Ministerial Alliance
Makka Buck MS Director, Arlington Chamber of Commerce
Will B. Boring, Ph.D. Professor, UTA Graduate School of Social Work
Multa Kultural Arlington Cultural Coalition
Gyve U. Pills Ph.D. Arlington Office, Tarrant MHMR
I. Rate Mental Health Advocacy Inc.
Ian Sight MPA Assessment Consultant, Arlington Human Service Planners
Nicen Tuff Ph.D. Family Division, Arlington Police Department
Dume N. Gloom Ph.D. Arlington Private Practitioners Association

Staff = Dick Schoech, Planner, City of Arlington

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Acknowledgment
Our sincere appreciation is extended to the citizens and agencies that are on the front lines helping to improve the mental health of Arlington citizens.
Arlington Mental Health Assessment: Executive Summary

Background

The Mayor and City Council in early 2007 commissioned the Arlington Mental Health Task Force to improve the mental health of Arlington citizens. The Mayor’s actions represent our community’s response to the tragic suicide of several Arlington youth. The Task Force defines its vision as follows:

*We envision a community and families that support infants, children, youth, young adults, middle aged, and the aged in Arlington to develop their maximum potential emotionally, intellectually, and socially. We envision a community support system comprised of families, employers and neighborhoods that encourage self-help and mutual support. We envision a mix of human service agencies ready to intervene if self-help measures, the family, and the community are not sufficient to solve the problems of Arlington citizens.*

Arlington’s mental health capacities and needs

The Task Force felt that time was not sufficient to collect new data and that the analysis of the available data was sufficient to recommend actions. The Task Force examined research on mental health, the causes of mental illness, best practices and model programs, the community of Arlington, and exiting mental health services. After this analysis, the Task Force developed the following needs and capacities.

**Arlington’s Mental Health Needs in Priority Order (only top 5 listed)**

1. Citizens need to be able to contact one “easy to remember” location (telephone number and Web site) and be linked to mental health promoting activities and services (highest need)
2. Neighborhoods and businesses need ways to promote and support the mental health of residents
3. Better use of existing resources and capacities are needed to cover services for all in need.
4. Young adults need healthy recreational activities available to them in the evenings and on weekends
5. All children need to have adequate nutrition for the first five years of life

**Capacities/strengths on which to build**

1. Residents of the community are very involved (greatest strength)
2. A growing and successful business sector community committed to the community
3. Several very stable neighborhoods, some with homeowners associations
4. A network of churches that influence the lives of many people
5. Arlington has many good human service agencies with dedicated staff
6. UTA is a relatively untapped resources for applied research and volunteers

The goals below summarized our recommended actions which are accompanied by detailed objectives and recommendations in the full document.

1. To have Arlington residents capable of receiving Metroplex social service help by dialing one easy-to-remember telephone number
2. To have residents aware of the I&R services and how to use 211
3. To have a detailed assessment/plan on how Arlington’s resources can best address residents’ needs
4. To promote healthy lifestyles in youth to increase their capacity to handle the problems of growing up.
5. To promote families and neighborhoods through existing services

We can make a difference

This assessment provides the basic information needed to make our community a mentally healthier place to live. The assessment also provides the information needed to design a better mental health service delivery system. Now that we understand where we are at, we are ready to move forward. If you can work with us, please contact the Mayor’s office at the City of Arlington. Visit us at www.arlingtonMH.com
"Suicide by a teen should be a rare occasion. Several in one year should be a wake up call for any community.” With these words, the Mayor of Arlington appointed the Arlington Mental Health Task Force in January of 2007 following a series of teen suicides. The Mayor and City Council commissioned this Task Force to advise them on how to develop more mentally healthy citizens in Arlington. The Task Force used a broad definition of mental health, defining it as emotional, intellectual and social well-being. This report contains the data and advice, the resulting prioritized list of needs and capacities, and goals, objectives and recommendations for future action. It is a blueprint for future actions.

**Process of Conducting the Assessment and Developing the Plan**

The Task Force developed the assessment/plan in five stages: (1) examining mental health as a condition of concern, (2) analyzing the characteristics of community of Arlington, (3) analyzing the exiting service delivery system for Arlington, (4) developing a summary list of needs and capacities, and (5) developing goals, objectives and recommendations for future actions. The Task Force met weekly during the first four months of 2007. It was aided by staff expertise and support from the Arlington Human Services Planners. This report is limited by time and the resources available to conduct it. Corrections and additional information will be gratefully accepted for inclusion in subsequent assessment efforts.

**Vision Statement and Guiding Principles**

Mental health services must not be delivered independent of a philosophy of human well-being and mental health treatment (Brueggeman, 2002, p. 32). The vision that united the diverse group of task force members was:

> We envision a community and families that support infants, children, youth, young adults, middle aged, and the aged in Arlington to develop their maximum potential emotionally, intellectually, and socially. We envision a community support system comprised of families, employers and neighborhoods that encourage self-help and mutual support. We envision a mix of human service agencies ready to intervene if self-help measures, the family, and the community are not sufficient to solve the problems of citizens.

The following principles provided the philosophy and basic values for the analysis and plan. We believe that:

1. The family is a primary place where citizens develop their maximum potential emotionally, intellectually, and socially. Human services that support and empower the family, e.g., family counseling, should be the preferred choice of intervention.
2. The workplace is important for emotional, intellectual, and social development. Human services provided through and supported at work should be a component of any human service delivery system.
3. The community is an important source of emotional, intellectual, and social growth. Citizens have a responsibility to enhance their community by challenging unjust policies and practices while advocating and working for improved conditions.
4. Human service agencies exist to supplement self-help and community measures. Human services that improve community functioning, e.g., empower diverse and cohesive neighborhoods and encourage mutual support, should receive priority funding.
5. Mental health promotion and mental illness prevention is preferable to treatment.
6. Social services should be as brief, close-to-home, and as non-restrictive as possible.
7. Human service delivery is a research-based science. Client problems and their progress towards solutions should be measured and evaluated.
8. Services should be coordinated so clients can call any agency and become linked to a comprehensive system of care rather than having to contact many separate agencies looking for help.
9. Potential clients, ex-clients, and client advocates should involved in improving policies and services.
10. Agencies should use citizen volunteers, especially teens, in their services.
11. Agency staff, boards, and policy making bodies should resemble the ethnic, income, and gender mix of their target populations because a diverse workforce is better able to serve clients.

