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ABSTRACT

One hundred eighty-nine documents published between 1960 and 1967 are abstracted. Documents are classified under the headings: "Background," "Legislation," "Planning," "Services," "Grants," "Manpower," "Roles of Organizations and Key Professionals," "Training--Inservice, Postgraduate, Staff Development," "Training--Residency and Academic Credit," and "Brochures and Curriculum Outlines." There is also a subject index. (EB)

annotated bibliography on INSERVICE TRAINING

FOR KEY PROFESSIONALS IN COMMUNITY MENTAL HEALTH

This annotated bibliography is the first in a group of three publications containing references on community and institutional mental health inservice training. Materials included were published between 1960 and 1967. Periodical literature is cited through August 1967. This is a first attempt to gather these materials. No claim is made for exhaustive coverage. The Health Services and Mental Health Administration is grateful for the permission granted by others to include their abstracts in this publication; in such cases, sources are given parenthetically.

In the expectation that these bibliographies will be ongoing, the project administrators (listed in the Introduction) welcome comments and suggestions with respect to additions, deletions, classification system, indexing, and technical or typographical errors.

ANNOTATED BIBLIOGRAPHY ON INSERVICE TRAINING FOR KEY PROFESSIONALS IN COMMUNITY MENTAL HEALTH

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HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

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INTRODUCTION

This bibliography pertains to inservice training of key professional personnel–psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses–for community mental health programs. It is the first of a group of three bibliographies on mental health inservice training. References in all three are arranged in classified order, annotated, and indexed by types of personnel and by specific training concepts. In any search, reference to the indexes of all three publications in the group is recommended.

Other titles in the group are:

Annotated Bibliography on Inservice Training for Allied Professionals and Nonprofessionals in Community Mental Health

Annotated Bibliography on Inservice Training in Mental Health for Staff in Residential Institutions

A related group of classified, annotated, and indexed bibliographies on training methodology consists of four publications:

Training Methodology–Part I: Background Theory and Research

Training Methodology–Part II: Planning and Administration

Training Methodology–Part III: Instructional Methods and Techniques

Training Methodology–Part IV: Audiovisiual Theory, Aids, and Equipment

These seven publications were developed as a joint effort of the National Institute of Mental Health and the National Communicable Disease Center of the Health Services and Mental Health Administration, Public Health Service, U.S. Department of Health, Education, and Welfare. The project was administered by the National Institute of Mental Health's Community Mental Health Centers Staffing Branch of the Division of Mental Health Service Programs; the Continuing Education Branch of its Division of Manpower and Training; and the Training Methods Development Section of the National Communicable Disease Center's Training Program.

ACKNOWLEDGMENTS

Due to the nature of this series of publications, the amount of coordination and cooperation required for its development, and the range of skills employed in getting it published, the following persons should be recognized: Miss Patricia Rogers, Technical Information Specialist (Education), Training Methods Development Section, Training Program, National Communicable Disease Center--compiler and project supervisor; Dr. Ross Grumet, Psychiatrist, Region IV Mental Health Service- technical reviewer; Mr. Alfred R. Kinney, Jr., Chief, Training Methods Development Section, Training Program, National Communicable Disease Center--advisor; Mrs. Anne W. Morgan, Health Educator, Region IV Office of Comprehensive Health Planning- technical reviewer; Dr. Robert D. Quinn, Staff Psychologist, Community Mental Health Centers Staffing Branch, Division of Mental Health Service Programs, National Institute of Mental Health--NIMH coordinator; Dr. Dorothy Schroeder, Professor of Social Work, University of Michigan--consultant; Mrs. Betty S. Segal, Evaluation Specialist, Training Methods Development Section, Training Program, National Communicable Disease Center--technical reviewer; Miss Marguerite Termini, Associate Professor of Psychiatric Nursing, University of Delaware--consultant; Dr. Thomas G. Webster, Chief, Continuing Education Branch, Division of Manpower and Training, National Institute of Mental Health--advisor. Original annotations and abstracts were written by seven graduate students and technical assistants employed especially for the project. These individuals were: Miss Connie Benson, Miss Mary Lavinia Campbell, Miss Rosemary Franklin, Miss Sharon Grilz, Miss Gale Lawrence, Mr. Garrett McAinsh, and Mr. Stephen Von Allmen.

CONTENTS

BACKGROUND

JOINT COMMISSION ON MENTAL ILLNESS AND HEALTH. **Action for mental health; final report of the Joint Commission on Mental Illness and Health 1961.** New York: Basic Books, Inc., 1961. 338 pp.

The body of this book is prefaced by a summary of recommendations for a National Mental Health Program and by an introduction by Jack R. Ewalt. There is a discussion of manpower problems beginning on page 140. A review of the manpower situation, training of professionals and subprofessionals, and role changes begins on page 244. No methods are mentioned. The principal chapters are: The First Question: Why Has Care of the Mentally Ill Lagged?; Treatment and Its Results; Rejection of the Mentally Ill; Some Significant Findings Relating to Recognition of Mental Health Problems, the Demand for Treatment, and Its Supply; Research Resources in Mental Health; and The Second Question: How Can We Catch Up? Seven appendices include: Mental Health Study Act of 1955; Joint Commission on Mental Illness and Health–Participating Agencies, Members, Officers, and Staff; Sources of Financial Support; Joint Commission Monograph Series; Footnotes; References; and Dissents. An index is included. **(1)**

Governors' Conference on Mental Health: policy statement. **Mental Hospitals** 13:1, January 1962, pp. 6-9.

Meeting in Chicago, Illinois, November 9-10, this conference endorsed state financial support of mental health training, the development of more persons knowledgeable in the techniques of teaching and encouraging mental health, and efforts to upgrade the counseling skills of caretaking personnel. It also called for intensification of recruitment and training, the addition of substantial numbers of less highly trained staff members, and the more efficient use of employees.

This policy statement is made up of sections on the following subjects: community mental health services, inpatient services, psychiatric services in general hospitals, research, clearinghouse, personnel, training, organization of a state's mental health activities, admission procedures, interstate cooperation, financing, mental health insurance, and action by the governors' conference. **(2)**

Mental health activities and the development of comprehensive health programs in the community. Report of the Surgeon General's Ad Hoc Committee on Mental Health Activities (Public Health Service Publ. No. 995). Washington: U.S. Govt. Print. Off., August 1962. 41 pp.

This report is the committee's response to a request from the Surgeon General that they "study and make recommendations . . . as to the role which the Public Health Service should play in (1) strengthening community mental health programs, (2) integrating mental health concepts and practices, and the social and behavioral sciences into other health and disease programs, and (3) estimating the resources, including trained personnel, for which provision should be made in order that these needs can be met." Problems in this area are described, and recommendations are made on the following topics: research, training, grants for programs, and technical assistance. **(3)**

COUNCIL OF STATE GOVERNMENTS. INTERSTATE CLEARINGHOUSE ON MENTAL HEALTH. **Action in the states in the fields of mental health, mental retardation and related areas; a report on recent financial, legal and administrative developments in the states' mental health programs.** Chicago: The Council, April 1963. 198 pp.

One section lists, by state, mental health training programs of several sorts: inservice, residency, psychiatric specialty, mental health and caretaking professions, and administrative and other staff functions of mental institutions. Other sections have information on manpower problems, use of volunteers, numbers of mental health workers (by professions), research, patient care, foster care, organization, licensing, legislation, committees and commissions, and programs for mentally retarded persons, alcoholics, drug addicts, and the like. A section on staffing contains statistics on professional workers in local mental health programs. **(4)**

KENNEDY, JOHN F. Special message to the Congress on mental illness and mental retardation. February 5, 1963. IN **Public papers of the presidents of the United States: John F. Kennedy . . . January 1-November 22, 1963.** Washington: U.S. Govt. Print. Off., 1964. pp. 126-137.

This address was the prelude to the bill proposing the Community Mental Health Centers Construction Act of 1963. It outlines the need for a new approach to the treatment of mental illness and lists three objectives: to find causes of mental illness and ways to prevent it; to expand manpower, training, and research; and to strengthen and improve existing programs.

The national program for mental health includes provision of funds for the planning, construction, and staffing of mental health centers; for improving care in state mental institutions, and for conducting research and procuring manpower. Funds for research and manpower will be provided for training professionals, as well as psychiatric aides. The services and financing of the centers, as well as voluntary health insurance to cover mental illness, are discussed. Mental hospitals are expected to assume a transitional role, to carry on pilot projects, and to provide inservice training. **(5)**

NATIONAL COMMISSION ON COMMUNITY HEALTH SERVICES. **Health is a community affair**. Cambridge: Harvard University Press, 1966. 252 pp.

The findings and recommendations of three projects of the National Commission on Community Health Services are the basis for the fourteen positions from which the Commission's recommendations stem. Subjects of the report and of the recommendations include health and the community; comprehensive personal and environmental health services; the consumer; health manpower; the places for personal health care; organization and management of resources; action planning; partners in progress: the governments; and partners in progress: volunteers. **(6)**

NATIONAL COMMISSION ON COMMUNITY HEALTH SERVICES. TASK FORCE ON COMPREHENSIVE PERSONAL HEALTH SERVICES. **Comprehensive health care; a challenge to American communities.** Washington, D.C.: Public Affairs Press, 1967. 94 pp.

Recommendation ten is relevant to mental health:

"An increasingly urbanized and complex society has produced its own stress patterns. These call for special psychologic and psychiatric measures in connection with health promotion and health care.

The psychological aspects of health and disease and the application of social sciences to the health field deserve increasing recognition by the health and other interested professions.

The importance of environmental stress in causation, and of environmental support in treatment, of psychiatric disorders, should be recognized in the organization of general medical, occupational, social, and welfare services.

Psychiatric services are needed in varying degrees by an appreciable part of those seeking medical care and should therefore be incorporated as part of all aspects of prevention and treatment.

—The current national movement towards 'comprehensive mental health and retardation services,' and the great resources that have been developed (public interest, experience, and money) should be integrated into community plans for comprehensive personal health services."

This recommendation is discussed in Chapter 5, "Special Areas of Need." The concepts of comprehensive care and continuity of care are outlined along with the United Automobile Workers' Plan for inclusion of psychiatric treatment in health insurance. **(7)**

NATIONAL COMMISSION ON COMMUNITY HEALTH SERVICES. **Health care facilities: the community bridge to effective health services. Report of the Task Force on Health Care Facilities.** Washington, D.C.: Public Affairs Press, 1967. 67 pp.

This report was designed to help determine the relationships of facilities and institutions providing personal health services to each other and to other community services. Included is discussion of changes required in their form and organization.

Mental health facilities for chronic care, rehabilitation, and other mental health programs should be planned as a part of the comprehensive community health care system. Payment mechanisms, governmental subsidies, and the locations of these services should be chosen to encourage such interrelationships. **(8)**

LEGISLATION

U.S. LAWS, STATUTES, ETC. National mental health act. Approved July 3, 1946 (Public law 487, 79th Cong., 60 Stat. 421-426). Washington: U.S. Govt. Print. Off., 1946. 6 pp.

The purpose of this act is to "amend the Public Health Service Act to provide for research relating to psychiatric disorders and to aid in the development of more effective methods of prevention, diagnosis, and treatment of such disorders, and for other purposes." It contains sections on definitions, the National Advisory Mental Health Council, details of personnel, research, investigations, training, health conferences, grants to states, and gifts. The Act also sets up the National Institute of Mental Health and appropriates money for its use. **(9)**

U.S. LAWS, STATUTES, ETC. Mental retardation facilities and community mental health centers construction act of 1963. Approved October 31, 1963 (Public law 164, 88th Cong., 77 Stat. 282-299). Washington: U.S. Govt. Print. Off., 1963. 18 pp.

Title II is the second of four titles under an act to provide assistance in combatting mental retardation through grants for construction of research centers and grants for facilities for the mentally retarded and assistance in improving mental health through grants for construction of community mental health centers, and for other purposes. Title II deals with the construction of community mental health centers and may be cited as the "Community Mental Health Centers Act." Any state desiring to take advantage of Title II must submit a state plan for carrying out its purposes which, among other things, provides "such methods of administration of the state plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis, as are found by the Secretary to be necessary for the proper and efficient operation of the plan." **(10)**

Community mental health centers act of 1963. Title II, Public law 88-164. Regulations. **Federal Register**, May 6, 1964. pp. 5951-5956.

Included are the fifteen sections of Part 54, Subpart C, entitled "Grants for Construction of Community Mental Health Centers." They specify the physical and programmatic standards which projects must reach in order to qualify for federal funds under this act. Specifications for buildings, services for people unable to pay all or part of the fees, range of programs, administration, fiscal and accounting requirements. d applications are given, as are the criteria for allot g money to each state. **(11)**

U.S. LAWS, STATUTES, ETC. Mental retardation facilities and community mental health centers construction act amendments of 1965. Approved August 4, 1965 (Public law 105, 89th Cong., 79 Stat. 427-430). Washington: U.S. Govt. Print. Off., 1965. 4 pp.

This is an act to authorize assistance in meeting the initial cost of professional and technical personnel for comprehensive community mental health centers, and for other purposes. It covers "Grants for Initial Cost of Professional and Technical Personnel of Centers" with specific reference to authorization, duration, and amount of grants; applications and conditions for approval; payments; regulations; authorization of appropriations; and records and audit. Under "records and audit," research projects are discussed. As used in this section, the term "research and related purposes" means research, research training, survey, or demonstrations in the field of education of handicapped children including experimental schools. **(12)**

Mental retardation facilities and community mental health centers construction act amendments of 1965. Public law 89-105. Regulations. **Federal Register**, March 1, 1966. pp. 3246-3248.

Included are the eight sections of Part 54, Subpart D, entitled "Grants for Initial Cost of Professional and Technical Personnel of Community Mental Health Centers." These define "eligible centers" which can receive federal staffing grants, tell which personnel are eligible under the Act, give the criteria by which staffing grants can be allocated, and describe how applications should be submitted and approved, how the money may be spent, and how records should be kept. **(13)**

U.S. LAWS, STATUTES, ETC. Comprehensive health planning and public service amendments of 1966. Approved November 3, 1966 (Public law 749, 89th Cong., 80 **Stat.** 1180-1190). Washington: U.S. Govt. Print. Off., 1966. 11 pp.

