DOCUMENT RESUME

ED 024 782 08 VT 005 724

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A Clinical Workshop in Mental Health and Psychiatric Nursing for Instructors in Schools of Practical Nursing. Final Report.

Kentucky Research Coordinating Unit, Lexington.; Kentucky State Dept. of Education, Frankfort. Bureau of Vocational Education.

Spons Agency- Office of Education (DHEW), Washington, D.C.

Bureau No- BR-7-0544

Pub Date Feb 68

Grant- OEG-1-7-070544-3759

Note- 77p.

EDRS Price MF-$0.50 HC-$3.95

Descriptors- Clinical Experience, Communication (Thought Transfer), Community Health, Health Occupations Education, Hospitals, *Mental Health, *Mental Illness, Mental Retardation, Nurses, Practical Nurses, *Practical Nursing, Program Descriptions, Program Evaluation, Psychiatric Hospitals, Psychiatric Services, *Teacher Workshops

Identifiers- Kentucky

Twenty directors and instructors in schools of practical nursing in Kentucky and a total of nine directors and instructors from six other states and the District of Columbia attended a 2-week workshop at the University of Kentucky in July 1967. The purpose was to assist participants to integrate mental health concepts into the practical nurse curriculum, improve instruction in psychiatric nursing, and to acquire knowledge about the newest materials and latest techniques and skills in the field. Kentucky State Hospital provided clinical experience, and field trips were made to Frankfort State Hospital and Home for Mentally Retarded and to the National Institute of Mental Health Clinical Research Center. Methods included films, tours, lectures, demonstrations, student-patient conferences, and student-faculty conferences. The National League for Nursing Psychiatric Nursing Achievement Test was used for pre- and post-testing; the group mean score was at the 32nd percentile on the pretest and at the 72nd percentile on the post-test. Abstracts of speeches included in the report are "Present and Future Trends of Mental Health," "Utilizing Mental Health Concepts in the General Hospital Setting," "Mental Health Concepts," "Communicating," "Mental Retardation," "Utilization of the Practical Nurse in Mental Health," and "Community Mental Health." (JK)

FINAL REPORT

Project No. 7-0544 PA-08
Grant No. OEG 1-7-070544-3759

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February 1968

U.S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

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A CLINICAL WORKSHOP IN MENTAL HEALTH AND PSYCHIATRIC NURSING FOR INSTRUCTORS IN SCHOOLS OF PRACTICAL NURSING

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in cooperation with the

Bureau of Vocational Education
State Department of Education
Frankfort, Kentucky

February 1968

The research reported herein was performed pursuant to a grant with the Office of Education, Bureau of Research, U. S. Department of Health, Education, and Welfare. Contractors undertaking such projects under Government sponsorship are encouraged to express freely their professional judgment in the conduct of the project. Points of view or opinions stated do not, therefore, necessarily represent official Office of Education position or policy.

U. S. DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE

Office of Education
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ACKNOWLEDGMENTS

We gratefully acknowledge our indebtedness to Dr. Dale Farabee, Commissioner, Kentucky Department of Mental Health; Dr. Mehmet Arik, Superintendent, Kentucky State Hospital; and Mrs. Tressa Roche, Director of Nursing Service, Kentucky State Hospital. Without the active support and continued participation of these administrative personnel, this workshop would not have been possible. The entire staff of Kentucky State Hospital cooperated throughout the planning and operation of the workshop to assist in making it effective and pleasant.

Mrs. Virginia Gudgel deserves a special accolade for her untiring efforts from the moment she suggested a workshop until it was completed.

We would also like to express our appreciation and thanks to the professional staff of the Frankfort State Hospital and School and the National Institute of Mental Health Clinical Research Center. Through their efforts and careful planning, the field trips were very meaningful experiences.

The attention and efforts of my secretary, Miss Norma Stivers, and the workshop secretary, Mrs. Mary Frances Lawson, were untiring and deserving of special recognition.

Doris Schmidt, Coordinator

A. SUMMARY

Twenty directors and instructors in schools of practical nursing in Kentucky and a total of nine directors and instructors from Colorado, the District of Columbia, Illinois, New Hampshire, New Mexico, Virginia and West Virginia attended a two week clinical workshop in Mental Health and Psychiatric Nursing at the University of Kentucky, Lexington, Kentucky and Danville State Hospital, Danville, Kentucky, in July, 1967. The workshop was sponsored by the Bureau of Vocational Education, Kentucky Department of Education, and the Kentucky Research Coordinating Unit for Vocational Education, College of Education, University of Kentucky, Lexington, Kentucky.

The workshop was designed to meet the expressed needs for better preparation to teach mental health concepts of instructors in schools of practical nursing, and had as its objectives:

1. To assist instructors to integrate mental health concepts into the practical nurse curriculum and to improve instruction in psychiatric nursing; and

2. to acquire knowledge of the newest materials and latest techniques and skills in mental health and psychiatric nursing.

Professional staff from the Bureau of Vocational Education, Kentucky Research Coordinating Unit for Vocational Education, The Kentucky Department of Mental Health, the Kentucky State Department of Health, Kentucky and Central State Hospitals, The National Institute of Mental Health Clinical Research Center at Lexington, The Frankfort State Hospital and School, and two psychiatric nurse specialists served as faculty.

Trainees were assigned participant observer experiences with patients, observed group therapy, and an Alcoholics Anonymous meeting, reviewed and discussed films, attended lectures and clinical presentations, toured a state hospital, the NIMH Clinical Research Center, Lexington, and the Frankfort State Hospital and School.

They prepared instructional materials and reviewed these, as well as daily work assignments and interaction notes with psychiatric

nurse faculty members.

By fall, 1967, all students enrolled in schools of practical nursing in Kentucky will have instruction, including clinical practice, in psychiatric nursing in the basic curriculum.

Several trainees from out-of-state were either planning or interested in exploring facilities and resources for teaching mental health and psychiatric nursing.

All trainees recognized the need to identify and teach the mental health aspects of nursing care in all courses. Each trainee prepared a sample lesson plan demonstrating this. These lesson plans included Personal and Vocational Relations, Nursing Fundamentals, Geriatrics, Medical and Surgical Nursing, Orthopedics and long term illness, Obstetrics, and Psychiatric Nursing.

An observer attended all sessions, accompanied trainees and faculty members on tours, and reported his observations at the close of the workshop.

B. INTRODUCTION

The clinical workshop described in this report was planned to promote and assist in the integration of mental health and psychiatric concepts into the total curriculum of the practical nurse educational program.

The practical nurse has contributed significantly to the care of patients in all types of health facilities over the years. She has achieved status and recognition for her performance in meeting the physical needs of all age groups with all degrees of disability. She is a valuable resource of health manpower. However, her focus on the patient's physiology has been to the near exclusion of his world of emotions. This state of emphasis has coexisted with the knowledge that man is a trifurcate being -- that his psychological and sociological states are as important to his total well being as his physiological good health. It is apparent that some shift in emphasis must be made to enable this large group of health workers to become more effective in meeting all of the needs of the patient.

It is reported that at least one person in every ten has some form of mental or emotional illness that needs psychiatric treatment.[1] It is further reported that "there are more people in hospitals with mental illness, at any one time than with all other diseases combined . . . ."[2] The lack of manpower is a crucial issue in mental institutions. Services and care are restricted because of the lack of adequately trained personnel. A majority of patients in state mental hospitals receive only custodial care instead of intensive treatment necessary for rehabilitation and recovery. The possibilities of obtaining sufficient professional personnel is very remote in the foreseeable future and it appears mandatory that some action must be taken to cope with the problem. The licensed practical nurse population is a resource sufficient in number to help fill the ever-widening gap of needed manpower. This is possible if her educational program is broadened to include psychiatric and mental health concepts. Consideration must be given as to how she can be taught to carry on varied therapeutic roles with patients and participate as an effective, sensitive member of the psychiatric nursing team. It has been demonstrated that the licensed practical nurse can function effectively

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[1]The National Association for Mental Health. "Facts About Mental Illness," 1966 Fact Sheet. New York.

[2]Ibid.

and efficiently in a psychiatric setting. However, unless she has some orientation and experience in the psychiatric hospital as a student she will generally avoid seeking employment in such an institution as a practitioner.

The mental institution is only one employing agency needing nurses trained in mental health principles. According to the 1966 Fact Sheet, "Facts About Mental Illness," at least fifty per cent of all the millions of medical and surgical cases treated by private doctors and hospitals have a mental illness complication."[3] The majority of licensed practical nurses seek employment in general hospitals where they have daily contact with individuals experiencing all degrees of emotional stress in the vast area of continuum between demonstrable physical illness and clearly defined mental disorders. Recognition of emotional symptoms, understanding behavior, and clear and adequate communications are important factors that the practical nurse must know to skillfully handle emotional stress problems.

The newer trends in treating mental illness are away from hospitalization and toward preventive action in the community. Because today's society is more accepting of mental illness, it is possible to give short term treatment in the community, to use group and family therapy, and to maintain day care centers. The practical nurse must be knowledgeable about the new concepts and available facilities if she is to assist in preventive measures, aid in rehabilitation, and promote optimum mental health.

In contemporary American society, mental health problems are at an all time high. We are living in a time of great social and economic change. The impact on many is overwhelming and precipitates behavior that is opposed to accepted standards. Alcoholism, drug addiction, and suicides have increased at alarming rates and are indicative of the depth and destructive force of the mental stress. The use of hallucinatory drugs, bizarre dress and action, and general revolt against authority among many young people are symptoms of mental frustrations. The nurse needs to recognize these emotional reactions as behavior which have meaning but be able to accept the individual without prejudicial judgment.

To prepare the practical nurse for her role in assuming new dimensions in the field of mental health and for carrying out her responsibility in giving total nursing care, this workshop was initiated for instructiors in practical nurse programs. Through this medium it is hoped that the

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[3] Ibid.

ultimate goal will be reached: a supply of practical nurses with an understanding of mental health problems and an interest in contributing to the development of a higher level of mental health care.

C. THE WORKSHOP

The workshop was planned by a committee representing the Bureau of Vocational Education, the Kentucky Research Coordinating Unit for Vocational Education, and Kentucky Practical Nurse Programs. Personnel from each agency participating in the program were also involved in the planning stages of the workshop.