**Mental Health: Our Condition of Concern**

This section of the assessment develops a basic understanding of the condition that concerned the Task Force. It presents a basic definition of the condition, who experiences the condition, historical and current thinking on why the condition exists, the politics of the condition, and a continuum of intervention strategies. It concludes with a summary of capacities, needs, and barriers identified by analyzing the condition.

**Definitions of Mental Health**

No agreement exists on the definition of mental health. Most definitions stress that mental health is not just the absence of mental illness or a mental disorder. The World Health Organization’s (WHO) constitution states that health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 2001). Thus, mental health involves both disease prevention and health promotion. WHO defines mental health as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

The Department of Health and Human Services (DHHS) views mental health and mental illness as points on a continuum. DHHS defines mental health as a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity. NIMH defines mental illness as the term that refers collectively to all diagnosable mental disorders. DHHS agrees with the American Psychiatric Association on the following statement:

*Mental disorders are health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning.*

*Alzheimer’s disease exemplifies a mental disorder largely marked by alterations in thinking (especially forgetting). Depression exemplifies a mental disorder largely marked by alterations in mood. Attention-deficit/hyperactivity disorder exemplifies a mental disorder largely marked by alterations in behavior (over activity) and/or thinking (inability to concentrate). Alterations in thinking, mood, or behavior contribute to a host of problems—patient distress, impaired functioning, or heightened risk of death, pain, disability, or loss of freedom* (Department of Health and Human Services, 1999).

However, DHHS admits that mental health is almost indefinable because to be mentally healthy is subject to many different interpretations that are rooted in value judgments that may vary across cultures. It also indicates that almost everyone has experienced mental health problems in which the distress one feels matches some of the signs and symptoms of mental illness.

For the purpose of this assessment, our Task Force will use the DHHS definitions.

**Characteristics of Those Experiencing Mental Disorders**

Mental illness constitutes one of the largest health problems worldwide. One in every four persons going to health services has at least one mental, neurological or behavioral disorder. Most often these are neither diagnosed nor treated (World Health Organization, 2001). Data developed by the Global Burden of Disease study conducted by the World Health Organization, the World Bank, and Harvard University reveal that mental illness, including suicide ranks second in the burden of disease in established market economies, such as the United States. By this measure, major depression alone ranked second only to ischemic heart disease in magnitude of disease burden. Schizophrenia, bipolar disorder, obsessive-compulsive disorder, panic disorder, and post-traumatic stress disorder also contribute significantly to the burden represented by mental illness (Department of Health and Human Services, 1999).
Another way to analyze those with a mental disorder is by studying those receiving treatment. A total of about 15 percent of the US adult population use mental health services in any given year. These data come from two epidemiologic surveys: the Epidemiologic Catchment Area (ECA) study of the early 1980s and the National Comorbidity Survey (NCS) of the early 1990s. Figure 1 displays visually those having mental illness vs. those receiving treatment (Department of Health and Human Services, 1999).

Causes of Mental Illness

Since no agreed upon definition of mental health or mental illness exists, causes are difficult to determine. Mental disorders affect and are affected by other chronic conditions such as cancer, heart disease, diabetes and HIV/AIDS. Causes can be genetic or situational and may vary by the age of the client. For example, one study of girls in treatment found that they experienced high levels of negative life events, family disruptions because of sexual abuse, and parental incarceration. It concludes that “mental health prevention and intervention programs that are family-, school-, and community-based need to be intensive and penetrate the systems that create prolonged risk for these youth. Simply targeting their depressive symptoms on an individual level or with medication will not eliminate the environmental factors related to their depression (Ruffolo, Sarri & Goodking, 2004, p. 244). In some cases, the cause of mental illness is still hotly debated. Drug addiction, for example, can be seen as a physical disease similar to cancer or as a character weakness. Suicide is still considered a crime against oneself and religions in the past have even prevented those committing suicide from being buried in church cemeteries.

Politics of Mental Health

Mental disorders are common to all countries, increase mortality, and cause immense human suffering, staggering economic costs, social exclusion, disability, and poor quality of life. However, stigmatization of people with mental disorders has persisted throughout history. Stigmatization reduces patients’ access to resources and opportunities while leading to low self-esteem, isolation, and hopelessness. It deters the public from seeking, and wanting to pay for, care. In its most overt and egregious form, stigma results in outright discrimination and abuse. Stigma can leads others to avoid living, socializing or working with, renting to, or employing people with mental disorders, especially severe disorders such as schizophrenia (Department of Health and Human Services, 1999). More tragically, it deprives people of their dignity and interferes with their full participation in society. Another manifestation of stigma is reflected in the public’s reluctance to pay for mental health services. Policy makers, insurance companies, health and labor policies, and the public at large discriminate between physical and mental disorders and on the responsibilities for preventing and treating the problems.

Best Practices, Evidence-based Interventions, and Continuum of Care

Cost-effective treatments for most disorders do exist and if used correctly, could permit affected persons to be functioning members of the community. Yet in most countries, there are major barriers to both the care and the reintegration of people with mental disorders. Society’s belief in the cause of mental illness has a large impact on the interventions and the resources provided for prevention intervention, and rehabilitation. Most middle and low-income countries devote less than 1% of their health expenditure to
mental health which means that mental health policies, legislation, community care facilities, and treatments for the mentally ill are dismally short of resources. (World Health Organization, 2001). Given this lack of resources, the US has recently attempted to focus on programs that work based on the experts and research. Often the practices distilled from experts are referred to as best practices, while practice distilled from research is often referred to as evidence-based (University of Texas at Arlington, 2002).

Reviews of best and evidence-based practices for the treatment of mental illness are lacking. In March, 2004, the Minnesota Department of Human Services called this situation “The Forest of Evidence-Based Practice” (Minnesota Department of Human Services, 2003). The report suggests that we have many small studies of what works in very specific cases, but find it difficult to summarize major principles of what works. Internet searches for mental illness best practices and evidence based practices result in surprisingly few major reviews. One recent review of the evidence on effective intervention for children and their family’s mental health found the following three groups of characteristics important to successful intervention.