This act authorizes appropriations and gives regulations governing their use for the period from July 1, 1966, to June 30, 1968, under the following headings: grants to states for comprehensive state health planning; project grants for areawide health planning; project grants for training, studies, and demonstrations; grants for comprehensive public health services; interchange of personnel with states; and continuation of grants to schools of public health. The Act also continues the authorization for training of personnel for state and local health work, and contains a "general" section amending some earlier regulations and definitions. **(14)**

U.S. CONGRESS. HOUSE. A bill to amend the mental retardation facilities and community mental health centers construction act of 1963 to provide grants for costs of initiating services in community retardation facilities (H.R. 5110, 90th Cong., 1st sess.). Washington: U.S. Govt. Print. Off., 1967. 5 pp.

The bill amends sections on the authorization of grants, applications and conditions for approval, payments, and regulations. In addition, funds are authorized for the fiscal years ending June 30, 1968, 1969, 1970, and 1971. The term "construction" is redefined to include "construction of new buildings, acquisition of existing buildings, and expansion, remodeling, alteration, and renovation of existing buildings, and initial equipment of such new, newly acquired, expanded, remodeled, altered, or renovated buildings." **(15)**

PLANNING

SURGEON GENERAL'S AD HOC COMMITTEE ON PLANNING FOR MENTAL HEALTH FACILITIES. **Planning of facilities for mental health services** (Public Health Service Publ. No. 808). Washington: U.S. Govt. Print. Off., 1961. 55 pp.

This guide for developing adequate mental health facilities offers suggestions for overcoming obstacles to, and implementing of, state mental health plans. In particular, it calls for consideration of all mental health services and programs before construction of facilities is undertaken. It emphasizes the need of comprehensive plans well coordinated with other health-planning programs. The use of community mental health services as training grounds for professional and ancillary personnel is suggested. Current problems and trends in treating the mentally ill and retarded, as well as social problems such as alcoholism, addiction, juvenile delinquency, and aging, are discussed. **(16)**

U.S. NATIONAL INSTITUTE OF MENTAL HEALTH. **State recommendations in final reports on comprehensive mental health planning.** Chevy Chase, Maryland: The Institute, October 1966. Mimeo. 430 pp.

Prepared by Dorothea Dolan, of the Office of Field Operations, this publication contains the recommendations made by forty of the fifty states in the field of mental health, listed by state. There is a subject index at the beginning, listing states and recommendation numbers relevant to each of approximately 140 subjects. Among the subjects by which this report has been indexed are: administration, appropriations, children, clinics, community mental health centers, consultation, correction institutions, data collection, education, education agencies, financing, goals, health education, hospitals, industry, interagency cooperation, law enforcement, legislation, manpower (general and by professions), mental hospitals, mental retardation, personnel administration, planning, public health, public welfare, recreation, rehabilitative services, research, schools and mental health, training, training–inservice, training–professional, vocational rehabilitation, and voluntary agencies and organizations. **(17)**

U.S. NATIONAL INSTITUTE OF MENTAL HEALTH. **The comprehensive community mental health centers program** (fact sheet). Chevy Chase, Maryland: The Institute, n.d. 8 pp.

Basic provisions of the Community Mental Health Centers Act of 1963 are stated and then essential facts are given under the following headings: What a Community Mental Health Center Is; What a Community Mental Health Center Does; Why the Community Mental Health Center?; What Are the Essential Services?; Full Comprehensive Service Also Includes (a list of five other services, including training, follows); The Center Provides Continuity of Care; The Importance of the General Hospital; The State Plan; Communities Working with the State; The Community's First Step; Five Points for Community Groups; Apply Through the State; The State Sets Priorities; Construction for the Centers Program; A Variety of Kinds; Assembling the Center; Financing the Services; A Variety of Sponsors; and The Five Basics for Federal Aid. **(18)**

U.S. NATIONAL INSTITUTE OF MENTAL HEALTH. **The comprehensive community mental health center; concept and challenge** (Public Health Service Publ. No. 1137). Washington: U.S. Govt. Print. Off., 1964. 22 pp.

Summarized is the intent of Congress in adopting the Community Mental Health Centers Act of 1963 (Public Law 88-164) authorizing Federal matching funds to finance part of the cost of building community mental health centers. The booklet describes procedures for sponsoring and financing community mental health centers. It lists treatment services to be included in them as the means by which patients will receive a continuity of treatment in the home environment. Examples of community mental health facilities currently providing basic services of the comprehensive treatment concept are presented as guidelines for communities which are preparing plans for similar centers. **(Public Health Reports)** **(19)**

U.S. NATIONAL INSTITUTE OF MENTAL HEALTH. **Essential services of the community mental health center: inpatient services** (Public Health Service Publ. No. 1624). Washington: U.S. Govt. Print. Off., 1967. 20 pp.

Inpatient service in a community mental health center provides immediate, personal, and intensive treatment on a 24-hour basis. Illnesses that require such treatment and the methods of treatment themselves (milieu, shock, recreational, and occupational therapies; psychotherapy; chemotherapy; and medical treatment) are described. Facility designs and space allocations are recommended. A reading list is appended. **(20)**

U.S. NATIONAL INSTITUTE OF MENTAL HEALTH. **Essential services of the community mental health center: outpatient services** (Public Health Service Publ. No. 1578). Washington: U.S. Govt. Print. Off., 1967. 28 pp.

Outpatient services in a community mental health center embody the idea of helping individuals to function at their best in daily circumstance, and they reach more persons than any other service. These services often include diagnosis and evaluation of physchiatric problems, and are the source of referrals to other services and agencies. Topics: organizing outpatient services, admissions policies, intake, treatment, projects and techniques for reducing waiting lists, facilities, administration and staff, financing, education of the public, and services for special groups such as children, the elderly, and the alcoholics. Recommended spatial relationships and a design for the facilities are included. A reading list is appended. **(21)**

U.S. NATIONAL INSTITUTE OF MENTAL HEALTH. **Essential services of the community mental health center: partial hospitalization** (Public Health Service Publ. No. 1449). Washington: U.S. Govt. Print. Off., 1966. 18 pp.

Included is a history of partial hospitalization; definitions of day care, evening and night care, and weekend care; and discussion of the advantages of partial hospitalization. The basic program of a partial hospitalization unit is described and modifications for children and the elderly are suggested. Staff, facilities, cost, and

sources of support conclude the discussion. Diagrams of the partial hospitalization unit and a reading list are appended. (22)

U.S. NATIONAL INSTITUTE OF MENTAL HEALTH. **Essential services of the community mental health center: emergency services** (Public Health Service Publ. No. 1447). Washington: U.S. Govt. Print. Off., 1966. 16 pp.

Emergency services should include 24-hour walk-in service, 24-hour telephone service, home visits, and suicide prevention. Special training is suggested for nurses and nonprofessionals who handle the phone service. All personnel should be trained in recognition of those special characteristics which distinguish emergency cases. Services of specific centers are alluded to intermittently. A reading list is appended.

U.S. NATIONAL INSTITUTE OF MENTAL HEALTH. **Consultation and education: a service of the community mental health center** (Public Health Service Publ. No. 1478). Washington: U.S. Govt. Print. Off. 1966. 31 pp.

By educating and providing consultation for community care-givers, the community mental health center is able to relay mental health knowledge and therapeutic help to the public. The educational programs must vary with the care-givers, but informal workshops, seminars, and lectures (with or without visual aids) are appropriate. Training of key professionals in technical consultation and educational services will supplement basic mental health knowledge, not supplant it. These special skills may emerge from on-the-job training and experience, or may be developed by participation in special courses now available at training centers. In-service training for personnel who have not been community-oriented can be provided by using local specialists as teachers, working out arrangements with neighboring universities or other institutions, and providing evening courses, weekend workshops, short-term seminars, regional conferences, and other training opportunities. (24)

GRANTS

FELIX, ROBERT H. Community mental health. **American Journal of Orthopsychiatry** 33:5, October 1963. pp. 788-795.

Presented at the 1963 Symposium on Community Mental Health, this paper is an overview, with some emphasis on financial support and the manpower problem. At the time of the symposium, the National Institute of Mental Health already provided grants for clinical and research training in the four core professions: research training in the biological and social sciences; mental health training in schools of public health; pilot projects in incorporating mental health concepts in the training of lawyers, educators, clergymen and other groups and in training in special areas such as aging, mental retardation and juvenile delinquency; training to help general practitioners play a more effective role in psychiatric treatment; medical school programs leading toward integration of behavioral sciences into education of modern physicians; and special projects to support conferences, institutes, workshops, and surveys of relevance to mental health training. "With the expansions that are seen for the next decade, it becomes more important to provide a wide variety of training opportunities for all levels of personnel in service settings. . . . This is planned for accomplishment through expenditures for inservice training grants for personnel improvement, particularly for attendants and similar personnel (hospital improvement grants). . . . If the President's recommendations on manpower are accepted by Congress, the National Institute of Mental Health will then be directing its future training efforts toward a number of goals." They include: inservice training of personnel; expanding existing graduate and undergraduate programs in the core mental health fields; extending research training, not only in the mental health professions, but also in the relevant biological and social sciences; expanding training for work in special areas such as mental retardation, juvenile delinquency, aging, and alcoholism; expanding training in mental health concepts to non-psychiatric physicians who play an important role in providing preventive and treatment services to the mentally ill or to patients whose illnesses have an emotional component; expanding training programs in the areas of public health, community mental health, and preventive services; devising new teaching and training methods to make communications of new knowledge more effective and to apply this knowledge to clinical problems; providing more information concerning the supply, demand, deployment, and utilization of manpower. "Success of the President's National Mental Health Program hinges on acceptance of the Comprehensive Community Mental Health Center concept, on thoughtful, coordinated, and adequate planning throughout the country, on the proper recruitment and utilization of manpower, and on an expanded and intensified search for new knowledge and techniques." (25)

U.S. PUBLIC HEALTH SERVICE. **Public Health Service grants and awards: fiscal year 1966 funds, part IV** (Public Health Service Publ. No. 1564, part IV). Washington: U.S. Govt. Print. Off., 1967. 119 pp.

This volume of the Grants and Awards Series includes Formula Grants, Project Grants, Regional Medical Planning Grants (projects approved during fiscal year 1966), and Community Mental Health Center Staffing Grants. The community mental health center grants are listed by state, city, and institution, with the number of each grant and its cash value being provided for each institution. The total number of grants and the total number of dollars given to each state are also listed. (26)

NIMH continuing education program. IN Mental health news digest. **Mental Health Digest** (National Clearinghouse for Mental Health Information). August 1967. p. 32.

The program administered by the Continuing Education Branch of the National Institute of Mental Health's Division of Manpower and Training Programs has expanded to include all types of mental health personnel. In addition to support of psychiatric training for general practitioners and other physicians, projects are planned to provide multidisciplinary mental health training to an entire hospital or clinic staff, to add to or update skills of professional and nonprofessional workers, and to increase the number and quality of continuing education programs. Support may be requested by any public or private nonprofit institution, including hospitals, community mental health centers, professional organizations, state or community agencies, and colleges and universities. (27)

MANPOWER

ALBEE, GEORGE W. Manpower prospects in mental health. **State Government** 31:3, March 1958. pp. 55-58.

The manpower shortage is ascribed to the low number of college graduates, poor utilization of brain power, high economic prosperity, and competition from other professions. The criteria for recognizing shortages are listed. Distribution of professionals is uneven, because they tend to gravitate toward urban areas and tend to stay where they are trained. For the future, the author suggests developing new techniques to treat more people and preventing mental illness by treating more children. (28)

ALBEE, GEORGE W. **Mental health manpower trends.** New York: Basic Books, Inc., 1959. 361 pp.

There are separate chapters or sections regarding manpower prospects in light of supply and demand for each of the following professions: psychiatrists, psychologists, physicians, psychiatric nurses, and psychiatric social workers, as well as occupational therapists, practical nurses, clergy, teachers, and attendants and aides. The manpower situations of psychiatrically oriented personnel are discussed in detail, and the author concludes that without a massive effort in all areas of education, on a national scale, there will never be enough professional personnel to eliminate the glaring deficiencies in our care of mental patients. (29)

ALDRICH, C. KNIGHT. Psychiatric consultation in general practice. **The Lancet** 1:7389, April 10, 1965. pp. 805-808.

Community consultation, as in the form of seminars led by a psychiatrist for members of other helping professions, is recommended to lighten patient-load by teaching the precepts and techniques of psychiatry to these persons. Differences between American and British psychiatry are discussed. (30)

BLUM, A. Differential use of manpower in public welfare. **Social Work** 11:1, January 1966. pp. 16-21.

Manpower shortages in social welfare necessitate basic changes in organizational structure and manpower utilization. The differentiation of tasks in relation to client needs and not solely from professional role definitions promises greater latitude for manpower utilization and better service to clients. The institutional treatment model incorporates this type of multi-functional arrangement by the coordination and use of a team of specialists who are utilized differentially as required by the needs of the client. As a specific case progresses, shifts in emphasis and service can be made. with the role of the professional social worker relating primarily to decision-making and accountability for services. More appropriate training than graduate social work education would be needed. It would be more specific and job oriented, with workers undertaking more complex functions as their ability increased. Rather than fitting students into the mold of either generalist or professional social worker, this approach provides for a range of talent utilization in the delivery of services. **(Abstracts for Social Workers)** (31)

BROWN, A. C. Psychiatrists' interest in community mental health centers. **Community Mental Health Journal** 1:3, Fall 1965. pp. 256-261.

A mail inquiry among psychiatrists in New York State disclosed that 59 percent of those who responded were interested in the possibility of working in community mental health service organizations. Of these, 16 percent indicated that they would like to work full time in a community organization. There was good correlation between the amount of time each wanted to spend in a community organization and the type of work he was already doing. Many saw work in the center as an opportunity to expand in the field in which they were already engaged. Because so many who showed interest in the community aspect of mental health were employed in state institutions, it is suggested that creation of such centers could aggravate staffing problems at state institutions. (32)

HALL, O. Organization of manpower in some helping professions. IN Schwartz, E. E. (ed.). **Manpower in social welfare: research perspectives.** New York: National Association of Social Workers, 1966. pp. 57-65.