1. Workshop Objectives

The proposed workshop is designed to contribute significantly to integrating mental health concepts into the total practical nurse curriculum and enhance the psychiatric affiliations. The objectives of the workshop are to assist instructors in schools of practical nursing to:

a. Integrate mental health concepts into the practical nurse curriculum and to improve instruction in psychiatric nursing.

b. Acquire knowledge about the newest materials and latest techniques and skills in mental health and psychiatric nursing.

2. Student Selection

Thirty students were selected from a group of registered nurse applicants actively engaged in instruction of practical nurse students. Twenty were selected from Kentucky, and ten were selected from other states with preference to Region III applicants.

There were thirty-two Kentucky applicants and twelve out-of-state applicants. The selection committee agreed to give first preference to individuals who had no basic psychiatric experience, and to allow only two from any one state other than Kentucky. There were three applicants from West Virginia, and the two with least psychiatric experience were selected. Twenty Kentucky applicants and ten applicants from seven other states were selected. One applicant from Virginia did not attend due to a crisis at home, and notice was received too late to notify an alternate.

3. Faculty Orientation

The Director, Assistant Director, and Coordinator met with a

faculty member in May to discuss the program and make specific plans. The assistant director and coordinator spent two days at Kentucky State Hospital in Danville to orient staff to the workshop objectives, and to be oriented to the hospital policies and treatment program.

4. Facilities

The University of Kentucky, Lexington, Kentucky, provided classroom facilities for the workshop. Two hours of resident college credit at the graduate for undergraduate level was possible for those eligible for admission to the University of Kentucky.

Kentucky State Hospital, Danville, Kentucky, was selected as the clinical facility. The hospital has 41 wards including an alcoholic unit. The daily census averages 1,100 patients. The twelve departments of clinical services in the hospital organization provided the trainees an over-view of the relationship of the various disciplines for the purpose of patient care and rehabilitation.

5. Resources

Students were sent a bibliography of mental health and psychiatric books, a list of journal articles, and a form to be completed and returned to the coordinator indicating the nursing course in which mental health and psychiatric nursing principles would be integrated. Integrating these principles into a course was one of the requirements.

Each trainee received a packet of books, reprints and booklets for her personal use. In addition, the library resources of the Kentucky State Hospital and the Danville School of Practical Nursing were available for use by students. The assistant director, coordinator and two faculty members were available to discuss projects in individual or group conferences. One faculty member held individual conferences with all students to discuss their clinical experience interaction notes.

Students participated in two field trips. They spent a full day at the National Institute of Mental Health Clinical Research Center. They toured patient-care facilities, and vocational and recreational therapy units. Presentations on programs and therapy were given by the professional staff of the Research Center, and students were given time to have their questions answered by the professional staff.

The students spent a full day on their second field trip, also. This trip took them to Frankfort State Hospital where mental retardation patients were presented after discussion of a short case history and

diagnosis for each patient. Students visited the patient-care areas, the workshop and resident school. All students attended a case conference in which a psychiatrist, social worker, nurse, rehabilitation counselor, and several other key personnel discussed a patient's progress and made plans for continued care.

6. Workshop Program

Topics included in the workshop were mental health trends, personality growth and development, communications, interaction, social and psychological aspects of patient care in general and psychiatric hospitals, mental retardation, drug addiction, alcoholism, geriatrics and new therapy concepts. Teaching aids and integration of mental health concepts into practical nurse curriculum were also presented and discussed.

Students spent more than ten hours in the patient areas on tours, orientation to the wards, observation of the group process, and in direct patient contact. Nineteen hours were spent listening to lectures and participating in discussions ofgeriatrics, growth and development and personality, mental health, group therapy, drugs, communication, alcoholism, addiction, mental retardation and community mental health. Six hours were spent viewing films and discussing their content. Areas covered were growth and development, patient support, communication and mental retardation. Time spent in individual and group conferences varied according to each student's needs.

D. EVALUATION

Evaluation forms were distributed to participants for the purpose of obtaining both positive and negative reactions. Suggestions and recommendations will be considered in planning for future workshops. The participants were requested to reflect on the total two weeks and to be completely honest in their response. Signatures were purposely omitted.

The tabulation of the participants' evaluation of the total workshop indicated that the outstanding features were the field trips, guest lecturers, and planned sequence of topics. There was unanimous agreement that the workshop achieved its stated objectives and that it was considered a worthwhile experience.

Other aspects of the workshop that elicited favorable commendation were: clinical assignments, availability of faculty for consultation, orientation, and books and hand-out materials presented to the participants.

The scheduled workshop hours (8 a.m. to 1 p.m., with one 20-30 minute break) were strongly criticized. However, most participants modified their criticism with comments regarding the reasoning in making the decision. Six days were scheduled in the clinical area at a state mental institution located about seven miles from the city limits. Public transportation was not available. Although the hospital dining facilities were available, the burden of 35-40 additional guests would possibly have overtaxed the food service personnel and added confusion to the space already in maximum use. A late leisurely lunch at a restaurant of one's choice without additional transportation problems seemed to be the most desirable solution.

After some verbal complaints were expressed regarding the late lunch, the participants were presented with the facts of the situation and then given a choice of maintaining the schedule as planned or dismissing for lunch at 11:30 a.m. and returning in the afternoon for the 1 1/2 hours of planned program. The group voted to stay in session until 1 p.m.

A second criticism related to the anxiety caused by the assignment of individual projects.

With the above two exceptions the evaluations and comments by the participants were very favorable. Most enjoyed the opportunity to exchange ideas and views with the other teachers, having the opportunity to be in the student role, and patient contact assignments.

PARTICIPANT EVALUATION

of

A Clinical Workshop in Mental Health and
Psychiatric Nursing for Instructors in Schools
of Practical Nursing
July 17 - 28, 1967

Directions: Please indicate your opinion by a check mark in the appropriate column.

	Very Much	Much	Little	Very Little
1. To what extent did sessions help reach the purposes of the workshop?	22	5		
2. To what extent were the ideas and methods discussed helpful to you?	21	6		
3. To what extent were the individual projects of concern and helpful to you?	9	13	3	
4. To what extent was the clinical assignment meaningful to you?	5	17	3	1
5. To what extent were the field trips helpful in gaining a better understanding of mental health concepts and psychiatric nursing?	23	4		
6. To what extent did the members of the group help toward the solution of your problems?	6	13	6	

	Very Much	Much	Little	Very Little
7. To what extent were bibliographic readings used in helping to solve problems?	4	10	7	4
8. To what extent do you think the workshop will be helpful in improving your curriculum?	13	13	1	____
9. To what extent do you feel that the workshop has helped you to become acquainted with, and to understand and appreciate mental health concepts and psychiatric nursing?	21	5	____	____
10. To what extent do you consider the workshop to have been a worthwhile experience?	26	1	____	____

SAMPLES OF TYPICAL RESPONSES FROM EVALUATION OF WORKSHOP MECHANICS

1. Were pre-workshop instructions adequate?

   Yes -- 26 No -- 1

2. Were accommodations satisfactory?

   Yes -- 26

3. Was program scheduling effective?

   a. A great deal of thought and planning was obvious, otherwise how could so much content presented by so many experts have been possible in so short a time. It was terrific!

   b. I would rather have gone through the lunch hour as we did and complete the sessions; however, I did get quite hungry and this makes it difficult to listen and learn.

   c. I know there was some criticism of the schedule. However, I liked having the program over at 1 p.m. and not having to return.

   d. There was very good sequence of events in the schedule.

4. Were workshop hours suitable?

   a. A little long, but I believe the planners made the best choice.

   b. No. I think lunch would have helped both physically and mentally.

   c. Yes! A workshop is a workshop!

   d. Although the group voted for lunch following the program, I believe we should have had lunch at a regular time.

5. Were social functions adequate for you to become acquainted with

other participants and provide sufficient relaxation?

a. Most participants too busy with homework.

b. Formal social functions were not necessary.

c. Another evening social function would have been nice. Picnic an excellent idea.

d. Relaxing was hard to do. Getting acquainted easy.

6. What do you consider the workshop's strong points?

a. Content. Excellent speakers and field trips.

b. Field trips, rich content.

c. The guest speakers and their information. Field trips.

d. Outstanding program. Well planned content.

7. What do you consider the workshop's weak points?

a. Felt need of a lunch period.

b. Omission of a regular lunch hour.

c. Very few. Perhaps the schedule was a little too long and I missed lunch.

d. I did not enjoy the presentation of projects. Not enough time to absorb what I learned.

8. Suggestions or comments.

a. This has been a very rewarding experience.

b. I feel the Kentucky people did everything possible to accommodate the out-of-state people. Of the many workshops this was one of the most stimulating and very much appreciated.

c. An excellent workshop, program and faculty. Excellent organization of material in proper sequence.

d. Every practical nurse instructor should have the opportunity to participate in a similar workshop.

e. I am impressed. What are you planning for next summer?

E. CONCLUSIONS AND RECOMMENDATIONS

The purpose of the workshop was to create an awareness of the need to integrate mental health concepts into the practical nurse program, and to develop new techniques and skills in implementing a mental health philosophy into the curriculum. The attitude of the students made them very receptive to the workshop goals. The Kentucky instructors were influenced by the fact that all Kentucky Schools of Practical Nursing planned to have psychiatric content and clinical experience in the fall. The students from other states stated their state supervisors had expressed the hope that psychiatric principles and experience would be offered in their schools in the near future. Knowing they would be using the knowledge gained in the workshop may have stimulated the high interest of the students.

Students were most enthusiastic about the opportunity for patient contact, and the conferences to discuss their interaction notes. They selected their projects before the workshop started, and started working on them immediately. A few changed their minds and selected a new topic. In most cases, this was done in order to work with a particular group. One student stated she was scheduled to give a report on the workshop at the next state meeting for instructors in Schools of Practical Nursing.

The students gave oral reports of their projects to the group. Most of them had made considerable progress toward integrating mental health concepts in the curriculum and they indicated that they would be able to continue working toward that goal at home.

Several recommendations can be made as a result of the workshop. Similar workshops should be held for instructors who have not had psychiatric nursing courses or experience since results of the pretest and post test indicate considerable understanding of psychiatric nursing principles can be gained by students in a two-week workshop. A plan to continue contact with students when they finalize their planning and actually begin to implement the new curriculum should be considered. It is probable that their peers in the home schools might reject their proposed curriculum since these peers have not been exposed to the same learning experience. Continued contact with the workshop faculty, or a follow-up conference might be helpful to the students.