1. Engagement (meeting basic needs, parents as partners)
2. Delivery of Clinical Services (the successful therapeutic relationship, individualized services, access and perceived depth of caring, collateral clinical services, medication, maintaining commitment to family goals)

Even when evidence or best practices are available, they are not frequently practiced. Drake, et. al. (2001) conclude that despite extensive evidence and agreement on effective mental health practices for persons with severe mental illness, research shows that routine mental health programs do not provide evidence-based practices to the great majority of their clients with these illnesses.

Communities provide different types of treatment programs and services for children and adolescents with mental illnesses. A complete range of programs and services is called the continuum of care. Not every community has every type of program on the continuum. However, a comprehensive continuum is useful for understanding a community’s approach to a social problem. A typical continuum of care for mental health and mental illness includes information and referral, prevention, education, screening, early intervention, crisis management, home-based treatment outpatient services, partial hospitalization/day treatment services, residential treatment, rehabilitation, case management, follow-up support, respite care, recreational support, self-help, and linkages to other health and social services (American Academy of Child & Adolescent Psychiatry 1995).

Capacities, Needs, and Barriers identified in the Analysis of the Condition/Problem

Examine the condition of concern has identified several capacities, needs, and barriers. Capacities allow future interventions to build on strengths (Kretzmann and McKnight, 1993). Needs help focus future interventions. Barriers focus on road blocks that must be addressed if future interventions are to be successful. The capacities identified by examining the condition of concern are the world wide recognition and study of mental health and mental illness and some solid evidence on how to intervene. The needs are for a better definitions of and public education about mental health and mental illness. Additional needs are for more resources for mental health services and summary research on best practices and their implementation. Barriers concern the stigma often associated with having mental illness and the lack of agreement on what the mental illness treatment system should look like.

Conclusion of the Conditions of Concern/Problem Section

This assessment of the condition of mental illness reveals that it is a long standing phenomenon which is very difficult to define. While the number affected is very large, the causes for mental illness are still debated. Some evidence and best practices for prevention, intervention, and rehabilitation exist, but not to the extent that we would expect for a societal problem with such a long history. Most all agree that the resources devoted to mental illness are inadequate given its pervasiveness and destructiveness in societies worldwide.
The Community of Arlington

Having discussed the condition of concern, it is now useful to describe the community being assessed. This section looks at the mental health of Arlington and how it handles citizens with mental illness. The goal is to better understand the characteristics of Arlington and how these characteristics impact the mental health and mental illness of its citizens. Several sources of data are presented to help understand the community. The data source, findings, and resulting capacities, needs and barriers will be presented.

Community Profile from the City of Arlington 2005 Visioning Report

Over the past decades, Arlington has changed from a small town located strategically between Dallas and Ft. Worth (http://www.ci.arlington.tx.us/history/) to a thriving, sophisticated city of 348,965 (http://census.dfwinfo.com/dp.asp?code=0175) at the heart of the Metroplex. Arlington sees itself as a beautiful, clean, safe and fun place widely recognized as the most desirable location in North Texas to live, learn, work and do business. “It is a diverse community where residents want to stay, businesses thrive and to which visitors and our children want to return” (City of Arlington, 2004). The rapid progress in recent years has been accompanied by an increase in problems such as teen suicide, violence, AIDS/HIV, unemployment, drug abuse, and homelessness. While mental health or mental illness is not mentioned in the visioning report specifically, it does point to Arlington’s overall strengths and needs. The following summarize Arlington’s vision of itself in 2025.

• A community where health and human services, including transportation and other supportive services, are accessible to all persons.
• A community with high quality core services and infrastructure provided to all people.
• A community with strong and sustainable neighborhoods.
• A community with affordable, coordinated and accessible programs for children and youth.
• A community of neighborhoods with easy pedestrian access to a system of parks, open spaces, trails and gathering places promoting interactions within and among neighborhoods.
• A community that wisely uses natural resources to create a healthful place to play, work, and live.
• A community with workforce development and a quality, highly ranked educational system that is aligned to support economic development strategies.
• A community where Government is committed to excellence, integrity and efficiency and encourages representation of all segments of the population at all levels.
• A community that preserves its history and celebrates and cultivates arts and culture.

While the above characteristics of Arlington would promote mental health, the visioning report lists the following challenges that impact mental illness.

• Ability to handle a 27% population increase by 2025 with the largest percentage increase of major regional cities by persons below the poverty level
• The lowest percentage increase in median single-family housing value in the region
• The lowest per capita taxable value of the largest cities in the region
• A decline in per capita property values, thus making the city less attractive to high income buyers
• Flat retail sales with retail leakage to other cities, thus eroding the tax base to pay for needed services

Summary of the capacities and needs identified in the visioning report: Arlington is aware of its challenges and is planning for its future. It values a healthy business climate, education, and maintaining a very livable climate for its citizens. Arlington has much competition from outlying suburbs in creating a healthy and desirable community. Its central location may bring the mental illness problems often associated with large city centers as mentioned in section 1 above, e.g., people living in poverty, teen pregnancy, and unemployment.

Community Profile from US Census Data

Source of data: Arlington 2000 Census data were obtained from the North Central Texas Council of Governments and Chamber of Commerce (http://www.netcog.org/ris/census/) Finally, Arlington is changing demographically. Arlington was 78.5 percent Anglo in 1990, but in 2007 less than 50% of the population
was anglo. Due to white flight, Arlington’s anglo population declined almost 24,000 from 2000 to 2005 and so has the average household income. With this increase in poverty has come many of the urban problems associated with poverty. However, since 2005, average household income has been rising.

**Findings:** US 2000 Census data suggests that Arlington has the following neighborhoods.

- **North Arlington** - New subdivisions of high to moderately priced houses. Most residents are middle-aged newcomers, professional, and mobile citizens who desire proximity to the DFW airport.
- **South Arlington** - New subdivisions of low to high income housing with many apartments. Residents are middle-aged newcomers, and a mix of industrial and professional residents.
- **East Arlington** - Older moderate to low cost homes and many apartments occupied by residents who have lived in Arlington for 10+ years. Many are blue-collar workers at plants such as General Motors. Industrial and entertainment parks exist.
- **Center Arlington** - Older, moderately priced neighborhoods and a small downtown area. The 25,000 students at the U of Texas at Arlington dominate the center. Most students are commuters, although several thousand students live permanently in dorms and surrounding housing. Many permanent students are athletes or students from foreign countries.
- **West Arlington** - Newer higher priced houses occupied mostly by professionals. Most residents have lived in their homes for over 6 years.