Trends toward increasing specialization and partializing of tasks, engendered by the expanding bureau-

cratization of professional services, affect all professions and breed feelings of threat and ambivalence related to recruitment. To control the provision of service, professions develop a variety of forms of organization. Medicine has an increasing number of subspecializations and uses lower-status helpers such as nurses. Nurses themselves have generated new categories, e.g., the nursing aide and the practical nurse. Many of them work in relative isolation from doctors, in schools, factories, and other agencies. Dentistry has added dental hygienists. For social work, major manpower issues are recruitment; the uses of alternative types of workers; choosing the workable "mix" of specialization and task delegation; resolving the struggle between agency executives, faculties, and the professional association for leadership in setting policies; denoting the effective combination of formal education and field training; and effecting the maintenance of standards. **(Abstracts for Social Workers)** **(33)**

HASSLER, FERDINAND R. Psychiatric manpower and community mental health: a survey of psychiatric residents. **American Journal of Orthopsychiatry** 35:4, July 1965. pp. 695-706.

Resident psychiatrists in Massachusetts answer queries concerning their current training, their impressions of and attitudes toward community mental health, their interest in becoming associated with future community mental health centers, and their short-range and long-range professional goals. Most respondents expressed interest in community mental health. **(34)**

KLUTCH, MURRAY. **Mental health manpower: an annotated bibliography and commentary**. Sacramento, California: California Department of Mental Hygiene, 1965. 199 pp.

Provided here is a comprehensive report of literature on manpower in the mental health field and in related scientific, professional, and technical fields. The annotated bibliography is arranged alphabetically by author, with a word or phrase at the beginning of each entry describing the field (such as psychiatry) and the application of each entry (for example, "ancillary personnel, utilization"). Following the bibliography, there is an index by subject and by profession, a discussion of conceptual approaches, and a list of suggestions cited frequently in the literature. Appendices are: Individuals and Organizations Knowledgeable about Manpower; Bibliography of Peripheral Sources: Current Research; and Analysis of Questionnaire to California Psychiatrists (concerning possible solutions to the mental health manpower shortage). The report was supported by a mental health planning grant from the National Institute of Mental Health, and is the first phase of a two-part study designed to provide a base for mental health manpower planning. **(35)**

LEVINE, M. Trends in professional employment. IN Schwartz, E. E. (ed.). **Manpower in social welfare: research perspectives**. New York: National Association of Social Workers, 1966. pp. 9-16.

The urgent need for research on how to fill manpower gaps in the helping professions is heightened by the continued population expansion, which creates demands for professionals in many competing and changing fields of service. Although the labor force will expand at a faster rate than the population, especially among professional, technical, and related workers, shortages will persist. Personnel needs in social work, heightened by attrition and new program demands, will not be met by the mere 29,000 who will receive master's degrees during the 1960's. Therefore, experimentation with even more effective social work roles is needed, for example, in the use of hard-core unemployed youth in experimental programs. Meeting the complex needs of disadvantaged workers requires comprehensive approaches that apply unique methods drawn from varied disciplines and that use services from a wide range of agencies. **(Abstracts for Social Workers)** **(36)**

Manpower implications of the interrelationship between social work and public health nursing practices (Proceedings of a conference co-sponsored by the Connecticut State Department of Health, The Connecticut State Department of Mental Health, The University of Connecticut School of Social Work, and The National Institute of Mental Health, October 27-29, 1965). 44 pp.

In the light of the manpower shortage, the purpose of the conference was to consider areas of competence, overlap, and the principles governing the practice of social work and public health nursing. The need for interdisciplinary communication was stressed because of the rapidly growing community mental health movement.

Two introductory lectures by Miss Martha D. Adam and Mrs. Beatrice Phillips outline the functions and roles of the public health nurse and the social worker in relation to mental health. The remainder of the conference was devoted to discussions. The reports of the recorders are given. **(37)**

RICHAN, W. C. Research in occupational restructuring. IN Schwartz, E. E. (ed.). **Manpower in social welfare: research perspectives.** New York: National Association of Social Workers, 1966. pp. 43-54.

The research methods of systems and operations analysis can be applied to social problems and would provide an immediate and rational basis for policy decisions on effective restructuring of manpower utilization. Continuing feedback and innovation, often through the use of computers, assures relevancy and overcomes the time lag so that decisions can be based on the very latest information. By contrast, demonstration-research projects have tended to be built around predetermined hypotheses concerning a few select factors, and time pressures often cause premature commitments to untested hypotheses. Nevertheless, this theory-oriented basic research on fundamental issues can still make necessary long-range contributions. The methodology of systems analysis is further enhanced by the use of cost analysis, which may include the conversion of nonmonetary factors, such as client functioning, into costs, such as that of continued unemployment or of social and health services. Two tracks, then, suggest themselves: basic research on fundamental issues of manpower utilization, for long-range contributions; greater flexibility and use of different strategies, to make the decision process more rational. The two tracks are complementary; they should not be confounded. **(Abstracts for Social Workers)** **(38)**

U.S. NATIONAL INSTITUTE OF MENTAL HEALTH. **Mental health manpower: current statistical and activities report (a series).** Chevy Chase, Maryland: The Institute, 1964– .

Not issued regularly, these reports of the Office of the Associate Director for Manpower and Training, Manpower Studies and Program Analysis Section, "provide current data and information on mental health manpower which is obtained by means of activities carried out by the Mental Health Manpower Program." Included are papers and discussions from Manpower Committee meetings and a series of pamphlets on professional mental health personnel employed in mental health establishments in the United States, based on a survey made in 1963. Statistics are given on such categories as education, hours worked per week, sex, age, specialization, location in country, and place of employment. Titles, dates, and total page numbers for each pamphlet follow:

No. 1. Selected Personal Characteristics of Professional Personnel Employed in Mental Health Establishments. January-March 1964. 8 pp.

No. 2. Education of Psychiatric Aides in State and County Hospitals in the United States. May 1964. 4 pp.

No. 3. Selected Characteristics of Psychiatrists in the United States. October 1964. 8 pp.

No. 4. Selected Characteristics of Psychologists Employed in Mental Health Establishments. February 1965. 8 pp.

No. 5. Highlights of Proceedings, Meeting of the National Mental Health Manpower Studies Advisory Committee. April 1965. 21 pp.

No. 6. Selected Characteristics of Social Workers. May 1965. 9 pp.

No. 7. Selected Characteristics of Nurses Employed in Mental Health Establishments–1963. July 1965. 8 pp.

No. 8. Survey of Mental Health Establishments–Staffing Patterns and Survey Methodology. October 1965. 29 pp.

No. 9. Occupational and Personal Characteristics of Psychiatrists in the United States–1965. February 1966. 13 pp.

No. 10. Professional Mental Health Personnel Employed in States. April 1966. 27 pp.

No. 11. Utilization of Mental Health Manpower (report of committee meeting). October 1966. 17 pp. **(39)**

U.S. NATIONAL INSTITUTE OF MENTAL HEALTH **Psychologists in mental health: based on the 1964 National Register of the National Science Foundation** (Public Health Service Publ. No. 1557). Washington: U.S. Govt. Print. Off., 1966. 9 pp.

"This report, developed by the Manpower and Analytic Studies Branch of the Division of Manpower and Training Programs, is primarily a description of the major personal and employment characteristics of the 11,560 psychologists (68.8 percent of the total in the Register) who said their 'service and product' was related to the field of mental health." Among the statistics given on psychologists in mental health are: age, sex, educational attainment, length of experience, salary, areas of scientific competence, most important job activity, types of employers, employment status, and geographical distribution. **(40)**

U.S. NATIONAL INSTITUTE OF MENTAL HEALTH. **A selected bibliography on the utilization of mental health manpower.** Bethesda, Maryland: The Institute, 1966. Mimeo. 26 pp.

This report was prepared by the Manpower Studies Unit, Training and Manpower Resources Branch. It is divided into four parts: (1) Utilization of Task Accomplishment Personnel Full-time, Permanent Staff Whose Work Relates Directly to Patient or Client Treatment or Service; (2) Utilization of Supporting Personnel Full-time and Part-time, Professional and

Nonprofessional: (3) Patient Self-help Organizations: and (4) General Discussion of Mental Health Manpower Utilization. Training articles are included in parts 1 and 2. **(41)**

WHITMAN, M. Social work manpower in the health services. **American Journal of Public Health and the Nation's Health** 55:3, March 1965. pp. 393-399.

In examining social work manpower in health services, two major national developments must be assessed: (1) the increased and more focused interest of the Department of Health, Education, and Welfare on professional manpower problems, and (2) the emergence of national efforts in health and mental health directed toward a massive approach to the amelioration of long-standing health problems. In order to capitalize on the current upsurge of interest in the expansion of health services and health functions there must be more precise definitions of practice in public health social work, psychiatric social work, and medical social work. Also, the utilization of both group work training and community organization training must be explored. More experiments in combinations of practice methods are needed, as well as new legislation to improve and extend health services. **(Abstracts for Social Workers)** **(42)**

ROLES OF ORGANIZATIONS AND KEY PROFESSIONALS

Organizations

BARTON, W. E. The role of the state mental hospital in the community mental health program. **State Government** 37:4, Autumn 1964. pp. 231-234.

A re-examination of the state hospital's role in community mental health programs is appropriate in light of the objections to its vastness, location, large wards, absence of integration with other medical facilities, personnel shortages, lack of insurance coverage, and cumbersome admission procedures. The comprehensive community psychiatric center had its programmatic origins from state mental hospital demonstrations, as did many of the innovative ideas in treating mental illness. Having pioneered these changes, the state hospitals now suffer from lack of personnel induced by the appeal of the more dramatic resultant community services. This loss of support is critical, as the state hospital is the key to the continuum of services for the patient requiring more than sixty-day care, which cannot be given economically in a community facility. To provide this service the state hospital must provide continuity of care, quality diagnostic examinations, prompt application of appropriate treatment, and full programs of pre- and post-hospital services. Notwithstanding, the new emphasis on the community mental health center, the state mental hospital remains indispensable. **(Abstracts for Social Workers)** **(43)**

BEGAB, M. J. Mental retardation: the role of the voluntary social agency. **Social Casework** 45:8, October 1964. pp. 457-464.

Voluntary family and child-care agencies are an essential part of the service necessary to implement the current philosophy that the mentally retarded belong in the community rather than in institutions. Mental retardation may be mild or severe, its nature and causes diverse and complex, and its determinants related to cultural and environmental circumstances. Therefore, the availability and effectiveness of professional intervention are often crucial in the family's adaptation to the experience. Essential services are family-oriented casework treatment geared toward helping with personal adjustment and parental responsibility, complementary services to parents for care of the child, help in defraying medical costs, and promoting the child's education and social skills. Adoption and foster care should be considered where necessary. It is important to remember that foster parents for retarded children need special qualities, such as the ability to get emotional gratification from small achievements and to deal with community attitudes. Voluntary agencies can engage in experimentation in treatment and research and also take responsibility for using their current knowledge of family life in championing the development of community services for the retarded. **(Abstracts for Social Workers)** **(44)**

CAIN, H. P., II, and L. D. OZARIN. Hospitals and the community mental health centers program. **Hospitals** 38:24, December 16, 1964. pp. 19-24.

The requirements of the Community Mental Health Center Act of 1963 indicate that the program it espouses can best be fulfilled when a community mental health center is affiliated with a general hospital. An applicant for mental health center funds must guarantee inpatient and outpatient services, hospitalization, emergency care, and consultation and education involving community agencies. These need not be under one roof, but a continuum of care must be insured. President Kennedy indicated that "the center could be located at an appropriate community general hospital." . . . To carry out the program there will need to be improved collaboration between the general medical fields and those of mental health. **(Abstracts for Social Workers**, Edited) **(45)**

CAPE, WILLIAM H. **A guidebook for the governing boards of community mental health centers.** Topeka, Kansas: State Department of Social Welfare, 1965. 201 pp.

This aid for public health officials, mental health administrators and members of governing boards, and for other persons interested in community mental health center operations, contains basic information on organization, facilities, staffing, and public relations; on responsibilities of the governing board and the professional staff; on planning and evaluating programs; on determining intake and referral policies; on financial support; on conduct of board meetings; on preparation of records and reports: and on the roles of the community mental health services, state mental hospitals and training centers. **(46)**

CRYSTAL, D. The family service agency as a mental health resource. **Social Casework** 47:6, June 1966. pp. 351-356.

The family service agency, as a community agency with an open door, performs a number of functions that are directed toward the preservation of mental health. For example, calamitous situations disruptive to family life, such as death and sudden unemployment, are dealt with in terms of emotional reactions as well as the modification of external situations. The family agency may be a threshold station seeking to maintain mental and social health via programs geared to family life education and other special preventive group discussions. In treatment involving problems in interpersonal relationships, the agency may offer the client the first and possibly only opportunity to begin to define his problem. The family agency regards its basic role as constant in an ever-changing society that inevitably creates the need for adjustment, adaptation, and the integration of shifting social and psychological elements. As its program reflects larger sociopsychological changes, this basic mental health resource will retain its dynamic and versatile character. **(Abstracts for Social Workers)** (47)

GOSHEN, CHARLES E. Community responsibility for mental health. **West Virginia Medical Journal** 59:3, March 1963. pp. 74-80.

This historical survey of the community's relationship to the treatment of mental illness includes an overview of contemporary community education efforts. Better mental health cannot be divorced from improvements in social and economic life. Crucial problems are lacks of leadership, manpower, and a climate attractive to practitioners. (48)

McCRANIE, E. JAMES. The role of the medical school in community mental health programs. **Journal of the Medical Association of Georgia**, vol. 54, May 1965. pp. 165-166.

As undergraduate psychiatry has developed in the medical school curriculum, specialty training in psychiatry has shifted from the state hospital to the medical school center. The functions of a medical school are training, research, and service. The medical school can play a critical role in all three areas in the emerging development of community mental health programs. Since the primary purpose of the medical school is the education of physicians, its primary contribution to the community mental health program is the training of psychiatrists and the psychiatric orientation of other professions. The association of a comprehensive mental health center with a medical school would also provide an ideal laboratory for research. The urgent need, then, is for the development of comprehensive mental health centers in connection with medical schools. (49)

PERLIN, SEYMOUR and ROBERT L. KAHN. The overlap of medical and nonmedical institutions in a community mental health center program. **Comprehensive Psychiatry** 4:6, December 1963. pp. 461-467.