APPENDIX A

Student Statistics

The following tables represent data taken from the applications submitted by students.

TABLE 1

YEARS STUDENTS EMPLOYED IN PRESENT POSITION

Years in Position	Number	Percentage
Less than one	3	10
More than one, less than three	10	35
More than three, less than six	4	14
More than six, less than ten	9	31
More than ten	3	10
Total	29	100

Forty-five per cent have been in their present position less than three years. Forty-one per cent have been in their present position six or more years.

TABLE 2

NUMBER OF YEARS OF TEACHING EXPERIENCE REPORTED BY STUDENTS

Number of Years in Teaching	Number	Percentage
Less than one	1	4
More than one, less than three	5	17

Appendix A

TABLE 2--Continued

Number of Years in Teaching	Number	Percentage
More than three, less than six	5	17
More than six, less than ten	9	31
More than ten	9	31
Total	29	100

TABLE 3

BASIC NURSING PROGRAM PREPARATION OF STUDENTS

Type of Program	Number
Diploma	25
Associate Degree	0
Baccalaureate	4
Total	29

TABLE 4

LEVEL OF EDUCATION OF WORKSHOP STUDENTS

Level of Education	Number
Diploma and less than 10 credits	5
Diploma - more than 10, less than 50 credits	13
Diploma - more than 50, no degree	4
Baccalaureate degree	3
Baccalaureate degree plus credits	4
Total	29

TABLE 5

PREVIOUS AFFILIATION, COURSES, OR WORK EXPERIENCE IN PSYCHIATRIC NURSING REPORTED BY STUDENTS

Type of Psychiatric Experience	Yes	No
Psychiatric Affiliation in Basic Program	15	14
Course(s) in Psychiatric Nursing	5	24
Work Experience in Psychiatric Setting	9	20

Nine of the students indicated they had no previous experience or course in psychiatric nursing.

Over two-thirds of the students belonged to the American Nurses Association, American Vocational Association, and the National Education Association. Twelve of the students held office(s) in their organizations or had served on the state board. None had held a regional or national office.

TABLE 6

MEMBERSHIP IN PROFESSIONAL ORGANIZATIONS OF STUDENTS

Organization	Number
ANA only	4
ANA and NEA	3
ANA and NLN	1
ANA, AVA, and NEA	16
ANA, AVA, NEA, AND NLN	5
Total	29

TABLE 7

PROFESSIONAL ORGANIZATION OFFICE(s) HELD BY STUDENTS

Level of Organization in Which Office Held	Number
District	2
State	3
District and State	6
None	17
Total	28

The students took the National League for Nursing Psychiatric Nursing Achievement Test on the first morning of the workshop, and at the end of the workshop.

Six of the nine students with no previous psychiatric nursing course(s) or experience scored below the thirtieth percentile on the pre-test.

TABLE 8

N.L.N. PRE TEST AND POST TEST PSYCHIATRIC NURSING TEST USING TOTAL-ALL PERCENTILE-SCORES

Total-All Percentile Score	Pre Test	Post Test
0 - 29	13	6
30 - 69	8	5
70 - 99	8	18
Total	29	29

Slightly greater gains were made on the Facts and Principles Section of the NLN Psychiatric Nursing Achievement Test than on the Nursing Practice Section.

TABLE 9

STUDENT PERFORMANCE ON NURSING PRACTICE SECTION OF NLN PSYCHIATRIC NURSING TEST

Percentile	Pre Test	Post Test
0 - 49	55.1%	34.5%
50 - 99	44.9%	65.5%

TABLE 10

STUDENT PERFORMANCE ON FACTS AND PRINCIPLES SECTION OF NLN PSYCHIATRIC NURSING TEST

Percentile	Pre Test	Post Test
0 - 49	58.6%	27.6%
50 - 99	41.4%	72.4%

APPENDIX B

Daily Schedule

Monday, July 17

8:00	Registration	Mrs. Charlotte Denny
8:30	Welcome	Dr. Stanley Wall
8:45	Orientation to the workshop	Dr. Carl F. Lamar
9:00	Introduction and Announcements	Mrs. Doris Schmidt
9:45	Pre-Test	Mrs. Doris Schmidt
11:15	"Present and Future Trends of Mental Health"	Dr. Dale Farabee
12:30	General Assembly	Mrs. Doris Schmidt

Tuesday, July 18

8:00	Orientation to the Kentucky State Hospital and Introduction of the Staff	Mr. Joseph C. Burgio
8:30	Orientation to the Clinical Departments of the Hospital: Nursing, Social Service, Psychology, Occupational Therapy, Recreational Therapy, and Rehabilitation	Dr. Mehmet Arik
9:45	Tour of the Hospital Clinical Areas	Mrs. Joanne Woods
11:30	Group and Individual Assignments	Mrs. Doris Schmidt
1:00	Film courtesy Danville Chamber of Commerce	Mrs. Doris Schmidt
3:00	Covered Wagon Tour of Danville by Chamber of Commerce	Mrs. Virginia Gudgel

Wednesday, July 19

8:00	"Personality Growth and Development"	Dr. Willard Dill
9:00	Film: "Preface to a Life," followed by discussion	Dr. Willard Dill
10:15	Ward Assignments	Mrs. Doris Schmidt
12:00	"Mental Health Concepts"	Mrs. Tressa Roche
1:00	Faculty and Kentucky State Hospital Nursing Staff Meeting	Mrs. Doris Schmidt

5:30	Happy Hour at Anne and Pierre's Courtesy Roche Laboratories	
7:30	Dutch Treat Dinner	

Thursday, July 20

8:00	"Using Mental Health Concepts in the Gneral Hospital Setting"	Mrs. Virginia Kilander
9:00	Film: "Mrs. Reynolds Needs a Nurse", followed by discussion	Mrs. Virginia Kilander
10:00	Ward Assignments	Mrs. Doris Schmidt
12:00	"Group Therapy", Demonstration followed by discussion	Mrs. Tressa Roche
2-5	Individual and Group Meetings with Faculty.	
6:00	Pioneer Playhouse	

Friday, July 21

8:00	Film: "The Third Eye", followed by discussion	Miss Cynthia Rector
9:00	"Drugs and Other Treatment Modalities"	Dr. Ray C. Hayes
10:15	Ward Assignments	Mrs. Charlotte Denny
11:45	Individual and Group Meetings	Mrs. Charlotte Denny
12:15	"Communicating"	Miss Linda L. Hays
2:30-5:00	Faculty available for individual and group conferences	

Monday, July 24

8:30	Field trip to National Institute of Mental Health Clinical Research Center, Lexington, Kentucky	
9:00	Welcome	Dr. Robert Rasor Mr. Jay C. Wertman
9:15	Discussion: Activities of the day, distribution of the program	Miss Margaret F. Carroll
10:00	Panel Presentation: Treatment of the Addict Patient, Admission to Discharge	Dr. Jimmie D. Hawthorne Moderator

		Dr. Alfred S. Nelson Dr. Donald D. Pet Mrs. Ruth P. Tweedale Mr. William D. Abbott Mr. Stanley Crawfort Dr. Byron L. Harriman Mr. Clarence E. Morgan
12:00	Film, slides and discussion	Miss Margret F. Carroll
1:30	Walking Tour: Hospital, Recreational and Vocational Facilities (two groups)	Nursing Service Staff
3:00	Discussion, questions, evaluation distribution of literature	Nursing Service Staff

Tuesday, July 25

8:00	Film: "The Patient is a Person", followed by discussion	Mrs. Tressa Roche
9:00	Individual and Group Projects	Mrs. Doris Schmidt
10:30	"Alcoholism" followed by discussion	Mr. Omar L. Greeman
12:00	Film: "The Eye of the Beholder" followed by discussion	Miss Betty Jane Ely
2:00-4:00	Faculty available for individual or group conferences to be arranged	
8:00	Alcoholics Anonymous Meeting, Kentucky State Hospital	

Wednesday, July 26

8:00	Field trip: Frankfort State Hospital and School	
9:00	"Mental Retardation"	Mrs. Bessie McCord
10:30	Tour of Hospital and School	Mrs. Bessie McCord
1:00	Staff Evaluation Conference	Dr. William McFall
2:00	Film: "Introduction to Mental Retardation", followed by discussion	Mrs. Bessie McCord

Appendix B

Thursday, July 27

8:00	"Utilization of the Practical Nurse in Mental Health", followed by discussion	Miss Annie Laurie Crawford
9:00	"Activities for Daily Living" (geriatrics)	Mrs. Tressa Roche
10:45	"Community Mental Health," followed by discussion	Miss Elaine Kiviniemi
11:45	Project reports followed by discussion	Mrs. Virginia Kilander
12:30	Appraisal of reports	Faculty Panel
1:00	Reaction by Participant Observer	Mr. Robert Swift

Friday, July 28

8:00	Trainee - Faculty Evaluation Conference	Mrs. Charlotte Denny
10:00	Post-Test	Mrs. Doris Schmidt
12:00	Summary	Miss Annie Laurie Crawford
12:30	Implications and Projections	Mrs. Doris Schmidt

APPENDIX C

SPEECHES

We regret that because of space limitations only a few of the presentations made during the workshop could be included in this report.

Appendix C

PRESENT AND FUTURE TRENDS OF MENTAL HEALTH

Dr. Dale Farabee

(Summarized from Transcription)

One of the greatest trends in mental health today is the increased interest in the subject at all levels of our society. As recently as 50 years ago, mentally ill and emotionally disturbed persons were looked upon in much of the same attitude as the witches of Salem in the generation before. The persons who succumbed to an emotional disorganization were thought to be weak willed, if not actually in the grip of Satan.

The untiring efforts of Dorothea Dix during the late 19th century produced a change for the better in most of the institutions. Freud and his followers were rapidly contributing much to our knowledge of anxiety, neurosis, and psychosis. In this same period, Dr. Adolph Myer of John Hopkins University was advocating a common sense approach to the treatment of mentally ill and disturbed persons. His work contributed greatly to the advancement, not only of the general medical approach to mental illness, but the strong social work background.

The efforts of Dr. Myer and Freud were to gather momentum and bear great fruit in the first half of the 20th century. The numbers of physicians, nurses, and social workers interested in mental health began to swell. But all too many of these people were held in the ghettos of the institution. The overwhelming mass of persons needing help were unable to get it.