Census data revealed that Arlington has a high percentage of elderly living along in the central and east Arlington area. In addition, several east Arlington census tracts have a large number of small single-family units with high occupancy.

**Summary of the capacities and needs identified by an analysis of Census data:** Special pocket of strength exists in many diversely populated areas of the city and a thriving entertainment community. Census data points to areas with a large potential for mental health problems, i.e., isolated seniors, overcrowded households, and single parent families in apartments.

**Community Survey Data**

**Source of data:** A November 2000 survey of 100 randomly selected households in five Arlington neighborhoods (above) was conducted by United Way interviewers walking through neighborhoods on weekends and interviewing the adult head of each household. Statistics comparing respondent demographic information to 2000 census tract information indicated that respondents were statistically similar to the general population in regards to age, ethnicity, and income.

**Findings:** Survey result (see Appendix A) demonstrates that some findings were consistent in all neighborhoods and some results varied widely by neighborhood. Results that were consistent across neighborhoods are the following.

- Few people knew what mental health services existed or how to locate them.
- All neighborhoods indicated that teen pregnancy and childhood nutrition was a problem. Many respondents stressed that low cost prenatal care and educational programs in the schools were inexpensive preventative service that pregnant teens needed.
- Youth at risk was listed as a high priority by all neighborhoods. Comments suggested that youth chemical dependency/misuse and lack of constructive recreation opportunities were problems. Several respondents suggested that healthy youth behavior be taught in the schools.

Results that varied by neighborhood are the following.

- Residents who have lived in East and Central Arlington rely more on neighbors in times of need than did residents in other areas. Professional white-collar workers in North, West, and South Arlington tend to rely on their place of work for mental health services. Blue-collar workers in East Arlington and the elderly in Central Arlington tend to rely on family and friends for help.
- Central/East Arlington felt the lack of transportation and access to services was the greatest need.
- North Arlington felt that the lack of child/dependent family member care was the greatest need.
- West and South Arlington felt the greatest need was preventing family distress/stress due to unemployment.
- East and Central Arlington were very concerned with violence and victimization and respondent comments indicated that several homeowner associations met regularly.
Summary of the capacities and needs identified from the survey: Arlington has strong neighborhoods and workplaces that function as natural support networks. Transportation is a major barrier. Knowledge of existing services and who to call for help is low. Teen and childcare problems are a high concern. People are worried that their natural support networks may be declining.

Key Informant Perspective

Key informant survey by the Stakeholders Committee: The Stakeholders committee of Tarrant United Way included educators, city and county leaders, businesses, chambers of commerce, foundations, and civic associations such as the Junior League of Arlington (http://www.unitedwaytarrant.org/home/CommunityImpact/source/9_Key%20Informant.pdf). The Stakeholders committee surveyed 338 key informants in 2000.

Findings from key informant survey: The top concerns of respondents concerned affordable health care for low income residents, addictions especially in youth, and mental health problems such as depression.

Summary of the capacities and needs identified: Arlington has a strong voluntary sector as evidenced by the broad participation of the stakeholders committee. The major problem concerns resources for helping those in need, since government sources along with traditional health insurance has declined. The number 1 ranking of affordability illustrates that the current system of paying for services is failing. A major need is for ways to provide the most appropriate services given the limited resources available.

Public Forum Testimony

Data collection methods: Two public forums were held by KERA, one on April 12, 2007 from 6-9 p.m. and one on April 19, 2007 from 6-9 p.m. One was held in the Southern part of Arlington at Vandergriff Park, the other in the northern part of Arlington in City Council Chambers (http://www.kera.org/)

Findings from public forum testimony: Forum results are presented in Appendix B. As the testimony from the first forum in Appendix B illustrates that citizens were supportive of this assessment and the Mayor's leadership. They wanted the residents of Arlington involved to the extent possible. For example, they recommended media coverage and preferred door-to-door surveys instead of telephone surveys. Agency representatives were also supportive and wanted to be involved in the planning process. The barriers to services identified by the public forum primarily concerned the inability to afford services, the inability to locate the appropriate service, and the lack of transportation.

Free transportation was provided to anyone wishing to attend the second forum. The second forum confirmed the results of the community survey mentioned above. The forum results also stressed that Arlington residents feel part of the social service system of both Dallas and Ft. Worth.

Summary of the capacities and needs identified: The major strength found was the willingness of residents to become involved and devote time and energy to problems of concern. Overall, testimony pointed to the need for better access to information about services and better public transportation. Part of the problem is that Arlington residents find it difficult to determine whether to look for services in Arlington, in Ft. Worth, or in Dallas. Specific mental health needs identified are similar to most communities, and mostly concern youth, e.g., teenage pregnancy, youth depression and violence, and school related problems.

Capacities, Needs, and Barriers identified by the Analysis of all Sources in the Community

Arlington’s capacities are in its civic pride and its citizens who are willing to volunteer to plan and manage its future. Included in this capacity are the resources of the U of Texas at Arlington. Arlington’s needs stem from an increasing number of wealthy residents moving to less expensive suburbs and an increasing number of persons with low paying jobs. Arlington needs to become more attractive to all its citizens. Arlington needs to better connect the haves and the have-nots in terms of services and resources and to find mechanisms for helping those without resources receive available services. Barriers include the lack of transportation and the increasing proclivity of businesses along with the state and federal government to push funding for services onto local communities.