Because patients' needs often are not met by services of any one agency, the Division of Psychiatry of Montefiore Hospital, New York City, has developed a cooperative program with nonmedical community agencies. A group worker is shared with a local community center, a psychologist with an elementary school, and a children's clinic with the Board of Guardians. The costs of salaries and facilities are divided among the agencies, and the shared staff serve primarily those people whose needs require the services of both institutions. This arrangement helps to furnish many of the kinds of services required of a comprehensive community mental health program. (50)

SHOOP, VIRGIL V. The relationship of the community mental health center with other community agencies. **Minnesota Welfare**, Summer 1962. pp. 1-19.

This address, given at the 69th Annual Conference of the Minnesota Welfare Department in 1962, describes mental health and mental health centers--Minnesota's in particular--explaining what the centers do, their desired partnership with other community and welfare agencies, and the necessity that responsibility in the community mental health movement be shared equally among all agencies. It illuminates problems that these centers may experience, such as lack of information and communication. (51)

SMITH, ELIZABETH REICHERT. Current issues in mental health planning. **Community Mental Health Journal** 2:1, Spring 1966. pp. 73-77.

Resolution of some of the issues identified by communities in planning comprehensive community mental health services is critical to movement from the planning stage to program development and operation. These issues relate both to the relationship of the local mental health system and to other major community systems: e.g., the general health system, the anti-poverty program and multi-jurisdictional political systems, and to the interrelationships of certain component parts within the mental health system itself (inlcuding the private practice sector of psychiatry, and other areas of medicine), delimited mental health services offered by voluntary agencies, the state mental hospital system,

nonpsychiatric agencies, and the "gatekeepers." Specific reference is made to solutions proposed by the District of Columbia. **(Community Mental Health Journal)** **(52)**

SUTHERLAND, J. D. The psychotherapeutic clinic and community psychiatry. **Bulletin of the Menninger Clinic** 30:6, November 1966. pp. 338-350.

Expanding community mental health services entail new roles for the psychotherapeutic clinic. Its staff has to initiate and maintain a large-scale training program whereby the psychotherapeutic skill of all the helping professions can be raised. Inside the clinic, psychotherapeutic practice, as well as preserving the traditional role of providing long-term individual treatment for some, must comprise work that closely parallels much of the work in the community. In particular, high expertise must be maintained in the treatment of the family and in group therapy and group dynamics. Lastly, because of the clinic's role in picking up the social breakdowns, it occupies a unique position as a servomechanism that must be integrated with key community institutions. **(Abstracts for Social Workers)** **(53)**

THOMSON, DERYCK. Community mental health and the family service association. **Canada's Mental Health**, vol. 13, November-December 1965. pp. 20-25.

Roles, functions, and goals of the mental health clinic and the family service agency are described and compared. The agency's involvement in the three levels of prevention is also covered. **(54)**

VISOTSKY, HAROLD M. Role of governmental agencies and hospitals in community-centered treatment of the mentally ill. **American Journal of Psychiatry** 122:9, March 1966. pp. 1007-1011.

This country's mental health services are reverting from the centralized facility that is the state hospital to individual community mental health centers. State hospitals should not be abandoned, however; they can still be useful to the populace in their immediate vicinity. The community mental health center's role in this return of the centralized services to the community is that of catalyst, growing edge of progress, and leader in activating and organizing the existing community, family, and individual sources of help. The community mental health center should not, by itself, undertake to "deliver the community toward health." The mental health professional should concentrate on organizing and coordinating existing services, for perhaps the critical need is not to introduce new services but to bring existing ones together. **(55)**

Key Professionals–General

BRAYFIELD, ARTHUR H. Community mental health centers "staffing" legislation. **American Psychologist** 20:6, June 1965. pp. 429-430.

This editorial expresses the opinion that "legislation designed to increase the supply of manpower for mental health should not be interpreted by administrative regulations in such a way as to reduce the supply of effective manpower" which can result if administrators must be physicians. Other members of the community mental health team, such as social workers and psychologists, might also be qualified to head the community centers. **(56)**

FREEMAN, HOWARD E. Social change and the organization of mental health care. **American Journal of Orthopsychiatry** 35:4, July 1965. pp. 717-722.

Anticipated shifts in the relationships among members of the mental health profession are discussed. The psychiatrist will probably function mainly on a technical level and deal with the control of manifestations of mental disorders in patients. Others who have marginal status in the field will improve their situations; competition and conflict are to be expected. **(57)**

HODGES, ALLEN. The mental health professional in the community: some generalizations for effectiveness. **Mental Hygiene** 48:3, July 1964. pp. 363-365.

With the realization of the contributions that community-based health programs can make to the mental health movement, some generalizations have been set forth as guidelines to the mental health professional. "1. Mental health professionals with rare exception comprise a subcultural group and, therefore, do not have communication-access or opportunities to influence the total community. 2. Community leadership is often vested in a few key individuals who are not always prominently visible. 3. A community's 'threshold of learning' varies according to community prestige and demonstrated civic responsiveness of the speaker. 4. Ultimate program decision making occurs at the community level and comes to fruition only over periods of time. 5. A community, like an individual, follows its own unique path of growth and development. 6. The professional's role in the community process is one of 'facilitator' rather than 'manipulator,' requiring a high degree of confidence in the community's capacity to grow, to learn, and ultimately to repair its own insufficiencies." **(58)**

HUME, PORTIA BELL. Community psychiatry, social psychiatry, and community mental health work: some inter-professional relationships in psychiatry and social work. **American Journal of Psychiatry** 121:4, October 1964. pp. 340-343.

The community approach requires the acceptances of new responsibilities as a result of changing relationships among the roles of its professional workers. In community mental health work, the psychiatrist is primarily a clinician with public health responsibilities. The psychiatric social worker is also potentially a clinician with public welfare responsibilities as well as a practitioner, public welfare administrator, supervisor, group worker, consultant-educator, and researcher. **(59)**

PAPANEK, GEORGE O. An exploratory model of community psychiatry. **Hospital and Community Psychiatry** 17:4, April 1966. pp. 91-95.

Malfunctions in social interaction add to impaired mental health. To combat this, mental health professionals (psychiatrists, psychologists, psychiatric social workers) at St. Luke's General Hospital in New York have combined with key community leaders who are in strategic positions to detect signs of difficulty early, to mediate among conflicting interests, and to keep disturbances at a minimum.

This interaction between professionals and the community is discussed with emphasis on aims and organization and on problems of clergy, police officers, teachers, social workers, and housing relocation personnel. Once the mental health professional enters the community agency he is forced to cope with questions of social and political action and of public morality. Acting as a consultant, the professional, disinterested but concerned, has a catalytic effect in fostering responsible self-evaluation in the community agent. **(60)**

RIOCH, MARGARET J. Changing concepts in the training of therapists. **Journal of Consulting Psychology** 30:4, August 1966. pp. 290-292.

The author cites Ernest Poser's appraisal of the relative efficacy of trained and untrained therapists, and suggests that professionals should concern themselves with the advancement of knowledge and leave the practice to new categories of workers such as students and mature married women. **(61)**

SCHATZMAN, L. and R. Bucher. Negotiating a division of labor among professionals in the state mental hospital. **Psychiatry** 27:3, August 1964. pp. 266-277.

In the context of institutional expansion and change, a process of negotiation occurs among psychiatric team members concerning the allocation of tasks and coordination of work. A study of five wards in a mental hospital, each with a different treatment ideology, noted similar attempts by professionals to bargain, form coalitions, and appeal to authority and experience to press their claims for the performance of certain functions. Since World War II, with the change from custodial to treatment goals in mental institutions, institutional order is increasingly being negotiated rather than given. As professional schools expand and proliferate, greater numbers of psychiatric professionals enter old and new work settings. They come with upgraded education and newer professional work models and missions, as well as with newer treatment ideologies that are often unknown to their professional colleagues. As psychiatric working situations become more interprofessional in nature, it may be expected that there will be increasing negotiations among professionals in order to establish their various claims. **(Abstracts for Social Workers)** **(62)**

ZANDER, ALVIN, ARTHUR R. COHEN, and EZRA STOTLAND. **Role relations in the mental health professions**. Ann Arbor, Michigan: Michigan University Institute for Social Research, Research Center for Group Dynamics, 1957. 211 pp.

A study of intergroup attitudes and behavior among psychiatrists, clinical psychiatrists, and psychiatric social workers was undertaken to ascertain the nature of the feelings and difficulties that a cross-discipline team needs to face if it is to survive as an effective unit. The mix described was chosen because most mental health agencies employ persons from these fields and encourage them to work closely together. Introductory chapters explain the approach to the study, give an account of the methods used to obtain data, and describe the professions and the expectations that members of each have, both for themselves and for members of the other two groups. The remaining chapters deal with relationships between psychiatrists and psychiatric social workers, between psychiatrists and clinical psychologists, and between psychiatric social workers and clinical psychologists. They also discourse on the attitudes of each professional group toward the other two groups, and reaction to colleagues within each professional group. Interpretations and conclusions end the report. **(63)**

Psychiatrists

ALDRICH, C. K. The new approach: intervention and prevention –the clinical psychiatry model. **Social Service Review** 40:3, September 1966. pp. 264-269.

The role and the functions of the community psychiatrist are defined by contrasting the psychoanalytically-oriented psychotherapist and the "biologic" psychiatrist. Good interprofessional relationships are needed to allow the skills of one professional to supplement the skills of others. **(64)**

BIEBER, T. B. and I. BIEBER. Psychotherapeutic focus in social psychiatry. **Archives of General Psychiatry** 13:1, July 1965. pp. 62-66.

Psychotherapy has an important and central contribution to make to community mental health programs. Psychotherapy is necessary for handling those psychiatric disabilities that are not amenable to milieu therapy, which has its limitations when an individual has had a persisting psychiatric problem and adulthood is reached with his disability fixed within the fabric of his personality. Resolution of the psychosis and severe neurosis requires the use of a competent therapist. Therapists, adequately trained in the use of psychoanalytic techniques, with the capacity to communicate simply and to relate to people without class or caste bias can provide the benefits of psychotherapy to all classes of people. Psychoanalysis can contribute its knowledge of the determinants of mental illness in helping to establish mental health programs for prevention and treatment. Money is required both for the training of competent personnel and for the payment of fees by patients with limited resources. **(Abstracts for Social Workers)** **(65)**

BLANK, H. ROBERT. Community psychiatry and the psychiatrist in private practice. IN Bellak, Leopold (ed.). **Handbook of community psychiatry and community mental health.** New York: Grune & Stratton, 1964. pp. 300-318.

Some usually ignored but important problems of the psychiatrist as planner, policy-maker, and worker in community psychiatry are delineated. A prediction is made of the deterioration of professional standards of community mental health programs unless psychiatrists in private practice devote substantially more of their time to these activities. Psychiatrists are enjoined to insist on the best qualified personnel and realistic plans for community programs. Among contributions the psychiatrist in the community setting can make are the conduct of a seminar, with an entire professional staff, based on either a presentation of a current case or a special subject illustrated by one or more cases. Specific suggestions are made for the psychiatrist's approach to community psychiatry. The economic and political issues involved are discussed. **(66)**

BRICKMAN, HARRY R., DONALD A. SCHWARTZ, and S. MARK DORAN. The psychoanalyst as community psychiatrist. **American Journal of Psychiatry** 122:10. April 1966. pp. 1081-1087.

Psychoanalysts in Los Angeles County are as well represented in the community mental health program as they are in the total psychiatric effort of the area. The psychoanalysts who participate in the county's program feel that the two kinds of psychiatry are not only compatible, but are reciprocally helpful. **(67)**

CAPLAN, GERALD. **Manual for psychiatrists participating in the Peace Corps program.** (Special publication for Peace Corps, n.d.) 111 pp.

Although it was written for the Peace Corps, hope is expressed that psychiatrists using this manual will "find it of use in understanding some of the broader problems of community mental health." Its major subjects are: philosophy of the Peace Corps, administrative arrangements for psychiatric programs, duties and responsibilities of the psychiatric consultant (including diagnosis of mental disorder, advice on job placement, mental health training, and training of Peace Corps physicians and representatives), and technical issues (defining the role of the psychiatrist, relations with trainees, crisis theory, the mental health course, and mental health consultation). Sections on defining the role of the psychiatrist (pp. 27-65) are entitled: Definition of Role by Peace Corps Policy Statements; Contributions of Local Project Director to Role Definition; Building and Maintaining Relationships with Project Staff in Defining and Sanctioning the Psychiatrist's Role; Overcoming Stereotyped Negative Expectations; and Orientation to the Social System of the Training Program. In the section on mental health consultation, a summary is presented on the main consultation techniques likely to be applicable in helping staff members at the training site understand more fully the mental health dimensions of their roles in training and selection. **(68)**

DORN, ROBERT M. The role of the psychoanalyst in community mental health. **Community Mental Health Journal** 2:1, Spring 1966. pp. 5-12.

The orthodox psychoanalyst is needed in community mental health work. He brings a viewpoint different than, yet related to, other professionals concerned with mental functioning and behavior. Attempts to provide better health for an entire population obscure

intrapsychic dynamics. The emphasis shifts to interpersonal, or more broadly speaking, environmental factors. Psychoanalytic training affords an important balance: the analytic role makes one most aware of the unconscious as an ever-persistent force, contributing to perception of reality, thinking, and behavior. **(Community Mental Health Journal)** **(69)**

FOLEY, A. R. and DAVID S. SANDERS. Theoretical considerations for the community mental health center concept. **American Journal of Psychiatry** 122:9, March 1966. pp. 985-990.

The trend among various disciplines in the mental health field to take on new functions, roles, and activities without clearly defined reason is questioned in the instance of the community psychiatrist who must be administrator, consultant, program planner, and educator, as well as clinician--despite his lack of preparation for other than clinical undertakings.