In the mid 1950's, a determined and dedicated research and development team made the tranquilizer available for treatment. Thousands of persons found the means of coping with the disturbance of the mind. Let no one depreciate the impact of this form of pharmacology. The change with this approach was dramatic.

However, much of the gain was lost when the patient went home to face the sad reality that his own community was unable to understand what had happened to him. The need of education for an entire society was made apparent.

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In a single decade we have moved from the hospital as the sole point of treatment to a new concept in which the mental hospital is just one essential link in a versatile complex of community based mental health services. We stand today on the threshold of a fantastic revelation of the mentally disturbed and the mentally retarded. Whether we accomplish this revelation in fact or not, rests with a surprising degree in people like yourself. The trend of present day and future mental health programs is toward preventive action in the community.

To be a community program, the community must be involved. Recent federal legislation supporting the community approach has confined community mental health centers to geographical areas with a maximum population of 200,000 persons. It is assumed that 200,000 people is the maximum number of people that should be served by a comprehensive program whether it be four city blocks or four counties.

A comprehensive mental health center would include five services: in-patient, out-patient, emergency, education, and consultation. These five services need not be under one roof. In fact, they may very well be miles apart. In most areas, particularly in a state such as Kentucky, a collective affiliation of these services is the only possible way to provide them. Special services such as rehabilitation, research, and training are needed for affiliated programs. These services would also affiliate and communicate with multiple other health services in the community.

In-patient facilities frequently are not available to a patient in his community when the primary diagnosis is psychiatric illness. We must, through every means possible, prepare a program for in-patient services that will utilize a nearby community agency.

Many people do not need 24 hour care. In the local setting 12 hour hospitalization care is possible or overnight, or day care. But this cannot be done when home is 100 miles away from the only psychiatric hospital facility. Transportation problems are too complex. Local agencies working together can educate and provide assistance in developing a therapeutic community for their own people. We need desperately to train a new breed of mental health workers to support the highly trained professionals. We need to train and use physicians, psychologists, nurses, and social workers as catalyst in leadership for a great number of lesser trained persons.

Appendix C

The chances of keeping the mentally ill patient in society are relative to the means available to accomplish it. To this end the community health centers are utilizing the housewife, the senior college graduate, and even the school drop-out as resources.

Family therapy, treatment in the neighborhood, treatment in the home, utilizing teams of people is a coming thing in many community programs. The development of a community alcohol program, youth service bureaus, and total social service programs revolving around community information and referral programs are very much indicated in the future.

We know that comprehensive community care programs must be provided to the patients if we are to bring them quickly back to ample social membership. But, we also know that the staff providing these services must themselves be comprehensive in their approach. In short, we must have a team approach, an interdisciplinary approach, a willingness to utilize collectively the knowledge and skills and interest all of our people working in the mental health and mental retardation area.

A fundamental trend in treatment in the community is the home visit. This requires interaction with other agencies such as public health, child guidance centers, school counselors, public assistance workers, juvenile court, police, etc. The family visitation team can cross refer or be used for referral to prevent hopeless duplication of effort and to provide a full range of social and health services. Centralized information, referral and screening services must be developed as a nerve center for the entire community. Consultations can be provided through a staff of professionals,but many laymen are much more effective in educating their peers. We must develop programs to utilize their skill.

In effect, this new program does not ignore or reject the concept of mental hospitals or hospitalization for mental illness or mental retardation. It does mean that it is a more selective process. The mental hospital will have the opportunity to concentrate on the things for which it was designed -- treatment of acutely ill patients.

Appendix C

UTILIZING MENTAL HEALTH CONCEPTS IN THE GENERAL HOSPITAL SETTING

Virginia Kilander

(Abstract)

We have all heard that mental health is the nation's Number One health problem and that our greatest hope for reducing the magnitude of this problem is through education on a broad scale. There are many handicaps to overcome in mental health education since we as a people generally reject mental illness and individuals who have problems which have a known emotional basis. Time and again we have been told that emotional factors and not physical causes account for at least fifty per cent of the visits that patients make to their doctors. This kind of information helps us realize the significance of including understandings and skills related to mental health in the educational programs of all those who help other people during stressful periods. We in nursing have been somewhat unrealistic in expecting students to automatically transfer their knowledge of psychiatric nursing principles to all other areas of nursing; not all students are able to do this. Many fail to recognize the significance of the general hospital patient's emotional distress and reject the patient because they cannot cope with the problems he presents.

Recognition that during illness people have increased anxiety which is brought about by the stress of illness and concern about its outcome is the first step for the health professional; acquiring the skills to help the patient live with the stress until it is relieved is the second step. These understandings and skills are basic to all of nursing and provide the background for dealing with the more profoundly immobilizing problems of the psychotic patient.

The core of psychiatric nursing is the nurse-patient relationship; this relationship will be therapeutic when the nurse develops skill in recognizing why the patient feels, thinks, and behaves as he does and acquires skill in recognizing why she reacts toward the patient as she does. If a relationship is to become therapeutic, the nurse must see the patient as a unique, important human being and accept the concept that all human behavior has meaning and is a response to a need which the patient has. As she learns to know

him, she develops some understanding of his emotional responses and the meaning of his behavior. This makes it possible for her to identify his emotional needs and be helpful to him. Basic human needs of warmth, love, and self-respect are satisfied through interactions with other people. Nursing offers many opportunities for close interactions with patients; the interpersonal relationship is characteristic of all nursing activities whether they are short-term or long.

By studying the interaction which takes place between nurse and patient we are often able to get clues which help us to understand and plan care for the patient. As students record their interaction they often see things about themselves and about their patients which they failed to recognize at the time they were interacting.

Basic understandings and skills of communication and counseling are utilized in everyday contacts with patients. Focusing on the patient, learning to listen, being emotionally honest with oneself, and recognizing meaning in verbal and nonverbal communication are all significant in studying nurse-patient interaction.

As students are encouraged to identify how they feel in relation to nursing situations, they learn how their feelings and behavior influence patients. There are sometimes strong feelings associated with aspects of growth and development, maternal and child care, and the suitability of pain and discomfort. Nursing situations which create strong feelings should be discussed permissively and problem solving methods utilized to resolve the difficulties associated with them. Aspects of anxiety, authoritarianism, dependence, and hostility should be explored when they occur in the nurse-patient relationship and attention directed towards appropriate methods of handling them.

Appendix C

MENTAL HEALTH CONCEPTS

Tressa Roche

The general purpose of this workshop is to integrate mental health concepts into the practical nurse curriculum. The purpose of this session is to discuss mental health concepts. Specifically, what are mental health concepts? At the risk of repeating what you have already heard and already know, I must break it down further and ask, "What does mental health mean?" and "What is a concept?"

Mental health generally means soundness of mind. An individual is said to be mentally healthy when his mind can resolve conflicts and adjust to stress, in such a manner that his behavior is considered "normal". However, there is no sharp line between normal and abnormal behavior and it is not safe to use terms in talking about people, or to classify them according to a pattern. What one individual considers good or right or normal behavior may mean something quite different to another person. Our own standards of behavior may merely reflect limited experience.

A concept is something conceived in the mind, i.e., a thought or a notion; it is an abstract idea which has been generalized from particular instances. For example, we say that things are warm or cold; good or bad; simple or complex. We are dependent for our understanding of ourselves, other persons, or events in the world on these concepts we use to organize our thoughts. How, for example, would a person explain his own and other's behavior without the concept of love and hate? Think how much behavior would simply puzzle or confuse him, or perhaps, just go by without really being perceived at all, for lack of this one concept.

Therefore, we refer to mental health concepts on the basic assumption, that to help people, one must know them, and to know them, one must be able to understand why they behave as they do. Right here is one of the difficult problems -- why we behave as we do and have certain attitudes rather than others -- is a complicated question.

Dr. Dill indicated the two major factors in personality development were the individual's biological inheritance and the experiences

which one acquires throughout one's life. Another way of saying it is that all behavior has meaning and is a result of specific antecedent events. Therefore, it is important for the nurse to recognize that the behavior of the patient is related to and affected by his family background and his life experiences. This is as true of the mentally ill person as it is of the well person.

Now, I would like to make another point arising from personal experiences which have a bearing upon the nurses' role in helping patients gain realistic and attainable health goals. I refer to my experiences in an "Out-Reaching Clinic in Appalachia." The mental health concept that is useful in all nursing practice -- that a patient is a human being who needs to be respected as a person, regardless of his behavior -- was clearly indicated in this area.

The Cumberland Plateau has aroused much national interest as one of the most severely depressed regions in the United States. The people have been described as listless, unfriendly, suspicious and defeated. As a "brought-on person" I did not find this to be an entirely accurate picture. The people of Appalachia had become accustomed to poverty and isolation. Now with outside economic and social forces being brought in to play, the people are not prepared to change their ways.

The point I am making here is that a professional working in this area needs a highly developed respect for sensitivity to the needs of these people if she is to conduct her relations with them in a manner which contributes to their dignity and self-worth and feeling of consequence instead of being on the receiving end of directions, orders, prescriptions and other hand-outs.

From a historical viewpoint, Frued's fundamental studies on the ego and the mechanisms of defense constituted the beginning of the development of the ego psychology. Probably there is some primary process in the business of getting psychotic which involves defeat of the ego, which involves some sense of frustration and inability to cope with things as one would like. It's enormously increased by the attitude taken by the family, the public, other persons -- an attitude which degrades the psychotic in his own eyes as in the eyes of others. One way of putting it is the patient's feeling of personal helplessness, a kind of self-distrust.

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One of the nurse's primary tasks is to evoke some kind of self-effort in the patient, some kind of self-trust in the patient. The patient has potential for growth toward health. The nurse realizes there are times when it is necessary to support the patient's dependence and is aware that a patient will not move toward greater independence until some of his dependence needs are met.

Another concept is the patient's communication, both verbal and nonverbal, is rational when it is understood. A person's response to you may have very little to do with you as a person -- he may be angry, rude, or indifferent -- and this behavior may be only a reflection of other worry. He is responding to some unmet need or fear in the only way he knows how. Observations of the nurse should be directed toward understanding the patient's needs. Each person is different from every other person even when there are striking likenesses, a dozen patients may all feel differently about the same disability, and act differently under the same circumstances. An individual may come to depend upon hostility, dependence, or withdrawal as a method for handling difficult situations. We can all recall an unpleasant or painful experience. People have different means of meeting these experiences; some of us might use denial by not admitting that it exists, or perhaps by making it seem like another person's fault. In the latter, one thus feels inclined to attribute one's difficulties to the outside influences of the "they" --, not only just the paranoid patients but many others also.