Conclusion of Community Section

This assessment reveals a city which is rapidly changing from a wealthy suburb of Dallas and Ft Worth to being the center of the Metroplex. As the Metroplex expands, Arlington has not been able to continue to be as attractive as many of the outlying suburbs. At the same time, Arlington is beginning to experience inner city problems of poverty, unemployment, and large numbers of people in need who lack the
resources to pay for services. While some areas of Arlington are doing well, other areas are experiencing severe needs. While some groups of citizens can pay for services, other groups cannot. Given the continuing lack of funding from the Federal Government and from business health insurance plans, the resources for intervening in mental health problems is limited. From a systems perspective, Arlington functions well. It has a vision, goals, and objectives for 2025. Yet the systems to build on its capacities and to address its needs seem to be strained. Data suggest a need to more closely link those with resources to those without resources and to have systems that make the maximum use of limited resources to address the growing need.

**Current Service Delivery System**

**Introduction**

Arlington’s service delivery system for mental health/illness must be placed in the context of the mental health/illness services in the US. President Bush’s New Freedom Commission on Mental Health reported in October 2002 that the “public mental health system is in shambles.” Only one-third of adults in the U.S. and even fewer children receive the mental health treatment they need (6Jan04: www.nmha.org/cantmakethegrade/).

**Inventory of Services in the Continuum of Care**

The listing of services in Figure 1 is organized using the continuum of care categories mentioned in section 1. More detailed information on the services provided by the agencies under each service category is available from the Task Force. After examining Figures 1 with service providers, the Task Force concluded that the current need for all types of mental health services was greater than the supply. Prevention and outpatient services have experienced smaller growth, but the waiting lists show an increasing demand. Professionals attributed the leveling off of outpatient services to service cuts and managed care restrictions. The increase in case management services illustrated in Figure 1 can be attributed to the rise in managed care. The waiting lists for prevention and outpatient services seem to be the largest. Services with a sliding scale fee structure are increasing more rapidly than full pay services.

**Figure 1: Existing DFW Mental Health Agencies**

<table>
<thead>
<tr>
<th>Category of service</th>
<th>Clients Served</th>
<th>Ave. # Waiting</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2001</td>
<td>2002</td>
</tr>
<tr>
<td><strong>Information and referral (Arlington calls only)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 agencies provided I&amp;R</td>
<td>25,540</td>
<td>27,679</td>
</tr>
<tr>
<td><strong>Prevention, education, screening, early identification, and self-help services (Arlington services only)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health Association</td>
<td>215</td>
<td>678</td>
</tr>
<tr>
<td>All other organizations (22 organizations)</td>
<td>586</td>
<td>612</td>
</tr>
<tr>
<td>Total</td>
<td>801</td>
<td>1290</td>
</tr>
<tr>
<td><strong>Crisis management, inpatient, day treatment, and rehabilitation (Arlington residents only)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General hospital psychiatric beds (5 beds)</td>
<td>112</td>
<td>116</td>
</tr>
<tr>
<td>Private psychiatric hospital (40 beds)</td>
<td>421</td>
<td>511</td>
</tr>
<tr>
<td>State hospital allocated beds and VA beds</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td>573</td>
<td>667</td>
</tr>
<tr>
<td><strong>Outpatient (Arlington residents only)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>County MH Center outpatient/aftercare *</td>
<td>9,876</td>
<td>10,897</td>
</tr>
<tr>
<td>Ten group practices</td>
<td>1320</td>
<td>1500</td>
</tr>
<tr>
<td>20 private practitioners</td>
<td>2248</td>
<td>2187</td>
</tr>
<tr>
<td>Family service agency*</td>
<td>17,865</td>
<td>18,991</td>
</tr>
<tr>
<td>Total</td>
<td>31,309</td>
<td>33,575</td>
</tr>
</tbody>
</table>

**Case management and follow-up support**
Capacities, Needs and Barriers Identified from the Analysis of the Service Delivery System

Figure 1 illustrates that a wide range of services and support systems exists. The yellow pages revealed that Arlington has an extensive system of schools, churches, and businesses throughout all segments of the city. Figure 1 illustrates that more family oriented services on a sliding scale fee structure are needed because they are in great demand. Ability to pay seems to be a major barrier. While the need for all services is growing, the need for some services (outpatient, inpatient, and prevention) is rapidly outstripping the current supply.

Needs, Capacities, and Barriers Identified by the Assessment

The Priority Ranking Process

The priority of the needs were established mathematically by the Task Force after rating all needs on (1) **magnitude** or what is the extent and scope of the problem at risk; (2) **severity** or what will happen if nothing is done; (3) **social concern** or to what extent is the community concerned; (4) **susceptibility to control** or what is the likelihood that action will be meaningful; (5) **relationship** to the planning body's sanctions, vision and goals; and (6) **community resources** available to combat the problem.

**Needs in Priority Order (Where 1 = highest priority)**

1. Citizens need to be able to contact one “easy to remember” location (telephone number and Web site) and be linked to mental health promoting activities and services (highest need)
2. Neighborhoods and businesses need ways to promote and support the mental health of residents
3. Better use of existing resources and capacities are needed to cover services for all in need.
4. Young adults need recreational activities available to them in the evenings and on weekends
5. All children need to have adequate nutrition for the first five years of life
6. School age children need to know how to become and stay mentally healthy
7. Residents need ways to handle problems in living, e.g., unemployment, parenting, divorce, death
8. The aged need low cost support and mechanisms in order to remain in their homes
9. Children/youth need personal growth building experiences, e.g. hiking
10. Agencies, especially those providing self-help, prevention, family, & community services must evaluate their outcomes

Other needs were identified and will be considered in future years. The other identified needs that were not considered 2007 priorities were low cost outpatient and inpatient mental health services, violence prevention, mass transportation, AIDS awareness, elimination of hunger, addictions services, child abuse prevention, and marital discord/divorce prevention.

**Capacities on which to Build**

To change our community, we must begin where the people are and tap into their talents and strengths. These are listed below.

1. Residents of the city are very involved (greatest strength)
2. The community has a growing and successful business community committed to the community
3. Several very stable neighborhoods exist, with homeowners associations
4. The area has a network of churches that influence the lives of many people
5. People value education and are willing to invest time and resources in their schools
6. Arlington has many good human service agencies with dedicated staff

**Barriers that restrict progress**
1. Arlington does not have a public transportation system, thus, those without cars find it difficult to travel.
2. Arlington is becoming more diverse and multicultural. Many agencies do not have a diverse staff and staff have not received adequate diversity training.