Additional training, the answer to the problem, is considered from the standpoints of the philosophy of the mental health center, the structure of such centers, and the risk of the psychiatrist's losing his professional identity because his role has been made diffuse through an excessive number of interests. **(70)**

FORSTENZER, HYMAN M. Consultation and mental health programs. **American Journal of Public Health** 51:9, September 1961. pp. 1280-1285.

Experiences in New York State are the basis for this discussion of the function of consultation in contradistinction to inservice training. Consultation is the appropriate function of the psychiatrist; inservice training is properly in the province of nonclinical persons. Consultation should not be used as a substitute for inservice training, although it can--through caretaker intermediaries--be valuable in dealing with large numbers of cases. **(71)**

HOCH, PAUL H. The responsibility of psychoanalysts in community mental health programs. IN Masserman, Jules H. (ed.). **Communication and community** (Vol. VIII of **Science and Psychoanalysis**). New York: Grune & Stratton, 1965. 262-267.

To reach more persons, American psychoanalysts should combine their own concepts of total cure with the European method which emphasizes relieving symptoms and facilitating adapting to the environment. Psychoanalysts must apply their concepts to the community, and must keep the community psychiatry movement from losing touch with human differences and individuality. **(72)**

MANION, MARY E. New help with problem patients. **Medical Economics**, vol. 43, 31 October 1966, pp. 176-177.

The psychiatrist in charge at the Northland Mental Health Center in Grand Rapids, Michigan, was available for around-the-clock telephone consultation to community physicians; he also offered to meet with them, either in their offices or in hospitals. His consultation is described. **(73)**

MILLET, JOHN A. P. Training for community mental health services. IN Masserman, Jules H. (ed.). **Communication and community** (Vol. VIII of **Science and Psychoanalysis**). New York: Grune & Stratton, 1965. pp. 278-287.

The role of the psychoanalyst is to be "captain" of the mental health "team," since his sensitivity to the subleties of human interaction qualify him to coordinate the activities of the others. The need for trained personnel is discussed and the residency training programs in community psychiatry offered by the Harvard School of Public Health, by the California Department of Mental Hygiene, and by the Columbia University School of Public Health and Administrative Medicine are briefly described. **(74)**

VISOTSKY, HAROLD M. Community psychiatry: we are willing to learn. **American Journal of Psychiatry** 122:6, December 1965. pp. 692-693.

The psychiatrist must learn to work cooperatively with other community resources for dealing with community mental health. This requires careful planning, communication, and evaluation. Though the psychiatrist is sometimes a leader, he must avoid the role of sole expert who solves all social ills. He is an intelligent participant with other community resources, professional disciplines, and colleagues. Interdiscipline endeavor is not intended to supplant private practice among the cooperating disciplines. Such endeavor is a drawing together of the major resources for attacking common problems. **(75)**

YOLLES, STANLEY F. The psychoanalyst and community psychiatry. IN Masserman, Jules H. (ed.). **Communication and community** (Vol. VIII of **Science and Psychoanalysis**). New York: Grune & Stratton, 1965. pp. 147-149.

The United States cannot have a comprehensive community mental health program without the leadership of psychiatrists whose knowledge is solidly grounded in clinical practice. There is no essential difference between individual-centered psychoanalysis

and community psychiatry: both deal with the individual and the environment only the emphasis is changed. No economic conflict will be occasioned by the psychiatrist's part-time participation in community programs. (76)

Clinical Psychologists

GELFAND, SIDNEY and JAMES G. KELLY. The psychologist in community mental health. **American Psychologist**, vol. 15, 1960. pp. 223-226.

Postdoctoral training with an interdisciplinary focus in the academic setting, but with intimate ties to field agencies, is advocated. Under such conditions, the psychologist will learn community skills and create a "scientist-professional" role that will preserve his identity. (77)

JARVIS, PAUL and SHERMAN NELSON. The therapeutic community and new roles for clinical psychologists. **American Psychologist** 21:6, June 1966. pp. 524-529.

In a therapeutic community as practiced at Fort Logan, the clinical psychologist and others on the treatment team daily assess and try to modify their patients' behavior by observing them and experiencing with them many varied interactions in a number of activities. Professionals become skilled in using (and developing through teaching and consultation) the therapeutic potential of ministers, teachers, lawyers, physicians, youth workers, policemen, and laymen. The clinical psychologist teaches in the research training program, and participates in administration and consultation. Society's demands for the services of the clinical psychologist are urgent and growing. (78)

LIBO, LESTER M. Multiple functions for psychologists in community consultation. **American Psychologist** 21:6, June 1966. pp. 530-534.

The New Mexico District Mental Health Consultant Program exemplifies the psychologist's role as consultant. Qualifications for this post are given, followed by an outline of training and activities. Consultants are given a two-month orientation in the community approach. This orientation consists of reading assignments; discussion of geography, state history, politics, and culture; visits to agencies and institutions; interviews with government officials; and reviews of appropriate files and correspondence. Four areas of the state are serviced by two psychologists, one psychiatric social worker, and one nurse-mental health consultant. The state-level consultant, a psychiatrist, travels the state by plane. Each consultant travels his circuit weekly engaging in community organization, case consultation, inservice training, and public information and education. (79)

SHULBERG, HERBERT C. State planning for community mental health programs: implications for psychologists. **Community Mental Health Journal** 1:1, Spring 1965. pp. 37-42.

Profound crises confront psychologists and their professional organizations. The psychologist's future schedule may include administration participation in decisions on staffing, training, budgeting, and organization of comprehensive mental health facilities. Other subjects are: states' planning and analysis of public and voluntary mental health programs reported 1963-65 as part of the national effort to provide community mental health services for regions of 75,000 to 200,000 persons, and experiences in the establishment and operation of the Massachusetts Project (the manner in which broad citizen and professional participation in mental health programs has been outlined is emphasized). Historical background and the structural and substantive issues of planning projects are included. (80)

YOLLES, STANLEY F. The role of the psychologist in comprehensive community mental health centers: the National Institute of Mental Health view. **American Psychologist** 21:1, January 1966. pp. 37-41.

The psychologist's functions in a community mental health center are to provide consultation for community agencies and to prevent mental illness. A psychologist who is a creative generalist is needed—one who has interdisciplinary skills and can act as an integral part of the mental health team. Leadership in these centers should be based on competence rather than specific professional identification. (81)

Psychiatric Social Workers

AMERICAN PUBLIC HEALTH ASSOCIATION. COMMITTEE ON PROFESSIONAL EDUCATION. Educational qualifications of social workers in public health programs. **American Journal of Public Health** 52:2, February 1962. pp. 317-324.

Social work and public health have the same broad goals; their functions are complementary. Specific functions of social workers in public health and mental health are: social work consultation; program planning policy setting, and implementation; social work for indviduals, families, groups, and communities; conduct of research, studies, and surveys; and educating students of social work and related professions. The personal and professional qualifications of public health social work-

ers is followed first by a description of the education, experience, knowledge, skills, and abilities required of each grade of social worker, and finally by a review of the social worker's graduate program. (82)

COHEN, JEROME. Changing dimensions of social work practices in the mental health field. IN Magner, George W. and Thomas L. Briggs (ed.). **Staff development in mental health services.** New York: National Association of Social Workers, 1966. pp. 99-113.

Support oscillates between psychological and social theories of behavior, but neither the psychological school, claiming environment to be constant and trying to change the individual, nor the social school, adopting the converse approach, can alone effect significant changes. Social work can contribute an understanding of the social environment's effect on the individual's psychological structure and on the external social structures that influence behavior. A proposed position of the American Psychiatric Association and the National Association of Social Workers recognizes the importance of each profession's prerogative to initiate and terminate its professional services—and the responsibility of each to seek consultation in the other's area of competence. A horizontal "leader among equals" pattern is replacing the traditional vertical hierarchy in mental health. The attendant changes will require new roles and increased autonomy for social workers. (83)

MAYO, JULIA A. Community psychiatry: a challenge for social work. **Comprehensive Psychiatry** 4:6, December 1963. pp. 409-416.

Community mental health centers demand a new functionally oriented practice—professionals must break out of their stereotyped roles. Psychiatric social workers can contribute to community mental health by giving diagnosis and therapy in addition to service. (84)

Psychiatric Nurses

ALEXANDER, J. B. The new nurse: her role and relations. **Perspectives in Psychiatric Care** 3:7, 1965. pp. 37-40.

The Joint Commission's Report, its emphasis on the manpower shortage, and the implication for psychiatric nursing are discussed. The important role of the nurses on the team should be formally recognized, and nurses should be allowed to undertake more therapeutic work. (85)

BOONE, DOROTHY and BERTRAM S. BROWN. The role of the mental health nurse in a mental health public health setting. **Mental Hygiene** 47:2. April 1963. pp. 197-204.

The role of the mental health nurse in a community mental health clinic is characterized by her association with community groups, families, and individuals within these groups. Recognized as a health practitioner, she is versed in community resources and is a skillful referral agent. As a member of the mental health nurse-and-psychiatrist team, she complements the doctor. More familiar to members of other helping professions than the psychiatrist, she provides liaison between hospital, home, and community. Within the clinic, the nurse operates in several areas, integrating direct clinical service, consultation, training, and development of the research and documentation aspects of the agency's program. (86)

GLITTENBERG, JOANN. The role of the nurse in the outpatient psychiatric clinic. **American Journal of Orthopsychiatry** 33:4, July 1963. pp. 713-716.

Presented is "an initial attempt to obtain a national composite of the functions and duties performed by the nurses. Also included in this survey are the nurses' perceptions of their potential contributions in outpatient psychiatric clinics." (87)

GLOVER, B. H. A psychiatrist calls for a new nurse therapist. **American Journal of Nursing** 67:5, May 1967. pp. 1003-1005.

Psychiatric nurses can be trained to function as individual or group therapists. They will work under the supervision of a psychiatrist to comply with legal requirements. A one-year inservice program intended to accomplish this training requires five to ten hours per week in instructive pursuits: the remainder of the time is spent in usual duties. Training consists of reading, discussing tapes, viewing clinical situations through a one-way mirror, and supervised therapy. (88)

HUBER, HELEN. Defining the role of the psychiatric nurse. **Journal of the Fort Logan Mental Health Center** 1:2, Winter 1963. pp. 87-101.

At Fort Logan Mental Health Center, a group consisting of a nurse, a social worker, a psychologist, and several psychiatrists worked out the broad aspects of each discipline's role. The factors that have contributed to the nursing profession's not defining a significant role in the treatment of the mentally ill are described, and efforts to establish a role for the staff nurse, to

determine her problems and responses, and to define the general mental health implications for nursing are discussed. The advantages and disadvantages—with respect to nurse, patient, and institution—of both delineated and nondelineated roles are presented. **(89)**

LESSLER, KEN and JEANNE BRIDGES. The psychiatric nurse in a mental health clinic. **Mental Hygiene** 49:3, July 1963. pp. 324-330.

A 14-month study in a Sanford, North Carolina, community mental health clinic discloses that a psychiatric nurse engaged in individual consultation, individual and family counseling, psychotherapy, psychological testing, supervision of patient medication, intake interviews, home visits, liaison between her clinic and referring agencies, and some clerical duties. It is suggested that she could help the psychiatrist in follow-up studies of medication and serve as a link between the community's general practitioners and the clinic. Much of her time may be spent with the welfare and health departments. The psychiatric nurse must consciously try to develop ways to be useful within the community mental health setting. **(90)**

LEWIS, RUTH V. The nurse in a community mental health center. **Journal of Psychiatric Nursing** 1:3. May 1963. pp. 228-232.

This description of the nurse in the Psychiatric Receiving Center of the Greater Kansas City Mental Health Foundation characterizes her role and functions as organizing and administering the ward, giving nursing-care orders, facilitating treatment, initiating group activities, and overseeing. She is a norm bearer and a mirror of reality. **(91)**

MERENESS, DOROTHY. The potential significant role of the nurse in community mental health services. **Perspectives in Psychiatric Care** 1:3, May-July 1963. pp. 34-39.

The nurse's role must be expanded to encompass new responsibilities—working with groups, dealing therapeutically with patients and their families in their homes, and undertaking preventive measures. Preparation for this wider activity should include a four-year college degree and graduate education, leading to knowledge of psychological theory, ability to be therapeutic in the use of self, and greater capability as a professional collaborator. **(92)**

NORRIS, CATHERINE M. The trend toward community mental health centers. **Perspectives in Psychiatric Care** 1:1, January-February 1963. pp. 36-40.

The trend to community care requires changes in the attitude and in the role of the psychiatric nurse. She must learn to function on an interdiscipline team, change her focus from the patient only to include the family and the community, learn measures of prevention, and develop a good relationship with public health nurses. **(93)**

O'CONNOR, DIANE. The nursing profession: II. The clinical nursing specialist in psychiatry. **Journal of the Kansas Medical Society**, vol. 67, March 1966. pp. 156-160.

The role of the psychiatric nurse specialist is indicated by her two functions—direct patient care and staff education. There is a description of personal experience with a patient. Staff education involved participation in staff development for psychiatric employees and consultation with nurses on nonpsychiatric duty. **(94)**

PEPLAU, HILDEGARD E. The nurse in the community mental health program. **Nursing Outlook** 13:11. November 1965. pp. 68-70.

The role of the public health nurse burgeons and gains importance in preventing mental illness as well as in aftercare. To discharge this new responsibility as a full member of the mental health team, the nurse needs expert guidance. Clinical supervisors, the key persons in community mental health nursing programs, should share their knowledge through clinical conferences with nurses and through review of nurses' work. Therefore, supervisors must not only function as nursing "scientists" and researchers, they must also keep up with advances in both nursing and mental health. Their education may need to be supplemented with short courses and workshops. **(95)**

STUEKS, ALICE M. Working together collaboratively with other professions. **Community Mental Health Journal** 1:1, Winter 1965. pp. 316-319.

Familiar to nurses in general medical settings, collaboration is not well understood by the psychiatric nurse in many mental health centers, particularly if her role is ill defined or if she tries to change from a custodial to a therapeutic role. Collaboration is discussed

from the standpoints of professional identity, professional integrity, overlapping of roles, and flexibility with relation both to nursing and to the other mental health disciplines. **(96)**

TOOLE, BEN and HAROLD BOYTS. New roles for mental health personnel: II. The nurse therapist. **Hospital and Community Psychiatry** 18:1, January 1967. pp. 21-22.