People want very much to control their own lives and would usually rather do things for themselves than be helped do them. Most people particularly dislike to have matters taken out of their hands and decided or done for them. Advice is seldom taken unless asked for, and even when requested is not always wanted. When the patient is unable to do so, the nurse helps him to set appropriate limits or, if necessary, sets these limits for him.

Which reminds me of an experience one of my nurses had recently. The nurses had just departed from an Inservice Education Session where the psychologist had been discussing behavior shaping. He had told the nurses that patients are likely to respond in a manner in which they are approached. He had suggested that if we didn't accept this "crazy talk" and told the patients so consistently he believed they would cease this talk. Well, Connie took him literally,

and as they were walking down the corridor a hallucinating patient approached them. Connie turned to her and spoke sharply, "Who are you talking to? There's no one with you." The patient replied, "I'm talking to myself, because I want to."

The point I'm making is that sometimes the patient must have the right to be as sick as he needs to be, to express his negative as well as his positive feelings, and be assured of support in working toward self-generated behavior at his own pace.

In closing, I should like to say that all people have similar basic needs and desires -- such as the need for love and security -- the desire to be adequate, to achieve, to be recognized. Everyone wants to feel unique, but not isolated. Some of these ideas are more or less alligned with psychiatry, but in essence they have to do with understanding people. According to some of the foregoing mental health concepts, the basic nursing principle is to restore, cultivate, evoke, otherwise set in motion some kind of self-regarding trust, self-regarding respect and self-generated behavior, other than merely fitting to the circumstances imposed by others.

Two Major Characteristics of any Group:

1. Group Maintenance -- Interpersonal and emotional aspects. Activities which contribute to the building of group centered attitudes or group centered behavior.

2. Group Task Functions -- Activities that contribute to getting work done, solving the problem, reaching the goal, activities related to the purpose for which the group exists.

Group Maintenance Roles:

Encouraging:	Being friendly, warm and responsive to others; regarding others by giving them an opportunity or recognition.
Expression:	Verbalizing group feeling, sensing feeling, mood, relationship within the group, sharing his own.

Harmonizer:	Attempting to reconcile disagreements, reducing tension, getting people to explore their differences.
Compromiser:	His own idea of status is involved in a conflict, offering to compromise his own position, admitting error, disciplining self to maintain group cohesion.
Gate Keeper:	Attempting to keep communication channels open, facilitating the participation of others, suggesting procedures for sharing opportunity to discuss group problems.
Standard Setter:	Expressing standards for group to achieve -- applying standards in evaluating group functioning and production.

<u>Task Function Roles:</u>

Initiator or Provocator:	Proposing tasks or goals, defining a group problem, suggesting a procedure of ideas for solving a problem.
Information or Opinion Seeker:	Requesting facts, seeking relevant information about group concern, asking for suggestions and ideas.
Information or Opinion Giver:	Offering facts, providing relevant information about a group concern, asking for suggestions and ideas.
Clarifier or Elaborator:	Interpreting or reflecting ideas and suggestions, clearing up confusion, indicating alternatives and issues before the group, giving examples.
Summarizer:	Pulling together, related ideas, restating suggestions after group had discussed them, offering a decision or conclusion for the group to accept or reject.

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Consensus Tester:	Sending up trial balloons to see if group is nearing a conclusion, checking with group to see how much agreement has been reached.

Appendix C

"COMMUNICATING"

Linda L. Hays

The dictionary defines communicating as "an act or instance of transmitting; a verbal or written message; an exchange of information; a process by which meanings are exchanged between individuals through a common system of symbols; a technique for expressing ideas effectively in speech or writing or through the arts."

In my remarks today, I would like to consider with you the part of the definition that pertains to the process by which meanings are exchanged between individuals. Cooley[1] has called the process of communication "the mechanism through which human relations extend and develop -- all symbols of the mind, together with the means of conveying them through space and preserving them in time." Gestures, sound, pictures, words, signs -- and actions too -- are the basic means we have for passing along our ideas, feelings, imaginations, and intentions from one person to another and from one generation to another.

Too frequently we tend to think of communication as a process of one person sending information to another individual or group. We assume that if the second person is given facts correctly he is supposed to act accordingly. If he does not act in such a manner, we make the assumption that he is resisting the message. This type of model of the communication process fails to recognize the growing body of motivational research concerning man's behavior and that communication is linked to personal needs, concerns, expectations, and intentions. These undercurrents of need and purpose are constantly present, shaping both the behavior of the communicator and the person with whom he is seeking to communicate.

In this discussion about some of the highlights of communication, let us first consider this from the standpoint of the communicator and then second, from the standpoint of the person with whom he is communicating. I am sure you will agree with me that this is an

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[1] Cooley, Charles H. The Significance of Communication. Glencoe, Illinois: The Free Press, 1950, p. 145.

artificial organization of the process, for one cannot discuss either of these roles without considering them in relation to the other.

The first communication we make with other persons in this world is through non-verbal gestures -- soft, warm pressures, facial expression, cooings, and gurglings. Is it any wonder then that non-verbal means of expression remain with us even after we have learned adult ways? Is it any wonder that other persons may find these signs, which may be still given unconsciously later in life, more realistic in judging intentions than the words or expressions we constantly employ?

One of the greatest difficulties in communicating across the boundaries of social and professional groups lies in the fact that we tend to perceive others as having the same personal needs, desires and purposes that we have. In many ways, you as a professional are better able to communicate effectively over language and cultural barriers with your professional friends than you are able to communicate effectively with members of your social group. In making a choice as to the most effective means of communicating with others, we must think in terms of the purpose.

The communicator is a unique individual with unique motives, beliefs, and attitudes which are related to his way of life and to the opportunities for experience that way of life provides. These motives, beliefs, and attitudes influence his selection of ideas to communicate and the emphasis he gives to his facts. He selects interpretations that have personal meaning and which he believes will have meaning for others.

In making choices as to the most effective means of communicating with each other, we are also governed primarily by purpose. This applies whether we think in terms of interpersonal communications or intergroup communications. If there is a single generalization that can be drawn from thousands of studies made to compare the relative effectiveness of different kinds of media, I believe it can be summed up in three words: effective for what? It does not make good sense to talk about effectiveness of media without considering both purpose and the nature of the existing physical and social conditions.

My second major point, then is that the behavior of the communicant in any communication process is motivated. The needs, values, and purposes that he has acquired through experience, his psychological set, and his expectations with respect to the communicator are

of primary significance in influencing the meaning the information will have for him and the way it becomes integrated into his pattern of knowledge, belief and action.

Each of us charts his course through the world by means of his perceptions. You may be thinking that words are different from perceptions -- what has perception to do with verbal communication? Words <u>are</u> perceptions. The meanings we associate with words are the meanings that help us most to act successfully in achieving the purposes of daily living.

Let us now turn our attention to some of the characteristics of all organizations which create communication problems. What is it about organizations that seems to make communication especially difficult? An organization may be considered a system of over-lapping and interdependent groups. These groups can be departments located on the same floor of a building, or they can be agencies scattered over the face of the earth. Other things being equal, people will communicate most frequently to those geographically closest to them, even within a relatively small institution.

It is also characteristic of organizations that persons are structured into different systems of relationships. A <u>work structure</u> exists: certain persons are expected to perform certain tasks together with other persons. An <u>authority structure</u> exists: some people have responsibility for directing the activities of others. The <u>status structure</u> determines which persons have what rights and privileges. The <u>prestige structure</u> permits certain persons to expect deferential behavior from others. The <u>friendship structure</u> is based on feelings of interpersonal trust.

A few principles from recent research show the following:

1. In the pursuit of their work goals, people have forces acting upon them to communicate with those who will help them achieve their aims, and forces against communicating with those who will not assist, or who may retard their accomplishment.

2. People have powerful forces acting upon them to direct their communication toward those who can make them feel more secure and gratify their needs, and away from those who

threaten them, make them feel anxious, and generally provide unrewarding experiences.

3. Persons in an organization are always communicating as if they were trying to improve their position.

Recent research also has something to tell us about the consequences that communication will have when various conditions exist within an organization.

1. The effect of any particular communication will depend largely upon the prior feelings and attitudes that the parties concerned have towards one another.

2. The effect of any particular communication will depend upon the pre-existing expectations and motives of the communicating persons.

3. The effect of a superior's communication with a subordinate will depend upon the relationship between them, and how adequately this relationship satisfies the subordinate's needs.

4. The effect of a superior's communication with a subordinate will depend upon the amount of support the subordinate receives from membership in a group of peers.

To summarize what has been said or implied, I should like to point to four problems which people in organizations must solve in order to overcome barriers to communication.

First there is the problem of trust or lack of trust. Communication flows along friendship channels.

Second there is the problem of creating interdependence among persons -- common goals and agreement about means for achieving them.

The third problem is inseparable from the two just mentioned. This is the problem of distributing rewards fairly so that people's needs are being met, and so that they are motivated to contribute to the over-all objectives of the organization.

Appendix C

Finally, there is the exceedingly important problem of understanding and coming to common agreement about the social structure of the organization.

Appendix C

MENTAL RETARDATION

Bessie McCord

Mental Retardation is one of the most important social and medical problems in the world today. About three per cent of the population are considered to be retarded or 5.4 million people. Of the 4.2 million children born each year, 126,000 are, or will be, classed as mentally retarded. There are an estimated 38,300 retarded children or individuals under 21 in Kentucky. Using the figure of three per cent of the population as being retarded, this means that there are roughly 91,000 retarded persons in Kentucky.

There are many methods of explaining and defining Mental Retardation, but perhaps the definition of the A. A. M. D. offers one of the simplest yet explicit definitions. The A. A. M. D. definition states that Mental Retardation refers to subaverage general intellectual function which originates during the developmental period and is associated with impairment in adaptive behavior. Let us examine this definition a little more completely. When we speak of subaverage general intellectual functioning, we are referring primarily to the fact that the child has a great deal of difficulty in following the expected learning pattern of the normal child. In many instances learning is practically nil.

DEVELOPMENTAL PERIOD cannot be precisely specified, but for practical purposes this period is regarded to be to the age of sixteen.

ADAPTIVE BEHAVIOR refers to one's ability to meet the social and natural demands of his environment.