### Goals and Objectives

To develop goals and objectives, the priority needs and capacities were presented to 10 groups of concerned citizens (e.g., J.C.s, homemaker clubs, Mental Health Advocacy), city and county elected officials, church leaders, school officials, and The Arlington Association of Service Providers. After a presentation on the priority capacities/needs by one or two members of the Task Force, each group discussed the following:

1. The feasibility of achieving each need
2. Possible goals and objectives to address needs
3. The feasibility of accomplishing each objective
4. Possible source of funds for each objective
5. Who may support and oppose each objective
6. Possible strategies/tasks to achieve objectives

The Arlington Mental Health Task Force, during an all day meeting on May 1, 2007, developed the following goals and objectives. Outcome objectives state what will be achieved. Process objectives state how it will be achieved. Following the goals/objectives is a list of the priority needs addressed.

**Goal 1: To have Arlington residents capable of receiving Metroplex social service help by dialing one easy-to-remember telephone number** (capacity 2 & 6; needs 1)

**Outcome objective 1.1:** To have Metroplex residents using a 211 telephone number for human service information by Dec 2008 as measured by phone company records.

**Process objective 1.11:** To develop a coordinated I&R services available in Arlington 24 hours a day by Sep 2008 as measured by advisory members testing of the system.

**Goal 2: To have residents aware of the I&R services and how to use 211** (capacity 1; needs 1)

**Outcome objective 2.1:** To increase by 10 percent the number of residents of Arlington who are aware of coordinated I&R services and how to access them by Dec 2008 as measured by a pre-post telephone survey of residents.

**Process objective 2.11:** To develop and distributing 15000 pamphlets describing all community agencies, the services they provide, and how to access them by Sep 2008 as measured by distribution records.

**Process objective 2.12:** To develop an I&R web site for all Metroplex human service agencies to inform Arlington residents of the range of services available and how to access them by Sep 2008 as measured by advisory board testing of the site.

**Process objective 2.13:** To develop and run at least 50 promotional spots during Oct 2008 using television, radio, the Internet, and print media in order to inform Arlington residents of the range of services available and how to access them as measured by media records.
Process objective 2.14: To survey a random sample of 2% of Arlington residents to determine their knowledge of the 211 social service telephone number in Aug 2008 and Dec 2008 as measured by the published survey results.

Goal 3: To have a detailed assessment and plan on how Arlington’s resources can best be used to addresses the needs of all its residents. (capacity 1, 2, 4, 6; need 3)

Outcome Objective 4.1: To have an assessment and plan to address pre and postnatal care and child risk screening by Mar 2008 as measured by a distributed written and web-based document.

Process objective 3.1: To appoint a task force with Arlington Independent School District, agency, and consumer members that will assess the problems and develop a plan to address pre and postnatal care and child risk screening Mar 2008 as measured by task force meetings.

Goal 4: To promote healthy lifestyles in children and youth to increase their capacity to handle the problems of growing up (capacity 2, 4, 5, 6; need 4, 9)

Outcome Objective 4.1: To increase by 10% the number of children and youth indicating healthy recreational activities as measured by the annual school survey administered in May 2008.

Process objective 4.11: To have the park board, school district, YWCA/YMCA, and boys and girls clubs initiate one additional program fostering constructive activities for Arlington children and young adults by Apr 2008 as measured by I&R service data.

Process objective 4.12: To have the Council of Churches find local businesses sponsors for each of the programs developed through Objective 4.11 by Apr 2008 as measured by Council records.

Goal 5: To promote families and neighborhoods through existing systems (capacity all; need 2)

Outcome objective 5.1: To increase the perception of family and neighborhood importance and viability by 10% in 5 “test” Metroplex neighborhoods as measured by pre-post survey data by Dec 2008.

Process objective 5.12: To have social service agencies in 5 “test” Metroplex neighborhoods develop at least one program (e.g., neighborhood pride programs, family events, etc.) to promote families and neighborhoods by Dec 2008 as measured by United Way records by Aug 2000.

Process objective 5.13: To have 30% of member businesses of the Chamber of Commerce which serve the 5 “test” neighborhoods better promote families and neighborhoods in their work policies by Dec 2008 as measured by Chamber records.

**Future Strategies and Recommendations**

Goal 1 & 2. Coordinated I&R and community awareness

Discussion by community groups and the Task Force indicated that the goal of coordinated Arlington I&R is feasible, but difficult to achieve. The most feasible way to provide this service is through an alliance of all existing providers. The alliance should be established and then it could create a new agency to provide the I&R service or contract for the I&R service with an existing agency. The I&R service should provide as a minimum:

1) I&R 24 hours a day for all callers via a widely publicized 211 human services phone number
2) a complete listing of Metroplex social services
3) planning data collected anonymously from those using the service
4) a yearly plan and an evaluation of the usefulness of the service, including user satisfaction.

Possible sources of funding are: Texas Health and Human Services Commission (THHC), a local foundation (seed money only); community development funds from the city; and United Way. As this
service becomes established, it is estimated that continuous funds will come from HMOs and managed care providers (15%), THHC (10%); city/county (12%); United Way (13%). The remaining 50% will come from fees to each agency based on the percentage of the total referrals they receive through the I&R service.

Considering the above discussion, several strategies were discussed.

- Give the current city of Arlington I&R (budget ($50,000/year) to the consortium and let them decide how to set up the service based on the criteria established by a representative board.
- Have experts in the I&R field conduct a study and recommend a service system. This study would cost an additional $8,000.
- Convene a blue ribbon panel of politicians, funding sources, and citizens who will design and take responsibility for implementing an I&R service. Service providers will function as technical advisors to this panel.

The Task Force recommended that a blue ribbon panel be appointed by the Mayor to develop criteria for an effective I&R service. The panel will serve as the initial board (a combination of the first and third strategy). The panel will recommend a Mayor appointed coalition of service providers to develop a program to meet the criteria.

**Goal 3: To assessment and plan on how Arlington’s resources can best be used to addresses the needs of all**

Arlington is rich in resources yet it also has large needs. Mechanisms need to be developed to better and more efficiently match resources to needs. The Task Force recommends that the UTA SSW Community Services Development Center or the UTA Center for Service learning conduct a study on how this gap can be narrowed while efficiently using existing resources.