The Adams County Mental Health Center in Quincy, Illinois, used a psychiatric nurse as a nurse-therapist to arrange and oversee aftercare for hospital patients and to supervise activities in a part-time demonstration day care program. The nurse evaluated the patient's home environment before, during, and after hospitalization; arranged home placement when a patient's own home was unsuitable; helped patients with vocational rehabilitation and job placement; provided home supervision and evaluation of medication; made home visits and gave supportive therapy in emergencies; and made the community mental health center and other resources more accessible and acceptable to patients and their families. The nurse also maintained liaison with local nursing homes, the public health department, other social and welfare agencies, and with the social service department of a state hospital. **(97)**

WOLFF, ILSE S. The psychiatric nurse in community mental health a rebuttal. **Perspectives in Psychiatric Care** 2:2, 1964. pp. 11-18.

In reply to articles by Catherine M. Norris and Dorothy Mereness, the author feels that they expect too much of the psychiatric nurse. She is already overextended and engages in too many different activities. Psychiatric nurses need better educational preparation for their jobs. **(98)**

WRAY, EDWARD O. Crisis intervention--a nursing role in community mental health programs. **Journal of Psychiatric Nursing** 3:5, September-October 1965. pp. 394-400.

New community programs will cause a change in the psychiatric nurse's role. In addition to functioning properly in a crisis situation, she will have to achieve a good relationship with public health nurses, be more mobile, function as a member of a team, and accept greater responsibility for planning the care of patients. **(99)**

Some General Principles and Procedures

AMERICAN NURSES' ASSOCIATION. DIVISION ON PSYCHIATRIC-MENTAL HEALTH NURSING. **Statement on psychiatric nursing practice**. New York: The Association, 1967. 41 pp.

This statement was developed to define psychiatric nursing, to show its relationship to all of nursing practice, and to set realistic goals for nursing in psychiatric services. It is based on study of historical patterns, developing trends in practice, and consideration of a profession's responsibility to respond to changing social needs. Staff development and training are discussed in a section on indirect nursing care roles of clinical specialists. "Every facility committed to the improvement of patient care provides for continuing staff development of employed nursing personnel. A director of staff development and training assists the psychiatric nurse administrator in accomplishing the overall nursing goals by planning programs for all levels of nursing personnel that will enable them to bridge the gap between previous education and new trends and developments in practice." The director schedules training program sessions, designates specific times and subjects for out-of-class study, and provides for evaluation of learning. The director identifies theory and techniques appropriate to each level of nursing personnel, participates in the teaching of theory, and assists personnel in relating this knowledge to nursing problems observed in the clinical units. "The director who serves as a role model in giving direct nursing care to patients can more effectively help the personnel to develop nursing skills." Other duties of the director are: to help provide opportunities for new skills and methods to be used, to advise nursing personnel regarding their continuing education and help them plan for it, and to assist faculty from schools of nursing in using the clinical facility for training. **(100)**

CAPLAN, GERALD. **An approach to community mental health**. New York: Grune & Stratton, 1961. 262 pp.

The community approach to preventive psychiatry; preventive intervention; mother-child relationships and family life; and the roles of nurses, social workers, and family doctors in preventing emotional disorders are considered in comments on the establishment of an effective community mental health team. In building such a team, training and consultation are important features. Teachers who are experienced in pilot community mental health ventures and workers who have had postgraduate training in community mental health work are suggested to give inservice training for professionals who, because many pre-professional institutions do not teach the community approach, are deficient in this concept. Consultation between psychiatrists and family doctors is needed so that they may teach each other their respective approaches. Training of social workers for consultation with caretaking agents will strengthen the rapport that makes an integrated effort possible. Technical study groups at which professionals discuss their current experiences are helpful. Some such discussion groups have met at intervals in institutes conducted by an outside consultant who shares the latest developments from his own pioneering venture or educational establishment and stimulates and supports continued development in line with local conditions. **(101)**

CAPLAN, GERALD. **Principles of preventive psychiatry**. New York: Basic Books, Inc. 1964. 304 pp.

This introductory work describes preventive psychiatry and its methods. Inservice training to give community skills to practitioners who have only general skills is held to be an important part of each community mental health program. This training can be short term (seminars, institutes, etc.) or continuing (auto-didactic study groups meeting weekly or biweekly and evening courses). Staff members might even be sent away for periods of concentrated education. Chapter 8 defines the settings and aims of consultation between the psychiatrist and the community professional. Chapter 9 describes a specific technique under the following headings: preparing the ground for consultation, the individual consultation relationship, assessing the consultation problem, delivering the consultation message, and ending and follow-up. **(102)**

CHOPE, HAROLD D. In-service training needs, problems, and potentials in the community. IN **Region VI conference on planning in-service training programs for mental health** (December 2-5, 1963, Omaha, Nebraska). Omaha, Nebraska: Nebraska Psychiatric Institute, Community Services Division, 1964. pp. 45-51.

The professional staff of a community mental health agency (psychiatrist, clinical psychologist, psychiatric social worker, and psychiatric nurse) need inservice training to further equip them for serving at the community level. The definition of inservice training used here is "the planned and continual attempt to impart new knowledge and skills to the professional staff." Inservice training includes four techniques which are described by specific examples: (1) a planned series of lectures or seminars given to the staff at their place of work; (2) special programs and short courses given away from the place of work; (3) residential seminars lasting several days to several weeks away from the place of work; and (4) on-the-job training by senior instructors to teach new skills by example to other staff. Some basic principles for community inservice training are: always involve some of the staff in planning the training, define a goal for training (measurable if possible), vary the training techniques to satisfy individual situations, and use existing staff skills in teaching. Intellectual stimulation, the prime motivating factor in professional work (as illustrated by research), is satisfied by inservice training. Thus, such training is a good administrative technique. **(103)**

COHEN, LOUIS D. The meaning of in-service training/staff development for certain aspects of community mental health. IN **Region 4 planning conference, in-service training for mental health programs**. Charleston, South Carolina, November 5-8, 1963 (sponsored by the South Carolina Mental Health Commission and the National Institute of Mental Health). pp. 24-28.

The author poses the question: "Why are these two relatively new, but clearly leading-edge type of problems, mental health education and mental health consultation, so minimally supported by the mental health professional?" The answer suggested is that these are areas in community mental health programs for which many current workers in the field are not prepared. "In view of their lack of preparation, there is a reluctance on the part of these workers to involve themselves in the developments." Inservice training or staff development is suggested. The need is cited for the creation of auspices and settings in which these skills and views can be developed. "We need to develop a university-community liaison which will make possible both the theoretical and the practical, as well as the experiential opportunities for the development of students." Programs offering training in consultation at Johns Hopkins, Vanderbilt, Duke, University of Florida, and Harvard are mentioned. **(104)**

Community psychology: a report of the Boston Conference on the Education of Psychologists for Community Mental Health. Chester C. Bennett, Chairman. Boston, Massachusetts: Boston University, 1966. 84 pp.

A report is presented of the 1965 conference at Swampscott, Massachusetts, in which thirty experienced community psychologists participated. Areas discussed were the psychologist in the community, relations with other disciplines, relations with psychology, education for research, and education for service. The latter discussion was in general terms, but it was decided that the Ph.D. degree should be a requirement. It was also decided that there is a need for pre-doctoral academic courses in community psychology. Reference was made at the conference to "inservice training opportunities and retooling of established professionals willing to extend their usefulness in this direction." The participants agreed that there should be a continuing and permanent medium of communication established among psychologists interested in community mental health. In its appendices the report includes three papers: John C. Glidewell, "Perspectives in Community Health"; Robert Reiff, "The Ideological and Technological Implications of Clinical Psychology"; and Louis D. Cohen, "Strategies and Logistics in Mental Health Research." There is a selected bibliography on community mental health. **(105)**

Conference on Continuing Education in Mental Health and Psychiatric Nursing (Atlanta, Georgia, February 15-17, 1967). Report. Atlanta, Georgia: Southern Regional Education Board, 1967. 29 pp.

The two basic purposes of continuing education are to keep up with new developments in a field and to provide opportunity for planned continuing exploration to add to the accumulated knowledge. An important consequence of efforts in this area has been the stimulus to further formal study for one or more individuals. In the introduction, a summary of recommendations from nurses who participated in previous planning conferences and mental health unit activities of the Southern Regional Education Board is presented with a summary of responses to questions before this conference concerning needs for regional short-term training in clinical and functional areas. Responses included those concerning needs for training psychiatric nurses for community mental health centers. In "Issues in Continuing Education in Nursing" by Dr. Florence Hill, the following issues are discussed: the student, the setting, program

planning, financing, and evaluation. Under program planning these questions are considered: planning the level of the program; the need to include content dealing with affect and behavior, as well as knowledge and skills; the need to make better use of other disciplines; and the exploration of methodology. Methods of teaching which deserve attention include programmed instruction, two-way radio, two-way telephone, closed-circuit television, correspondence courses, and small group discussion-decision techniques. The importance of evaluation to programs and the need for research on basic questions of appraisal are suggested. Other papers presented are: "Television as a Tool for Continuing Education," by Dr. Mary Howard Smith and "SREB's Mission and Concern in Continuing Education for Mental Health Personnel," by Dr. Howard L. McPheeters (which includes a brief discussion of the difference between inservice and continuing education, as well as discussion of advantages of educational or instructional television, computers, and other programmed learning devices for reaching large numbers of people). Interests, activities, and resources of the USPHS Division of Chronic Diseases, Children's Bureau, and the National Institute of Mental Health (Regional Offices, Continuing Education Branch, Psychiatric Nursing Branch, short-term training grants) are discussed. A resolution was adopted for the establishment of a Council on Mental Health and Psychiatric Nurses under the auspices of SREB's Mental Health Training and Research Unit to serve as a forum to identify and clarify issues relevant to establishing regional training and research programs, to keep current a profile of needs, and to stimulate commitment by schools, nurses, and employers. **(106)**

EARLEY, L. W. **The need for and problems of continuing education for psychiatrists** (presented at the 1967 annual meeting of the American Psychiatric Association, May 8-12, 1967, Detroit, Michigan, Wednesday, May 10, 1967- Session III: Continuing Education for Psychiatrists). Mimeo. 12 pp.

The general factors leading to increased interest in continuing medical education led to the interest of the APA Committee on Medical Education in post-residency education of psychiatrists. It found, upon investigation, an extremely sparse bibliography on the subject. A task force on postgraduate education in psychiatry has been appointed. It is hoped that the task force will not only concern itself with the collection of facts necessary to support the concern about post-graduate education of psychiatrists, but will also concern itself with the setting and practical methods of continuing education for psychiatrists. Psychiatry should be able to profit from the earlier experiences with postgraduate education in the general medical fields. Some of the problems specific to continuing education for psychiatry and questions raised about continuing education in the literature on medical education are discussed. There is a growing body of knowledge in new treatment techniques as well as demand for new expertise in social-community psychiatry. Psychiatrists are being asked to participate in training programs of new health professions. (Self-discipline will be needed to assure that the psychiatrist's own education does not stop.) Other questions concern where continued education should be centered—at the universities or in a national body such as the APA; how information can best be stored and distributed (which methods, and by whom: the APA, universities, the National Institute of Mental Health, etc.); and how to organize psychiatric medical training for both specialization and broadened outlook. It is suggested that a blueprint of available tracks and routes is needed to make refurbishing attractive to one already in practice. The relevance of the role of the individual entrepreneur to the broad programs society is demanding needs to be constantly assessed. Consideration must also be given to the new teaching devices (television, programmed instruction, etc.); analysis of the teaching process; and evaluation. Particularly important is the problem of motivation—building into all psychiatrists the urge to continue learning. **(107)**

FURMAN, SYLVAN S. Obstacles to the development of community mental health centers. **American Journal of Orthopsychiatry** 37:4, July 1967. pp. 758-765

The goals of community mental health centers are: to define the geographic area to be served, to bring under center control the formerly independent services, and to ensure availability, continuity, and access to these services. Problems about funds, physical facilities, and manpower should not be overemphasized because the paramount obstacles will be: the illusion that a "cure" is the goal; unrealistic emphasis on long-term or open-end psychotherapy and deprecation of other methods; rigid concepts of professionalism and interdisciplinary conflicts; overestimation of public tolerance of the mentally ill; complacency because of a magical aura attached to the term "community mental health center"; the primacy of research which can influence admissions policies and so frustrate the fundamental purpose of the center; inappropriate training models in community mental health settings leading to the same self-defeating result; and abuse or distortion of the mental health consultation and referral processes. **(108)**

HOBBS, NICHOLAS. Mental health's third revolution. **American Journal of Orthopsychiatry** 34:5, October 1964. pp. 822-833.

The "third revolution" is the use of public health methods in community mental health. George W.

Albee's **Mental Health Manpower Trends** indicates that unless treatment methods are changed, personnel shortages will persist. Developments of training programs for social work, nursing, psychiatry, general medicine, clinical psychology, and the various adjunctive disciplines should be guided by nine objectives: (1) the mental health specialist must be a person of broad scientific and humanistic education; (2) specialists must work with other professionals to develop social institutions that promote effective functioning in people, (3) the specialist must be trained in ways to multiply his effectiveness by working through other less extensively trained people; (4) mental health training programs should give more attention to mental retardation; (5) curriculum constructors in social work, psychiatry, and psychology must come to terms with the issue of the relationship between science and practice; (6) the mental health specialist must work through social institutions; (7) at least 75 percent of the resources should be devoted to mental health problems of children; (8) new curricula should reinstate morals and ethics (classical, not professional); (9) programs should build habits of continuing scholarship and independent study. Professionals should be retrained in the public health approach, in the new concept of consultation, and in the use of inservice training for subprofessionals. **(109)**

HOWERY, VICTOR I. **Continuing education: capturing the new synthesis in the knowledge fields and their application to practice** (paper presented at the Annual Program Meeting of the Council on Social Work Education, Salt Lake City, January 26, 1967, Session 46). 1967. Mimeo. 18 pp.