IMPAIRED ADAPTIVE BEHAVIOR may be reflected in (1) maturation, (2) learning, and/or, (3) social adjustment.

The degrees of retardation vary greatly among individuals. It may be so severe that the person must have protective care throughout his life. In others, the retardation is so mild that many tasks can be learned and a measure of independence in everyday life can be achieved. As with definition there is no fully satisfactory way of characterizing the degrees of retardation. They range, according to one classification, from mild to profound, and are related to intelligence quotient (IQ) as follows: Mild 53-68; Moderate 36-52; Severe

20-35; Profound - below 20.

Another classification used in relation to educational programs makes use of a three-way division: Educable - about 50-75; Trainable about 25-50; Custodial - below 25. You will note that these classifications disregard the old classification of "idiot", "imbecile" and "moron".

Other classifications group the retarded in somewhat different ways and make use of other terminology. All of them recognize graduation of Mental Retardation, although the exact boundary lines vary. Regardless of the particular classification used, it should be understood that seldom, if ever, is IQ the only determining factor in Mental Retardation. Other factors that affect intellectual competency are social adaptability, emotional control and mental age.

The discussion today will be limited to the medical aspects of Mental Retardation as it would be impossible in the time allotted to fully explore the physiological and educational classifications. It should be recognized, however, that in a classification, based on etiology, there is no consistent degree of Mental Retardation. An individual with a particular etiology may fall into any specific degree of retardation.

It should be recognized that M. R. is not a syndrome in itself, but is a symptom of some other disease process. M. R. is due to only two basic causes. The first cause is the lack of formation of adequate normal brain tissue, due to any etilogy. The second is damage or destruction of existing brain tissue so extensive that the person cannot function normally.

To illustrate the great studies made in recent years in the area of Mental Retardation, in 1954 there were seventy known causes of Mental Retardation. Today, over 200 causes are known. The first of these is Mental Retardation due to infections. This includes the infections that may occur in the prenatal period, manifesting themselves in the mother and in the infections postnatally, manifesting themselves in the child. Some of the signs and symptoms vary with the different infections, the final result is the same and the brain damage is similar. The infection reaches the Central Nervous System, producing an

inflammatory reaction which destroys certain tissues, primarily cortical which is vital to the normal function and development of the person.

One of the most frequent causes of prenatal infections which results in mental retardation are the viruses. The infection in the mother may be very mild, but disastrous for the child.

Prenatal Rubella, or German measles is one of the most frequent causes of mental retardation in the child particularly if the infection occurs in the first trimester. The principal conditions occurring are varying degrees of hearing and visual handicaps, cardiac abnormalities and mental retardation. If this infection occurs later in pregnancy abnormalities seldom occur. Other diseases which may produce mental retardation prenatally are mumps and Asiatic flu.

Infections occurring in and around the brain after birth may produce mental retardation. These may be meningococci or tuberculous bacillus.

Mental Retardation Associated with Diseases and Conditions Due to Intoxication:

1. Toxemia of pregnancy

2. Lead poisoning

Lead poisoning is often a result in those children who have an abnormal craving for non-nutritious or even harmful substances such as clay, plaster, ashes and charcoal. In a study in New York over thirty per cent of the children with pica had lead poisoning. Children most commonly affected are those in the age range from eighteen months to four years, as children of this age will chew and swallow almost anything. Lead poisoning was almost completely ignored until the 1930's. Children died from lead poisoning which was often diagnosed as intestional disorders. The recognition of possible lead poisoning and awareness that pica may be associated with lead poisoning, is demonstrated by lack of appetite, listlessness, increased irritability, abdominal pain, vomiting, convulsions or unexplained unconsciousness. A simple screening test can be employed. This test consists of adding a few drops of acetic acid, hydrogen peroxide and ether to the urine. If lead is present a cherry red color appears. Lead poisoning can also

be confirmed by the presence of abnormal blue spots in the red blood cells and by abnormal density of the ends of the bones as seen by x-ray. Special tests are also used which show abnormal concentration of lead in the blood and urine.

Intoxication from arsenic, salicylates and other chemicals usually results in death or complete recovery, but lead poisoning is far more likely to do permanent damage.

Mental Retardation Associated with Diseases and Conditions Due to Trauma or Physical Agent:

1. Encephalopathy due to prenatal injury

2. Encephalopathy due to mechanical injury at birth

3. Encephalopathy due to anoxia at birth

4. Encephalopathy due to postnatal injury

Mental Retardation Associated with Diseases and Conditions Due to Disorder of Metabolism, Growth or Nutrition:

There are a number of conditions that are classified under this catagory, the most widely known is Phenylketonuria. PKU is a hereditary disease, which usually causes mental retardation unless detected and treated early.

The defective gene is inherited by a "recessive trait" which means both parents must carry the gene, even though both appear normal.

When one child in a family has PKU, other children may also be born with the disease. The incidence is one in every 10,000 children. Approximately one in every 100 patients in institutions are PKU.

Children may appear normal at birth, but they lack an enzyme which is needed to convert phenylalanine (amino acid in protein foods) into a form to be utilized by the body. Phenylalanine hydroxylace →
melanin.

Appendix C

After birth when a baby takes milk, either breast or cow's milk, phenylalanine and its by-products begin to accumulate in his body producing phenylpyruoic acid which produces brain damage.

Detection of PKU is done by two methods:

1. Urine test -- phenistix is placed in the diaper. Test cannot be done until by-products of phenylalanine appear in urine six to eight weeks.

2. Guthrie test -- few drops of blood from baby's heel placed on filter paper. Done in four to five days after birth. Important advantage, may be done before the baby leaves the hospital.

Children with PKU need a special diet. The food used should contain little phenylalanine but provide enough protein for normal growth. Lofenala is a powdered synthetic food low in phenylalanine. The doctor will determine the number of milligrams of phenylalanine needed in a child's diet. Initially the diet consists of six daily feedings.

The goal of the diet is to maintain the phenylalanine blood level around two milligrams per 100 milliliters of blood.

Another condition is Gargoylism (Hurler's Disease) which is probably the most widely studied carbohydrate metabolic error. The condition is due to an autosomal recessive genetic trait, which may be sex linked or sporadic in occurrence. It is caused by an error in connective tissue micropolysaccharide metabolism. Almost every tissue of the body is involved in this abnormality.

The child usually appears normal at birth. Symptoms begin to appear from shortly after birth up to five or six years. The patient may show any or all of the following symptoms (1) cardiac abnormalities, (2) short stature (3) flexion contracture involving the upper extremities, (4) enlarged abdomen, (5) short lobster-like fingers, (6) peg teeth, (7) thick, coarse, dry hair, (8) shortened neck, (9) thick, heavy eyebrows, (10) thick lips. The patient deteriorates progressively until death. There is no known treatment available at this time. However, extensive work is being done in many areas, particularly at the University of Florida.

Appendix C

Mental Retardation Associated with Diseases and Conditions Due to New Growths:

Tuberous sclerosis is a condition characterized by sebaceous adenoma of the face, mental retardation and seizure activity. This is a genetically determined condition. All tissue are involved with tumors found not only on the face but also throughout most tissues of the body.

Another condition listed in this classification is Sturge-Weber Syndrome. This condition is probably genetically transmitted, a trisomy of the 13-15 chromosomal group has been reported. There is a capillary involvement of the face or the port-wine stain. Patients have seizure activity which is very difficult to control, visual disturbances are also common.

Mental Retardation Associated with Diseases and Conditions Due to (Unknown) Prenatal Influence:

Some of these conditions are Hydrocephalus, Hypertelorism (Greig's Disease) and Microcephaly.

Hydrocephalus -- There are four cavities in the brain called ventricles. CSF is a clear, colorless fluid produced by a vascular process formed from the lining of the ventricles. It flows through the cavities to emerge from the fourth ventricle, goes into the subarachnoid space, over surface of the brain, finally to be absorbed through the dural venous sinuses. (100 ml. spinal fluid produced in a day.)

The brain and spinal cord float in this fluid which acts as a shock absorber and supplies nutrients to the brain.

Normally there is a delicate balance between the rate of formation and of absorption of CSF. The entire volume is absorbed and replaced once every 12 to 14 hours.

Excess CSF due to:

1. Excessive production

2. Impaired absorption

3. Obstruction of the discharge pathways

Appendix C

TWO TYPES OF HYDROCEPHALUS:

1. Obstructive Type: Block of normal flow of CSF somewhere in the ventricular system. Produces an accumulation of fluid within the system and increased pressure with dilation of the ventricles.

   Communicating: Free flow of CSF within the ventricular system to the subarachnoid pathways over the spinal cord and surface of the brain. Defeat here is in reabsorption.

2. Secondary to a meningitis which obliterates the subarachnoid spaces.

Common causes of hydrocephalus:

A. Congenital origin

   1. Disturbances in the development of the aqueduct

   2. Defective germ plasma

   3. Vitamin deficiencies

B. Infectious origin

   Congenital infections

Hypertelorism is a term used to refer to a wide separation of the eyes. The cause is often an over growth of the lesser wings of the sphenoid, with an undergrowth of the greater wings of the sphenoid. Patients may be normal, near normal or severly retarded. The cause of the retardation is unknown.

Microcephaly refers to a condition in which there is usually a small or imperfectly developed head, presupposing a reduction in volume of the brain. It has been estimated that the genetic incidence is 1:25,000 to 1:50,000 in the general population.

It may be found in syndromes associated with congenital toxoplasmosis; in offspring of mothers infected with rubella during first trimester.

The most frequent and consistent findings are reduction in head size and mental retardation. Other clinical findings accompanying microcephaly are extremely variable and depend upon severity of the pathologic process and causitive agent.

There is no specific treatment. Management consists of treating the symptoms and habilitation.

Mental Retardation May be Due to Chromosomal Causes.

The most common anomaly in this classification is Down's Syndrome. Mongolism is one of the more common chromosomal anomalies and occurs in about one of every six hundred live births. About ninety per cent are instances of the trisomy 21 variant.

One important consideration is the fact that mongolism, particularly in the newborn, cannot be diagnosed unequivocally on purely clinical grounds in all instances.

STANDARD TRISOMY: 1:600 births

Total chromosome count is 47 instead of 46. This type is rarely familial. Usually occurs in children born to older women (35 years or older.) Failure of the two chronosomes of pair 21 to separate during gametogensis produces an abnormal ova resulting in three chromosomes instead of a pair at location 21 on the karotype (classification system).