**Goal 4: Child and teen health and resilience**

Strategies and recommendation for goal #3 will be developed by the groups recommended in the objectives. Church sponsorship involves the community in services and reduces funding problems.

**Goal 5: Promoting family and neighborhoods**

In keeping with our guiding principles, this goal hopes to reorient existing organizations to use neighborhoods, families and other natural support systems to prevent and help meet some of the major service needs of residents. The Task Force recognizes that research is not available to point to specific programs that promote the resiliency of families and neighborhoods. Therefore, the Task Force recommends that 5 pilot neighborhoods be designated to receive agency and business efforts. Once the success and failures of these programs have been evaluated, a more detailed plan can be developed.

An additional study would be made after the second year to try to answer the question of impact, or whether the information and referral system helps meet the vision, i.e., mentally healthy citizens and a system that promotes mentally healthy people.

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**Concluding Remarks**

This assessment only provides a statement of our current situation and ideas for the next step, which is to develop a detailed plan with implementation strategies. Implementation is the most difficult stage of developing a community where residents help themselves and others and use social services when necessary to develop their maximum potential emotionally, intellectually, and socially. The mayors of Arlington, the Task Force, and a concerned group of citizens have led the way. We must all become involved to implement this plan and continue to work for the mental health of all Arlington residents.

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**Reference list**


http://www.surgeongeneral.gov/library/mentalhealth/chapter1/sec1.html#footnote1

http://www.dhs.state.mn.us/Contcare/mentalhealth/Training_Materials.


Kretzmann, J. P., and McKnight, J. L. (1993). Building communities from the inside out: A path toward finding and mobilizing a community's assets. Evanston, Ill.: Center for Urban Affairs and Policy Research.


http://www2.uta.edu/ssw/trainasfa/ebpconcept.htm.

## Appendix A: Neighborhood Survey Results

<table>
<thead>
<tr>
<th>Question</th>
<th>No</th>
<th>So</th>
<th>Eas t</th>
<th>West</th>
<th>Cen</th>
<th>Tot</th>
</tr>
</thead>
<tbody>
<tr>
<td>I rely on my family MH problems</td>
<td>2.3</td>
<td>2.1</td>
<td>4.1</td>
<td>2.0</td>
<td>4.5</td>
<td>3.0</td>
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<td>Youth at risk are the biggest need in Arlington</td>
<td>4.5</td>
<td>4.6</td>
<td>4.7</td>
<td>4.9</td>
<td>4.8</td>
<td>4.7</td>
</tr>
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<td>Lack of information/transportation access to services is the biggest need</td>
<td>4.2</td>
<td>4.4</td>
<td>4.7</td>
<td>4.0</td>
<td>4.5</td>
<td>4.4</td>
</tr>
<tr>
<td>Teen pregnancy is the biggest need in Arlington</td>
<td>4.4</td>
<td>4.1</td>
<td>3.8</td>
<td>4.4</td>
<td>4.7</td>
<td>4.3</td>
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<td>School drop out is the biggest need in Arlington</td>
<td>4.2</td>
<td>4.1</td>
<td>3.9</td>
<td>4.4</td>
<td>4.3</td>
<td>4.2</td>
</tr>
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<td>Chemical dependency/misuse is the biggest need in Arlington</td>
<td>4.1</td>
<td>4.2</td>
<td>4.4</td>
<td>3.9</td>
<td>3.5</td>
<td>4.0</td>
</tr>
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<td>Lack of child/dependent family member care is the biggest need in Arlington</td>
<td>4.1</td>
<td>4.2</td>
<td>4.1</td>
<td>3.9</td>
<td>3.9</td>
<td>4.0</td>
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<tr>
<td>Violence/victimization is the biggest need in Arlington</td>
<td>3.4</td>
<td>3.6</td>
<td>4.4</td>
<td>3.5</td>
<td>4.5</td>
<td>3.9</td>
</tr>
<tr>
<td>I rely on people at work MH services</td>
<td>4.5</td>
<td>4.6</td>
<td>3.0</td>
<td>4.4</td>
<td>2.3</td>
<td>3.8</td>
</tr>
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<td>Illiteracy is the biggest need in Arlington</td>
<td>3.5</td>
<td>3.6</td>
<td>3.7</td>
<td>3.5</td>
<td>3.7</td>
<td>3.6</td>
</tr>
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<td>Homelessness/hunger is the biggest need in Arlington</td>
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<td>3.2</td>
<td>3.8</td>
<td>3.1</td>
<td>3.7</td>
<td>3.4</td>
</tr>
<tr>
<td>I know where to find out what MH services exist</td>
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<td>3.3</td>
<td>3.0</td>
<td>3.5</td>
<td>3.4</td>
<td>3.3</td>
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<td>Mental Illness is the biggest need in Arlington</td>
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<td>3.4</td>
<td>3.5</td>
<td>3.1</td>
<td>3.5</td>
<td>3.3</td>
</tr>
<tr>
<td>Unemployment/underemployment is the biggest need in Arlington</td>
<td>3.3</td>
<td>4.2</td>
<td>4.5</td>
<td>3.4</td>
<td>3.1</td>
<td>3.3</td>
</tr>
<tr>
<td>Family distress/stress and life crisis is the biggest need in Arlington</td>
<td>3.4</td>
<td>3.5</td>
<td>2.9</td>
<td>3.1</td>
<td>3.2</td>
<td>3.2</td>
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<td>Inadequate Financial Resources are the biggest need in Arlington</td>
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<td>3.1</td>
<td>3.4</td>
<td>3.2</td>
<td>3.4</td>
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</tr>
<tr>
<td>Neighborhood disintegration is the biggest need in Arlington</td>
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<td>2.9</td>
<td>4.0</td>
<td>2.5</td>
<td>4.5</td>
<td>3.2</td>
</tr>
<tr>
<td>Physical illness/health problems are the biggest need in Arlington</td>
<td>3.3</td>
<td>3.2</td>
<td>3.1</td>
<td>2.9</td>
<td>3.4</td>
<td>3.2</td>
</tr>
<tr>
<td>I rely on my friends to help solve MH services</td>
<td>2.4</td>
<td>2.0</td>
<td>4.4</td>
<td>1.9</td>
<td>4.4</td>
<td>3.0</td>
</tr>
<tr>
<td>I rely on my neighbors MH services</td>
<td>1.9</td>
<td>1.8</td>
<td>4.1</td>
<td>2.3</td>
<td>4.5</td>
<td>2.9</td>
</tr>
<tr>
<td>I know what mental health (MH) services exist</td>
<td>2.1</td>
<td>2.3</td>
<td>2.2</td>
<td>3.0</td>
<td>3.0</td>
<td>2.5</td>
</tr>
<tr>
<td>Discrimination is the biggest need in Arlington</td>
<td>2.4</td>
<td>2.1</td>
<td>2.3</td>
<td>2.4</td>
<td>3.0</td>
<td>2.4</td>
</tr>
<tr>
<td>Isolation is the biggest need in Arlington</td>
<td>2.3</td>
<td>2.4</td>
<td>2.2</td>
<td>2.1</td>
<td>2.3</td>
<td>2.3</td>
</tr>
<tr>
<td>Lack of affordable housing is the biggest need in Arlington</td>
<td>1.1</td>
<td>1.4</td>
<td>3.4</td>
<td>2.1</td>
<td>2.9</td>
<td>2.2</td>
</tr>
<tr>
<td>Physical disabilities are the biggest need in Arlington</td>
<td>2.2</td>
<td>2.1</td>
<td>2.4</td>
<td>2.1</td>
<td>2.2</td>
<td>2.2</td>
</tr>
<tr>
<td>Lack of Developmental Disability services is the biggest need in Arlington</td>
<td>2.1</td>
<td>2.2</td>
<td>1.9</td>
<td>2.1</td>
<td>2.3</td>
<td>2.1</td>
</tr>
<tr>
<td>I rely on professional to help solve MH services</td>
<td>2.1</td>
<td>2.3</td>
<td>1.9</td>
<td>2.3</td>
<td>1.3</td>
<td>1.9</td>
</tr>
<tr>
<td>Disasters/unsafe and life threatening environments are the biggest need</td>
<td>1.3</td>
<td>1.4</td>
<td>1.5</td>
<td>1.2</td>
<td>1.4</td>
<td>1.4</td>
</tr>
</tbody>
</table>