"Continuation education may be described as planned educational experiences based upon differential pre-service educational bases for the differentiated staff groups in social welfare agencies and members of professional associations in order to facilitate professional development, to sustain an opportunity for continuing learning, and to maintain staff performance in the extension of social services at a level reflective of an increasing knowledge base and changing patterns in administrative systems and professional practices." The need for such programs is based on such factors as: the mushrooming of new knowledge (particularly in the foundation social sciences); new patterns for service delivery such as the comprehensive mental health center or the decentralized and detached workers associated with neighborhood centers and settlement houses, or community-based follow-up services; new service priorities requiring new patterns for evaluation of effectiveness; modifications in pre-service education placing more emphasis upon continued learning; and increasing financial support available for continuing education. The self-concept of the adult has great significance for the design of continuation education so that traditional methods of pre-service education must not be totally carried over into such programs. The continuation education concept applies to several levels of staff within agencies. The major part of the paper covers these areas: (1) how experiences of colleges, universities, agencies, and professional associations in implementing current assignments may be used as a base for potential involvement in continuation education programs as sponsor, educational designer or educational administrative implementer; (2) the special assignments in continuation educatio which seem pertinent to universities, agencies, or professional associations; (3) descriptions (as illustrations) of some current or past continuation education activities (including aspects of educational design such as statements of educational objectives, selection of educational methods, and organization of learning experiences); and (4) a brief summary of some of the predicted trends in the development of expanded programming of continuation education. "Objectives of continuation education will be best obtained if the criteria for financial support includes a requirement for mechanisms for collaboration and cooperative participation" among academic institutions, agencies, and professional organizations. It is recommended that each of the groups recognize that it has a unique contribution to make and that strategies of cooperation and collaboration different from those already established for preservice education or inservice training are needed. **(110)**

HUME, PORTIA BELL. General principles of community psychiatry. IN Arieti, Silvano (ed.). **American handbook of psychiatry**, vol. III. New York: Basic Books, Inc., 1966. pp. 515-541.

A summary of the history, concepts, processes, methods, and services of community psychiatry concludes with the suggestion that a dynamic theory is developing and describes this theory as humanistic, process oriented, forward looking, and end creating or openminded. A proposed outline entitled "Ingredients of Community Psychiatric Programs" includes training methods. A distinction is drawn between training for the parapsychiatric professions and training for the less specialized community health worker. A multidimensional training faculty and a student body composed of both parapsychiatric and psychiatric professions is said to enrich the training situation. Training methods listed include lectures, seminars, reading, field study and experience, tutorial conferences, and directed research. The program at the Center for Training in Community Psychiatry and Mental Health Administration in Berkeley is described. There is a ten-page bibliography. **(111)**

LIBO, LESTER M. Training the community-minded mental health worker. IN **Proceedings, planning for comprehensive in-service training in a state mental health program** . . . Norman, Oklahoma, October 21-24, 1963 (sponsored by the National Institute of Mental Health and the University of Oklahoma). pp. 55-58.

To make all resources more available communication between universities, agencies, institutions, private practitioners, and the community may be effected by: (1) establishing joint appointments for professional personnel: (2) creating university training programs in community mental health (community psychology, social psychiatry, community organization, etc.): (3) conducting interagency and interdisciplinary research, training, and service projects; (4) sponsoring research utilization conferences; (5) encouraging "community caretakers" to participate in training programs (as either trainers or trainees); (6) using agency and university personnel as community consultants to strategic allied professions; (7) encouraging organization of community mental health advisory boards; (8) involving community groups in volunteer services to agencies and institutions; (9) involving local groups in community surveys on mental health needs and resources and implications for training; (10) sponsoring orientation tours and exchange visitations; (11) granting sabbatical leaves; and (12) offering traineeships in comprehensive community mental health for the neophyte professional worker. **(112)**

LOURIE, NORMAN V. Social change and its implications for training. IN Magner, George W. and Thomas L. Briggs (eds.). **Staff development in mental health services**. New York: National Association of Social Workers, 1966. pp. 11-24.

Current social problems are a measure of the magnitude of the social worker's task. Successful community mental health programs will demand the resolution of four areas of confusion in social work and the mental health field: division of responsibility between professionals and nonprofessionals; methodological priorities; attitudes toward cooperation among agencies and concentration on the clientele's problems; and differences between public and professional interest. Major mental illness and mental health service must be clearly defined if comprehensive mental health programs are to be properly executed. Six principles of planning and operating comprehensive mental health programs which can minimize competitive behavior and increase coordination are discussed. Personnel in such programs will need to be reoriented. Areas in which social work may need to give special attention in training are: the use of new instruments for classifying psychosocial disorders: multiphasic screening and diagnosis at intake: the use of a broader range of skills than are needed in casework alone: administration and planning: broadening the range of service provided by hospital social workers: sorting out differences between professional and nonprofessional tasks: dealing with encroachment by other professionals and nonprofessionals: delineating responsibility for training other groups: understanding policies of agencies other than their own: and awareness of the necessity and procedures for liaisons. "This will require a whole new set of training devices cutting across agency lines." New models of crisis intervention and aftercare will also require special training. **(113)**

MAGNER, GEORGE W. and THOMAS L. BRIGGS. Major issues—a survey of the institutes. IN Magner, George W. and Thomas L. Briggs (eds.). **Staff development in mental health services**. New York: National Association of Social Workers, 1966. pp. 114-120.

Staff development includes the traditional methods of one-to-one supervision and consultation, and formal teaching. It also includes modifications of traditional methods, such as group and peer supervision and consultation. The magnitude of the staff development task is related to manpower difficulties of all professions in mental health facilities. Major difficulties of staff development include: differences in training, motivation, and capacity; the necessity of personnel assessment and programing (a task requiring time and effort that may conflict with demands for services); and problems of role diffusion among professionals (affecting institutional sanctioning of professional growth and staff identity with the department's principles and goals). Methods advocated include traditional supervision, consultation, and seminars, as well as peer supervision and role playing. Needs and interests of staff, of the profession, and of the institution should all be considered. Staff development should prepare social work personnel in mental health to face change and to make needed alterations in roles. It may involve continued modification of traditional teaching methods and the continued development of work methods and relationships uniquely valuable within mental health settings, such as the establishment of teams of social worker-case aide, or of social worker-case aide-nurse. **(114)**

Planning psychiatric services for children in the community mental health program (a report based on proceedings of a conference, Washington, D.C., April 20-21 and July 12-14, 1964, sponsored by the American Psychiatric Association, American Academy of Child Psychiatry, American Association of Psychiatric Clinics for Children, and the American Orthopsychiatric Association). Washington, D.C.: American Psychiatric Association, 1964. 47 pp.

Three types of consultation available to community agencies are noted: case presentation; consultation with agency workers ("this type of consultation is in effect inservice training"); and consultation on community organization or program planning for children's psychiatric services. The American Association of Psychiatric Clinics for Children offers advisory and consultative service to communities contemplating clinic service for children. The child psychiatrist, the clinical child psychologist, and the child psychiatric social worker have certain (discussed) roles and functions. Contributions of pediatricians, pediatric neurologists, psychiatric and public health nurses, teachers, school guidance counselors, occupational therapists, and child care workers should also be noted. Personnel are scarce, but new approaches in using manpower and inservice training can mitigate the situation. Training is vital: it will attract a better qualified staff and enhance performance. New ways of training semiprofessional personnel and volunteers are being developed and should be explored; new types of service are stimulating new patterns of training. Quality should be maintained by following specific and realistic criteria for initial appointments and by using inservice and other training for upgrading. Chapter headings are: extent of childhood emotional illness, principles of planning, essential elements of a psychiatric program for children, major types of service (with sub-headings: consultation, coordination and collaboration, diagnosis and treatment, training, research and evaluation, and epidemiological assessment), staffing, and prevention. Appendices offer: a roster of the conference, tables showing phases in establishing children's psychiatric services in a community, a list of some sources of information about various aspects of planning, and a suggested reading list. **(115)**

ROBINSON, REGINALD, DAVID F. DeMARCHE and MILDRED K. WAGLE. **Community resources in mental health** (Joint Commission on Mental Illness and Health Monograph Series No. 5). New York: Basic Books, Inc., 1960. 435 pp.

Community planning must include not only clinical treatment services, but all mental health resources. One of the four broad recommendations of this volume concerns manpower and training. It is recommended that an expanded national educational effort be enacted to recruit college graduates in the resource areas for graduate work; that more opportunities be provided for on-the-job training institutes; and that salaries be fixed at levels competitive with those of other professions. Field-work institutes, conferences, and extension courses are suggested methods for broadening the perspective of mental health personnel. Appendices contain "Definitions, Coding Procedures, and some Basic Tables of the Community Mental Health Resources Score" and "Joint Commission on Mental Illness and Health." **(116)**

ROOS, PHILLIP. Ways in which mental health agencies, colleges, and universities can collaborate in training programs- the mental health agency approach. IN **Proceedings, regional conference, Norman, Oklahoma, October 21-24, 1963** (sponsored by the National Institute of Mental Health and the University of Oklahoma). pp. 27-32.

Joint training programs should lead to a better understanding among academic programs of the needs of mental health agencies. Closer association would also provide more professionals, easier recruiting, positive attitudes toward mental health careers, awareness of the changing needs of service agencies, and enhancement of the competency of employees. Communication between universities and mental health services can be improved by exchange of information; joint committees for planning and/or coordinating; student placement; cosponsorship of brief, intensive training; reciprocal consultation; joint appointments and faculty exchanges; and cooperative research ventures. **(117)**

Seminar for directors of mental health centers: a report (sponsored by Topeka, Kansas, Community Health Services, Division of Institutional Management; and the University of Kansas Governmental Research Center. Special Report No. 114). October 1962. 97 pp.

The following addresses were delivered at a seminar at the University of Kansas in 1962. W. H. Cape's "The Lay Board: Philosophy and Function" suggests that board members and administrators can be trained through experience "on-the-job": by attending board meetings; by committee work, group discussion, and reading materials; by attending institutes (including case studies and role playing); and by using a "board members' manual." H. M. Kern's "The Training of Psychiatric Residents as Consultants in Community Psychiatry" describes a Maryland program: senior psychiatric residents learn better by working one day a week in the informal and less competitive setting of a county (versus metropolitan) mental health center. H. G. Whittington's "A Pattern of Organization for the Com-

munity Mental Health Center" outlines role-differentiation for various workers in community mental health centers, their professional preparation in terms of theoretical orientation, clinical training, duration, breadth and complexity of training, and intensity and closeness of supervisory contacts during training. Other papers are: "Communication Between and Within Small Groups," by B. L. Scruggs; "A Community Mental Health Program—Its Rise and Fall," by C. C. Stepanek and C. V. Willie; "Public Relations for the Community Mental Health Program," by C. C. Stepanek; and "What Is Social Psychiatry?" by Joseph Satten. Summaries of discussions by small groups illuminate several areas of personnel relationships: within the staff, between the staff of the center and its lay advisory board, between the staff and the community, and between the staff and other professionals outside the center. **(118)**

SMITH, M. BREWSTER and NICHOLAS HOBBS. The community and the community mental health center. **American Psychologist** 21:6, June 1966. pp. 499-509.

This outline of the community mental health program suggests (in a brief section on training) that a training director's responsibilities might include three areas. First, inservice training of the center's staff. Second, a center-sponsored training program—including internships, field placement, postdoctoral fellowships, and partial or complete residency programs—for a wide range of professional groups. Third, university-sponsored training programs that require center facilities to give students practical experience. The center budget should allocate between five percent and ten percent of all funds explicitly to training. **(119)**

TORGERSON, FERNANDO G. Mobilization of institutional resources for change. IN Magner, George W. and Thomas L. Briggs (eds.). **Staff development in mental health services.** New York: National Association of Social Workers, 1966. pp. 83-98.

The necessity for change in current institutions to provide service to the community requires an increase in mental health personnel and marked changes in roles of the core disciplines: psychiatry, psychology, nursing, and social work. A change in emphasis in training from problems of individuals to institutional and community service is necessary, involving better understanding of organizational theory and behavior and public health concepts and principles (such as prevention, epidemiology, community organization, administration, rehabilitation, consultation, social welfare, and positive mental health practices). A flexible posture is needed toward the entire field of mental health, enabling professionals to act with judgment and skill based on community or individual needs rather than specialized techniques and methods. Associated disciplines can be trained to assist in comprehensive programs so that personal and task specialization may be carried out by the core disciplines. Consultation to caretakers in community mental health programs requires a skill which is not typically acquired in routine basic training programs for the core professionals. The content of training should include public health principles and doctrines, knowledge of administration, the "caretaker" setting, and community organization so that knowledge of individual behavior is "supplemented by understanding of social systems and cultural determinants at a much higher level of abstraction than is usually provided." Thus, training should include the acquiring of special knowledge and the development of skill through practice under supervision. **(120)**

Training of personnel for community mental health administration and research. IN **Proceedings, 1959 annual conference; Surgeon General, Public Health Service with state and territorial mental health authorities** (Public Health Service Publ. No. 705). Washington: U.S. Govt. Print. Off., 1959. pp. 26-28.

This is a summary of discussion group IV at the conference. Consensus was that professionals should not be sent away to training centers because this results in their leaving the service area. Professional personnel should be given on-the-job experience and training. The manpower problem in the profession of psychiatry and the relationship between state and federal governments in joint planning and activity on the problems of recruitment, training, and research developments were also discussed. **(121)**

Training the psychiatrist to meet changing needs (report of the Conference on Graduate Psychiatric Education, held in Washington, D.C., December 2-6, 1962. Walter E. Barton and William Malamud, co-chairmen). Washington, D.C.: American Psychiatric Association, 1964. 263 pp.