TRANSLOCATION: Rare

Actual chromosome count is 46 (normal). This type is familial. Children usually born to younger parents, one of whom carries the 15/21 translocation. The carrier has a chromosome count of 45 instead of 46 but has the same amount of chromosome 21 material as the normal. The abnormally large chronosome in pair 15 is the result of the translocation of extra chromosome 21 becoming attached to one chromosome at 15 location.

MOSAICISM: Very rare

Result of an error in division of an early embryonic cell.

Co-existence in one individual of cells with different chromosome counts. One of the cells of the developing embryo gets an

extra chromosome 21 and passes it on to its descendants resulting in two cell lines with different chromosome numbers. (Ex.) Cultures of skin may show 46 chromosomes, blood cells 47 chromosomes.

Mental Retardation Associated With Diseases and Conditions Due to Unknown or Uncertain Cause With the Structural Reactions Manifest:

Some of the diseases are Krabbe's, Greenfield's and Schilder's. These conditions are characterized by encephalopathy associated with diffuse schlerosis of the brain.

Mental Retardation Due to Uncertain Causes:

The most widely known type of Mental Retardation in this group is the cultural-familial type. This was once thought to be the principal cause of mental retardation. Now it is felt that only a small percentage of all mental retardation is due to this cause. This group comprises a large number of borderline and dull normal retarded children and makes up the large group that can be rehabilitated.

Appendix C

UTILIZATION OF THE PRACTICAL NURSE IN MENTAL HEALTH

Annie Laurie Crawford

The LPN is a relatively new recruit to mental health and psychiatric nursing services. Traditionally the non-professional worker in psychiatric nursing services has been an untrained or on-the-job trained attendant. During the past quarter century titles for many of these workers have been changed (psychiatric aide, psychiatric technician, psychiatric nurse technician, etc.). Training programs have also been established. Few institutions now acknowledge that untrained workers are assigned to care for patients on a continuing basis, but there may be a considerable time lag between employment and initiation of training.

If we examine the content of the fundamentals of nursing courses included in many institutional on-the-job training programs we find that instruction in basic nursing skills, and supervised practice in the care of physically ill adult psychiatric patients is quite similar to the basic nursing skills and procedures taught practical nurse students. However, these training programs differ markedly from practical nurse education in two important aspects.

First, persons enrolled in the training programs provided by employing institutions have not generally sought an education in a chosen health occupation, but have had as their primary objective getting a job which paid them a wage to live by.

Second, educational and legal authorities do not participate in setting standards or examining the achievements of the product of the training program (Ark. is an exception). These factors limit status, recognition and promotion to a role within the institution or the state in which the training takes place.

The basic techniques and skills these workers display in nursing adult physically ill patients, as suggested previously, often equal those of the licensed practical nurse. Their knowledge and skill in basic psychiatric nursing certainly should be, and generally is, much more extensive than that of the licensed practical nurse. Why then should administrators of mental health programs, licensed practical

nurses, and others recommend and support the inclusion of mental health and psychiatric nursing instruction in basic practical nurse education? -- And recommend utilization of licensed practical nurses in psychiatric nursing services? These recommendations are documented.

The Joint Commission on Mental Health in their report to Congress and the Nation in 1961, recommended that licensed practical nurses assume a more extensive and significant role in state hospital nursing services in the future.

A number of states, "Comprehensive Mental Health Plans" prepared during 1963-65 recommended that mental health and psychiatric nursing instruction be included in practical nurse education, and that additional licensed practical nurses by employed in psychiatric nursing services.

The Washington State Division of Mental Health, the State Department of Vocational Education, and the Skagit Valley College began joint sponsorship of a twelve week course in psychiatric nursing for licensed practical nurses in 1965. The course is designed to meet the current need for more comprehensive care to institutionalized patients, and to meet future needs for community mental health workers. By spring, 1967, sixty-five licensed practical nurses had completed this course.

A limited inquiry by the Southern Regional Education Board in 1965 disclosed that a number of State, Federal, and private psychiatric hospitals and most of the general hospitals having psychiatric units in the Southeast employ licensed practical nurses, and would employ more if available.

The salaries offered licensed practical nurses in state psychiatric hospitals in the Southeast, at the time of the survey, ranged from a minimum of $15 to a maximum of $63 above that of the attendant or aide. One state hospital administrator reported that the salary offered there exceeded that in local general hospitals by about $40 per month. Many of the States' Civil Service or Merit System job specifications for State Psychiatric Hospitals include licensed practical nurses in the nursing service series.

Webster has defined utilization as, "making use of, or getting

profit or benefit from using". What are some of the benefits to be expected from the work of practical nurses in mental health and psychiatric nursing? What steps do we need to take to assure that all potential benefits accrue to worker and service? What influences and experiences will be most useful in determining the steps to be taken?

For nearly two centuries the care and custody of mentally ill patients took place in profound geographic and professional isolation. During the past quarter century and especially during the past decade efforts to integrate health services for emotionally disturbed and mentally ill patients into the mainstream of health programs have increased dramatically. The Community Mental Health Centers now being established throughout the U. S. represent an enormous investment in a redesign of facilities and procedures for delivery of mental health and psychiatric care. If this movement is to succeed in its mission a redesign of attitudes, beliefs and skills of the workers is also essential.

Dr. N. R. E. Fendall, a member of an expert panel of the World Health Organization, and a former member of a panel on training of auxiliaries (a title he prefers to sub or non-professional) defines the "auxiliary" worker as a helper who has a technical education limited in breadth, depth, and time -- "training for a specifically defined area of work and level of competency." He describes auxiliary workers as single-purpose, multi-purpose, and all-purpose. He is convinced that single-purpose workers "have limited usefulness and are difficult to absorb into general health services when specific programs end."

Dr. Fendall's experiences and observations can be quite useful in understanding where we now are, and in assessing the work necessary to expedite the change from isolated institutional care to community health service for emotionally disturbed and mentally ill patients. We can capitalize on the widespread interest, and make economical use of the human and educational resources we have available by expanding and improving programs which promote acquisition of the new knowledge and skill which workers require to do the job.

Auxiliary workers, (aides and attendants) in mental health and psychiatric services, long used to the isolation of a single-purpose program (custody of a large residue of chronically ill patients residing in institutions set geographically and professionally apart from other health services) will require re-education to become all-purpose in philosophy and practice, to become participating members of an all inclusive health team, instead of an authoratative and responsible

custodian. Licensed practical nurses, most of whom are now multi-purpose workers in general nursing, must acquire the skills and the psychiatric know-how to become all-purpose workers. This trend has already been established in both groups.

The number of psychiatric aides and attendants who enroll in practical nurse schools is increasing, and a number of state departments of mental health now offer these individuals stipends and grants to support them during the period of study. Licensed practical nurses are enrolling in extension and post-graduate courses, and seeking employment where planned inservice training in psychiatric nursing is available -- programs which are at this time largely supplemental or remedial. Should our goal be all-purpose training with the focus following employment on continuing education to keep abreast of new developments? It seems so.

Dr. Fendall describes the work roles of auxiliary workers as assistant (to the professional) or substitute who can handle emergencies in the absence of, or until the professional becomes available. He believes that the status of the group should be assured through protective legislation, specific functions should be delegated, and that professionals who supervise them should act as consultants being sure not to usurp the functions delegated. He further states that the basic education program should prepare for the assistant role; that further training should be provided for workers who must function in the substitute role; that the first criterion in planning training should be a good field analysis of the job to be done; and that schools training auxiliaries should, whenever possible, be in a setting where the relationship between students in professional schools and those preparing for auxiliary work could begin at the student level. This contact, he believes, helps each to recognize that he (or she) is not working in isolation but is a part of an essential whole (team).

I believe Dr. Fendall has rendered a profoundly significant service in his lucid analysis of the work and his description of appropriate training for auxiliary health personnel who comprise so large and significant a group of workers. We need all the support and guidance we can muster as we seek to prepare practical nurses to go to work in settingswhich are new to them, and where they may be overwhelmed (indeed, as many registered nurses continue to be) by single-purpose workers whose knowledge and competence in that single purpose may be relatively unassailable. And we need unusual finesse to present students as "all-purpose" role models who inspire these

"single-purpose" workers to seek similar training.

How shall we prepare the practical nurse, which is our task, to do effective work and cope with the interaction and interpersonal stresses which these adjustments and changes in values provoke? This will take patience, imagination, and perseverance -- and day-by-day practice of some of the mental health concepts you have been exploring these past days. If we can do this well, all of the old timers will seek remedial and supplementary instruction. The new ones will come to the job equipped with a solid basic preparation.

The objectives of this workshop, (1) To integrate mental health concepts into the practical nurse curriculum and to improve instruction in psychiatric nursing, and (2) To acquire knowledge about the newest materials and latest techniques and skills in mental health and psychiatric nursing, -- as well as your presence here demonstrate one index of the commitment instructors and students are making to fulfill the expectations of program directors. As you integrate what you learn into your teaching you approach achievement of your goals and those of the program directors who wish to utilize the practical nurse in mental health work.

In closing, I want to raise several questions for you to reflect upon, and use to guide you in preparing your students for orderly transition to all-purpose effective team work.

Where are the jobs in mental health and psychiatric nursing now?

Where else should there be jobs? Why?

What is the work role?

How well is the LPN from your school prepared to assume the work role?

Are changes appropriate to your philosophy and educational objectives indicated? -- And possible?

Appendix C

COMMUNITY MENTAL HEALTH

Elaine Kiviniemi

The term, Community Mental Health Center is very much in the news these days. As Dr. Farabee told you last week, the trends in mental health are toward community based programs, for treatment as well as prevention. I'd like to talk with you today about community mental health programs -- what a community mental health center program involves, how the pattern for community mental health centers came about, and its relevancy to nursing.

In 1961, the Joint Commission on Mental Illness and Health released a report entitled "Action for Mental Health," which documented the nationwide inadequacy and inappropriateness of services available to the mentally ill.

In February, 1963, President Kennedy sent a Special Message on Mental Illness and Mental Retardation to Congress, in which he proposed a "bold new approach." This bold new approach called for community based programs, which would incorporate prevention, treatment, and rehabilitation, and which would be planned and implemented by the concerted action of local, state and federal levels.