* = Average response on a 5 point scale where 1 = strongly disagree; 2 = disagree, 3 = unsure, 4 = agree and 5 = strongly agree.
Sample survey: 100 households randomly selected, 20 from each neighborhood.
Appendix B: Public Forum Testimony

A KERA sponsored public forum on Community Mental Health Needs was held on June 12, 2007, from 6-9 p.m. at Vandergriff Park. Below is a summary of the testimony of 31 citizens, 15 agency representatives, and 5 elected officials that was recorded and summarized by staff.

<table>
<thead>
<tr>
<th>Testimony</th>
<th>Times mentioned &amp; and by whom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Praise to KERA for taking the lead</td>
<td>21 citizens/agency representatives/elected officials</td>
</tr>
<tr>
<td>Many people should be involved in solving MH problems</td>
<td>15 citizens/agency representatives/elected officials</td>
</tr>
<tr>
<td>A survey should be conducted in person not by phone</td>
<td>19 citizens</td>
</tr>
<tr>
<td>Unable to afford services</td>
<td>17 citizens</td>
</tr>
<tr>
<td>Unable to find appropriate services</td>
<td>16 citizens</td>
</tr>
<tr>
<td>Print the process/survey in the newspaper</td>
<td>11 citizens</td>
</tr>
<tr>
<td>Experts need to be involved</td>
<td>9 agency representatives</td>
</tr>
<tr>
<td>Transportation is a problem</td>
<td>7 agency representatives</td>
</tr>
</tbody>
</table>

A second public forum was held by KERA September 5, 2007, 6-9 p.m. in Arlington City Council Chambers to discuss what could be done to improve the Mental Health of Arlington Citizens. A United Way booklet containing the list of existing Arlington Mental Health Agencies was handed out for information and corrections. Prior to accepting testimony, United Way survey data was presented to the audience. The testimony of 53 citizens, 17 agency representatives, and 2 elected officials who attended is summarized below.

<table>
<thead>
<tr>
<th>Testimony</th>
<th>Times mentioned &amp; and by whom</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information on services is hard to find</td>
<td>35 citizens/agency representatives</td>
</tr>
<tr>
<td>Teenage pregnancy is a problem</td>
<td>24 citizens/agency representatives</td>
</tr>
<tr>
<td>Current information on services is unreliable</td>
<td>22 citizens</td>
</tr>
<tr>
<td>Arlington is becoming unsafe</td>
<td>19 citizens/elected officials</td>
</tr>
<tr>
<td>Our youth have nothing to do</td>
<td>18 citizens</td>
</tr>
<tr>
<td>Schools should teach how to be mental health</td>
<td>18 citizens</td>
</tr>
<tr>
<td>I&amp;R services must cover Dallas &amp; Tarrant CO</td>
<td>17 citizens/agency representatives</td>
</tr>
<tr>
<td>Arl lacks services to keep the aged at home</td>
<td>14 citizens/agency representatives</td>
</tr>
<tr>
<td>Children and youth have nothing to do</td>
<td>13 citizens</td>
</tr>
<tr>
<td>People cannot afford mental health care</td>
<td>11 citizens</td>
</tr>
<tr>
<td>Transportation to services is a problem</td>
<td>8 citizens/agency representatives</td>
</tr>
<tr>
<td>Mental health is not taught in the schools</td>
<td>8 citizens</td>
</tr>
<tr>
<td>Arlington has an unacceptable infant mortality rate</td>
<td>6 health professionals</td>
</tr>
<tr>
<td>Some children go to bed hungry</td>
<td>4 citizens/agency representatives</td>
</tr>
<tr>
<td>People must travel to receive AIDS services</td>
<td>3 citizens</td>
</tr>
<tr>
<td>Jogging paths are needed; jogging promotes MH</td>
<td>1 consumer</td>
</tr>
<tr>
<td>Pornography causes Arlington's MH problems</td>
<td>1 consumer</td>
</tr>
</tbody>
</table>