In October, 1963, Congress followed through by passing the Community Mental Health Centers Act (P.L. 89-105) which authorized appropriation of $150 million, over a three year period, for construction of mental health center facilities. However, a building isn't much use without staff, so this bill was amended in 1965 to include assistance for initial cost of personnel for new mental health services. Thus, with the combination of local, state and federal funds, monies became available for new facilities and staff who could co-ordinate existing services and fill in the service gaps of the local community.

What is a community mental health center? It is a co-ordinated program of mental health services in a community. As defined by the Community Mental Health Act, five elements of service are essential, if federal funds are to be allocated. These are: (1) in-patient services; (2) out-patient services; (3) emergency services; (4) partial hospitalization and (5) consultation and education. In addition, the

following are eligible for initial staffing support, if they are new services: (6) diagnostic services; (7) rehabilitation services; (8) pre-care and after-care services; (9) training and (10) research and evaluation. As you can see, provision of these ten elements makes comprehensive care a more realistic goal.

It is not necessary that these services be provided under one roof. What is important is that there be a coordinated program so that the individual or family needing help can obtain the kind of aid the program requires, at the time needed.

To facilitate continuity of care and prevent duplication of effort, mechanisms are established to provide free flow of clinical information about the patient. In addition, professional staff can continue to treat their patient as he moves from one service element to another.

Let us go back to discuss in more detail the five basic elements of service.

In-Patient Service -- As affiliates to community mental health centers, many general hospitals are now, for the first time accepting patients who have a primary psychiatric diagnosis. Some hospitals have admitted such patients in the past, but under the guise of a medical diagnosis. For many communities when hospitalization has been needed, the only recourse for in-patient service has been the state hospital, often a three hour drive away. In addition, many patients whose conditions did not require total hospitalization have been sent to the state hospital because of the local paucity of mental health services (such as out-patient or partial hospitalization) more appropriate to their needs.

Studies of the effects of hospitalization have shown that much of what we have considered to be "part of the patient's illness" -- for example, the desocialization of chronic schizophrenics -- is a result of "institutionalization." We have found that treating the patient out of the context of his family and work environment often causes new problems or return of symptomatology when he returns home, and oftentimes, the so-labelled patient is not the sickest family member.

Not only does hospitalization within the local community alleviate some of these problems, but also reduces the stigma of mental illness in the eyes of the public. This is not to say that state hospitals are not needed or are not a part of community mental health

programs. With community-based mental health programs, the state hospital need not be the sole resource, trying to be "all things to all people." Instead, more appropriate utilization of state hospital resources can be developed.

Out-Patient Services -- Though out-patient service is one of the more traditional modes of delivery of services, it is by no means extensively offered. In addition to more clinics, unique and flexible ways of delivering such services are being tried. For example, multi-disciplinary teamsare holding weekly clinics in health departments of outlying counties. In urban areas, store-front psychiatry has been implimented. Close liaison is being established with other service groups such as public health and public assistance agencies, general practitioners, police and schools.

In Kentucky's community mental health centers, Information-Screening-Referral units are being established to make help-seeking a less formitable process, for both patients and professionals.

Partial Hospitalization -- For those children and adults who need more intensive therapy or group living experiences not available in out-patient services, but do not need to be hospitalized around the clock, day care and/or night care programs are being established. Not only will this provide a unique treatment modality, with increased emphasis on group interaction and strengthening of mechanisms for coping with problems in realistic ways, but it will also alleviate some of the burden previously placed on in-patient units.

Emergency Services -- By utilizing the in-patient, out-patient and partial hospitalization services, 24 hour emergency coverage will be available. In many parts of the country, the police and jails have been the local resource for emergency care, with the jail serving as an interim facility before a trip to the state hospital could be made.

Consultation and Education -- For prevention, early case-finding and treatment, consultation and education programs are a vital part of a community mental health program. In addition to education of the general public, program and case consultation is being made available to other agencies and professionals, such as the juvenile courts, police, schools, public health nurses, general practitioners, and others who must cope first-hand with persons having emotional or social problems.

Appendix C

We have discussed the basic framework of community mental health programs. Implimentation of these must be adapted to the special characteristics and needs of each community. This is the progress we are making toward more ably helping patients, families and communities meet their needs, when the needs arise, and as close to the situation as possible.

Obviously, with the expansion of community mental health programs, manpower needs have multiplied. This expansion is a result not only of increasing numbers of services but also of a changing philosophy. We are moving away from a purely medical model, with its emphasis on the one-to one relationship, to a psycho-social model, with its multi-disciplinary approach.

Consequently nurses are developing new roles, not only within in-patient services, but also in each of the other service elements we have discussed today. Nurses are becoming more active participants in therapeutic and educative roles.

Much thought is being devoted to further development of the roles of non-professional workers -- such as licensed practical nurses -- in community mental health programs. This is evidenced in your interest and participation in this workshop. Your ideas will be needed and valuable contributions to the development of the mental health program in your own community.

Appendix D

APPLICATION FOR PARTICIPATION IN THE CLINICAL WORKSHOP IN MENTAL HEALTH AND PSYCHIATRIC NURSING FOR INSTRUCTORS IN SCHOOLS OF PRACTICAL NURSING

University of Kentucky
Lexington, Kentucky
July 17-28, 1967

Name of Applicant _____

Title or Position _____

School, Office, or Hospital Address _____
(Street)

_____ Phone _____
(City) (State) (Zip Code) (Area Code) (Number)

Kentucky Applicants: Miles from your home to Lexington _____

Out-of-State Applicants: Cost of round trip from your home to Lexington by commercial transportation _____

If necessary, would your state supplement your expenses for travel above $100.00? ___

Are you now actively engaged in the instruction of practical nurse students? Yes ____ No _____ If no, what job are you performing? ___
If yes, in what areas? _____

Years in present position _____ Total years of education work ____

Employment History (Start with present job)

Date From	To	Name of Employer	Address of Employer	Title of ~~High~~hest Position Held

Appendix D

Academic Background

College Attended	Date From	To	Degree Received	Work Above a Degree

Did your basic nursing program include a psychiatric affiliation?_____
Have you had courses in psychiatric nursing beyond your basic nursing program? _____

Has any of your work experience been in the area of mental health or psychiatric nursing? _____ If yes, explain briefly._____

_____

Do you want to receive college credit for this workshop? _____
Graduate _____ or Undergraduate _____

Were you enrolled at the University of Kentucky last summer or anytime during the 1966-67 school year? _____If yes, list course number. _____

Do you wish to make application for a degree at the University of Kentucky? _____ If yes, what degree? _____

Will you want to transfer this credit to another college or university? _____ If yes, what college or university? _____

Professional Activities:

Organizations _____

Offices held in professional organizations _____

Professional or academic honors received _____

State briefly your purpose for wanting to attend the workshop. _____

_____

_____

Appendix D

PARTICIPANT-OBSERVER WORK SHEET

Service: _____

Date: _____

Name: _____

Observations

Participation

What I Learned:

Ways I will use:

Questions I have:

Appendix D

PARTICIPANT EVALUATION

of

A Clinical Workshop in Mental Health and
Psychiatric Nursing for Instructors in Schools
of Practical Nursing
July 17 - 28, 1967

Directions: Please indicate your opinion by a check mark in the appropriate column.

	Very Much	Much	Little	Very Little
1. Did the general sessions help reach the purposes of the workshop?	___	___	___	___
2. To what extent were the ideas and methods discussed helpful to you?	___	___	___	___
3. Were the individual projects of concern and helpful to you?	___	___	___	___
4. To what extent was the clinical assignment meaningful to you?	___	___	___	___
5. Were the field trips helpful in gaining a better understanding of mental health concepts and psychiatric nursing?	___	___	___	___
6. To what extent did the members of the group help toward the solution of your problems?	___	___	___	___
7. To what extent were bibliographic readings used in helping to solve problems?	___	___	___	___
8. To what extent do you think this workshop will be helpful in improving your curriculum?	___	___	___	___

9. To what extent do you feel that this workshop has helped you to become acquainted with, and to understand and appreciate mental health concepts and psychiatric nursing? ____ ____ ____ ____

10. To what extent do you consider this workshop to have been a worthwhile experience? ____ ____ ____ ____

Evaluation of Workshop Mechanics

1. Were pre-workshop instructions adequate?

2. Were accomodations satisfactory?

3. Was program scheduling effective?

4. Were workshop hours suitable?

5. Were social functions adequate to meet other participants and provide sufficient relaxation?

6. What do you consider the workshops' strong points?

7. What do you consider the workshops' weak points?

8. Suggestions or comments:

APPENDIX E

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DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
OFFICE OF EDUCATION

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ERIC ACCESSION NO.	CLEARINGHOUSE ACCESSION NUMBER	RESUME DATE	P.A.	T.A.
		03 -11- 68		

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TITLE

100 A Clinical Workshop in Mental Health and Psychiatric Nursing for Instructors in
101 Schools of Practical Nursing. Final Report.
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INSTITUTION (SOURCE) — SOURCE CODE

300 KRCU for Voc. Edu., College of Edu., Univ. of Ky., Lexington, Ky.

310 REPORT/SERIES NO.

OTHER SOURCE — SOURCE CODE

320 Bureau of Voc. Edu., State Dept. of Education, Frankfort, Kentucky

330 OTHER REPORT NO.

OTHER SOURCE — SOURCE CODE

340

350 OTHER REPORT NO.

400 PUB'L. DATE March - 11 - 68 CONTRACT/GRANT NUMBER OEG 1-7-070544-3759

PAGINATION, ETC.

500 77 p.
501

RETRIEVAL TERMS

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IDENTIFIERS

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ABSTRACT

800 A two week workshop was held at the University of Kentucky to assist instructors in
801 schools of practical nursing to (1) integrate mental health concepts into the practi-
802 cal nurse curriculum and to improve instruction in psychiatric nursing, and (2) ac-
803 quire knowledge about the newest materials and latest techniques and skills in men-
804 tal health and psychiatric nursing. Methods included use of films, tours, lectures,
805 demonstrations, student-patient conferences, and student-faculty conferences.
806 Kentucky State Hospital provided the clinical setting. Field trips were made to
807 Frankfort State Hospital and Home for Mentally Retarded, and the National Institute
808 of Mental Health Clinical Research Center.
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811 The National League for Nursing Psychiatric Nursing Achievement Test was used for
812 the pre test and post test. The group mean score was at the thirty-second percen-
813 tile on the pre test and at the seventy-second percentile on the post test. Several
814 speeches are included in the report.
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