This conference met to consider "the graduate training of physicians for competence as general psychiatrists and for careers in clinical work, research, teaching, and public service." After a series of chapters on preparing the physician for psychiatric practice, pressures for change resulting from research, the impact of public need on training, and guidelines for evaluation, some conclusions of the editorial board are discussed in the Epilogue. The student-preceptor model of an ideal training situation has given way to a more broadly based program, cutting across theoretical and academic discipline boundaries. "Psychiatric education has gone far in the direction of recognizing the distinction between the

teacher and the practitioner. . . . Psychiatrists, in their attempt to move beyond the practitioner phase of their educational operation, have allied themselves with co-professionals from other disciplines. Collectively, this teacher-group will in time comprise a profession in its own right. Hopefully, its members will collaborate in an effort to synthesize a comprehensive experience for psychiatric residents." Remarks of Dr. John C. Whitehorn are quoted as a closing for the conference overview. He called attention to the need for continuing self-education as the alternative which can take off some of the encyclopedic pressure during the residency years. "This might be carried out by seminar-type arrangements at the annual meetings of professional societies, and by other methods." The task of the training aspect of the residency period is to develop competence and confidence in dealing with well-recognized professional tasks. "The educational aspect of the residency period is to cultivate constructive, intelligent discontent and imaginative awareness of the potentialities for improvement." Approaches to evaluating residency programs in terms of their value to the individual psychiatrist, to his patients, and in meeting society's needs are discussed. The success of the educational aspect of residency programs has resulted in great discontent with psychiatric practice. In the future psychiatrists will need to function in the broad field of community psychiatry, as a step toward better meeting society's needs. Three problems resulting from this trend are: developing educational experiences to acquaint at least some residents with community organization and group leadership, getting acceptance by the American Board of Psychiatry and Neurology for these types of psychiatric educational experience, and developing a better understanding of leadership and a wider range of leadership skills for psychiatrists than the traditional authoritative approach. Formalized courses in community action are not needed so much as provision for the personal development of selected residents through opportunities for responsible action, under competent guidance. Even the group psychotherapist might have a tendency to treat everyone as a "patient," whereas consultative and evocative styles of leadership are needed in community work. Appendices include: Preparatory Commission Documents and Selected References for the Conference; Preparatory Commission Reports and Background Documents for the Conference on Training in Child Psychiatry, 1963; Eight Tables on Manpower; Essential Elements of Approved Residencies, AMA; and Directory of Approved Psychiatric Residencies, AMA, 1963. There is an index. **(122)**

WHITTINGTON, H. G. **Psychiatry in the American community**. New York: International Universities Press, Inc., 1966. 476 pp.

This is an introductory text. There is a table indicating the roles associated with practitioners in this field. Outside consultants are recommended to resolve role difficulties and to identify inservice training needs. The sponsoring of such inservice training, and of continuing education, is indicated in Chapter 23 to be a function of the state mental health authority. The questions of when to train, where to train, and goals of training are discussed in Chapter 28. There are ten case studies of community mental health centers in the appendix. Chapter titles are: Community Mental Health Services: Something New?; Organization of Community Mental Health Services; The Nurturant Society; An Introduction to Community Organization; The Team: Role Definition and Interrelationships; The Prevention of Mental Illness; The Consultation Program; Consultation with Health Agencies; Consultation with Welfare and Social Agencies; Consultation with Educational Agencies; The Clinical Program of the Community Mental Health Center; General Considerations; Intake and Evaluation; The Treatment Program; Persuasive Communication, by Susan Ellermeier; Public Information and Mental Health Education, by Susan Ellermeier; The Governing Board; Program Evaluation; Special Problem Areas; Aftercare; Juvenile Delinquency; Addictive Diseases; Mental Retardation; The Role of the State Mental Health Authority; The State Mental Hospital; Planning for Mental Health Services; Budgeting and Accounting; Administration: Art and/or Science; The Supervisory Process; Research in Community Mental Health; Training for Community Mental Health Practitioners; and Perspectives. There is a 46-item bibliography. **(123)**

Some Descriptions of Practice

BALER, LENIN A. Community mental health: training program in a school of public health. **Community Mental Health Journal** 1:3, Fall 1965. pp. 238-244.

In 1954, the Harvard School of Public Health established a postdoctoral training program in community mental health. This program covered community mental health theory, practice, and research. It was designed to get individual-oriented trainees to adopt the public health approach to health and illness and was open to psychologists, psychiatrists, and social workers. Sponsored by the National Institute of Mental Health, the course lasts twelve months during which lectures, seminars, and tutorial sessions are supplemented by experience in field agencies where students have supervised practice in community consultation or community organization. **(124)**

BINDMAN, ARTHUR J. and LEWIS B. KLEBANOFF. Administrative problems in establishing a community mental health program. **American Journal of Orthopsychiatry**, vol. 30, 1960. pp. 696-711.

In 1952, the Division of Mental Hygiene of the Massachusetts Department of Mental Health began to cosponsor, with local communities, mental health centers for children of preschool through high school age. State and community had equal roles in the development of these centers, each of which had a psychiatrist, a clinical psychologist, a psychiatric social worker, and a mental health consultant who worked with community groups. An orientation seminar met weekly for one year. Division personnel from the centers assembled each month to hear speakers and discuss program problems. Mental health consultants received several years' training in consultation techniques from a leading theorist and practitioner at the Harvard School of Public Health. In later years, monthly seminars were held on advanced concepts, and a special seminar for directors of the mental health centers was established. The original expectation—that 75 percent of the staff's time would be spent in the community—has not been realized because of difficulties in financing, establishing good relationships with the special education programs of the public schools, obtaining cooperation from school counselors and social workers, and achieving a good community attitude. There have also been problems within the staff. Effective mental health personnel must be sensitive, technically competent, and aware of community attitudes. **(125)**

Bronze award: the versatile program at the Fort Logan Mental Health Center, Denver, Colorado. **Mental Hospitals** 15:10, October 1964. pp. 552-554.

Among the educational and training activities of the Fort Logan Center are a study seminar on the theoretical bases of the therapeutic community, a program providing visiting consultants to encourage continual staff development, and other seminars that attract students from nursing, social work, pastoral counseling, and various undergraduate programs. A six-month inservice training program for mental health technicians or psychiatric aides is described in detail: 350 hours in the classroom and the remaining time with a mental health team teach the students to be active team members, to interact with patients, and to examine and use their reactions effectively. **(126)**

CALIFORNIA UNIVERSITY, LOS ANGELES, SCHOOL OF NURSING and CONTINUING EDUCATION IN MEDICINE AND HEALTH SCIENCES. **Pilot project—mental health training for public health nurses and school nurses** (Final report. USPHS Mental Health Grant No. 8891, 1964-1967). Los Angeles, California: The University, 1967. 67 pp.

The growth of community psychiatry has altered service patterns and emphasized the need for supplementing the training of personnel in various caretaking agencies. Nurses employed in public health agencies (including community mental health centers) and school health programs in southern California could not avail themselves of full-time study in regular university programs dealing with mental health, so short-term, intensive demonstration workshops and consultation on-the-job were needed. A series of such workshops were given in subregions of southern California and evaluated during the three-year project. Qualified psychiatric and public health nurses from the subregion communities were released by their educational institutions and agencies to help in planning and staffing the workshops and the on-the-job consultation. Objectives, number and type of participants, procedures (including preliminary questionnaire), evaluation, results, and recommendations are given for each of the three years. Methods of instruction were: lecture-discussion, small group discussion, role playing, reading material, self-assessment scales, films, and filmstrips. Pretests and posttests were used in evaluation. Results indicated that the workshops were well-received and provided stimulation and new knowledge to nurses from many areas of practice. The trend over the three-year period, as a result of feedback from participants and staff, was toward a narrowing of focus from the general survey of many new mental health concepts to a primary focus on crisis theory and intervention. A need was indicated for further training in the actual application of the knowledge. Lectures, discussions, and role playing helped to introduce new concepts and stimulate thoughts on utilization. Supervised practice in counseling is now needed to instill competency and security necessary for putting the new knowledge to work. There is a 101-item bibliography. Ten appendices reproduce the questionnaire, self-assessment forms, various evaluation and report forms, and a consultation form letter. **(127)**

CAPLAN, GERALD. An approach to the education of community mental health specialists. **Mental Hygiene** 43:2, April 1959. pp. 268-280.

Programs in community mental health offered by the Harvard School of Public Health are described. In the main program a one-to-three-year course is offered to psychiatrists who have completed specialty training, psychologists with some years of experience after the

Ph.D., and senior well-qualified social workers. Students in this program are admitted for one, two, or three years at a level in keeping with their previous training and experience in public health and community mental health. Various degrees may be obtained in this program. There is also opportunity for senior psychiatrists to come for three-to-six months as fellows to gain some understanding of the community mental health field. Another program in collaboration with the Harvard Medical School Department of Psychiatry at Massachusetts General Hospital offers training to younger workers in community mental health (third or fourth year residents, psychologists about to receive the Ph.D., or social workers with several years experience). A third type of program gives inservice training in mental health consultation to the Massachusetts Department of Mental Health psychiatrists, psychologists, and social workers. For two or three years they attend regularly, throughout the year, one of two weekly seminars. During this period they learn theories of community organization and mental health consultation and participate in discussion of consultation cases from their own or colleagues' practice. This program allows for fruitful interchange between university faculty members and community mental health practitioners from the field. Harvard's six field stations are described, and the need for support in developing the Laboratory of Community Mental Health is discussed. Such a laboratory would provide a stable group of university workers who would continue the described integrated approach to pioneering service, research, and training. **(128)**

HUME, PORTIA BELL. Principles and practice of community psychiatry: the role and training of the specialist in community psychiatry. IN Bellak, Leopold (ed.). **Handbook of community psychiatry and community mental health**. New York: Grune & Stratton, 1964. pp. 65-81.

The community psychiatrist must have knowledge of and experience in clinical psychiatry; but he must also know some law, communication theory, group dynamics, special research design, and—most important—he must know something of governmental, administrative, and community organization processes. A discussion of the nonclinical training needs of the community psychiatrist is followed by a description of the program at the Berkeley Center for Training in Community Psychiatry. This course consists of eight consecutive seminars totaling a minimum of twenty months in duration. Five to eight hours of work are required per week from each trainee—psychiatrists, psychiatric nurses or mental health nursing consultants, clinical psychologists, and psychiatric social workers. All, other t. an psychiatrists (who may be in the third year of their residency), must have completed their formal training before undertaking the seminars. A certificate is given upon completion of the program. **(129)**

FELSINGER, JOHN M. VON and DONALD C. KLEIN. A training program for clinical psychologists in community mental health theory and practice. IN Strother, Charles R. (ed.). **Psychology and mental health: a report of the Institute on Education and Training for Psychological Contributions to Mental Health, held at Stanford University in August, 1955**. Washington, D.C.: American Psychological Association, Inc., 1956. pp. 146-150.

The program described was that of the Massachusetts General Hospital, which is associated with Harvard Medical School. Two field stations were a part of the institution. Clinical training for predoctoral and postdoctoral students included the teaching of clinical test procedures, interviewing skills, rehebilitation planning, and situational or social system analysis Community practice entailed combined field work and seminar training in four areas: mental health consultation, preventive group methods, preventive intervention, and community organization and dynamics. **(130)**

GLASSCOTE, RAYMOND, DAVID SANDERS, H. M. FORSTENZER, and A. R. FOLEY. **The community mental health center: an analysis of existing models** (a publication of the Joint Information Service of the American Psychiatric Association and the National Association for Mental Health in association with The Division of Community Psychiatry, Columbia University and The Department of Mental Health, American Medical Association). Washington, D.C.: The Joint Information Service, 1964. 219 pp.

The structures and services of eleven representative institutions already giving care as specified by the Community Mental Health Centers Act of 1963 are analyzed and compared. Seven centers offered residency training for psychiatrists (either three years or a short rotation). Five centers provided training for psychology interns, six accepted social work students for field training, and five offered training for student or graduate nurses. Four centers specifically indicated inservice training for staff. Methods of training mentioned include seminars, professional meetings, staff conferences, weekly lectures (some with visiting speakers), group psychotherapy observation, and individual supervision. All eleven centers provided some degree of consultation service via the case-centered approach, formal training programs, or screening services. These services were provided to such agencies and individuals as schools, courts, ministers, physicians, public health nurses, and policemen. Topics other than training and consultation include areas served, physical plants, administration, staffing, patient services, services for children, emergency services, alcoholism and addiction, mental retardation, the aged, rehabilitative services, transitional and

placement services, financing, research, and evaluation and results. **(131)**

KERN, HOWARD M., JR., WAYNE E. JACOBSON, and JANE BRADSHAW HESS. **The inductive method; a report of four years of experience in continuing education** (presented at the annual meeting of the American Psychiatric Association, Detroit, Michigan, May 1967). 1967. Mimeo. 8 pp., 3 appendices.

A demonstration program was developed at the Johns Hopkins University to demonstrate the way training in community psychiatry is included within the customary three years of psychiatric residency at various training institutions in Maryland. The demonstration began early in 1962, thus predating the nationwide program in community psychiatry. Over a four-year period, 117 psychiatrists and other mental health professionals from twenty-three states participated in week-long demonstration sessions. The primary goal was to effect changes in the thirty-nine psychiatric residency training programs represented by participants. The secondary goal was to effect changes in attitudes toward the field of community psychiatry. These goals represented a maximal challenge to a program of continuing education. A description of the planning, implementation, and evaluation of the program is given in the major portion of the paper. Results were quite positive for both goals of the program. Success was attributed to the use of the inductive method of teaching which depends upon two factors in the structure of the learning situation: (1) the establishment of a climate wherein the student is allowed increasing responsibility (an anxiety-provoking situation) and (2) the presence of a consultant-teacher (who was himself a continuing student). **(132)**

KRYSTAL, HENRY. The current status of postgraduate psychiatric education. **American Journal of Psychiatry**, vol. 119, November 1962. pp. 483-484.

"A questionnaire sent to the departments of psychiatry of the colleges of medicine in the United States revealed that eighty-two percent of responding colleges felt that continuing psychiatric education is the responsibility of the medical schools. Since sixty-two percent of the colleges responded, this represented about fifty-two percent of all American medical schools. Only nineteen responding colleges were offering such courses at the time, and five more of them had such courses in preparation. Most respondents felt that a . . . period of advance preparation via advertising and notices addressed to the practicing psychiatrists should precede the offering of the courses and would substantially improve the response [author summary]." "Respondents indicated that psychiatrists took the continuing education courses for the following reasons: to fill in gaps in training, to prepare themselves for the boards, to get help in the handling of transferences, and to keep up with areas in which much research is being done." "The 'rounding out' of . . . training as a means of complementing a one-sided orientation residency training seemed to be of special concern to the educators." **(133)**

LEVY, JEROME. Local inservice training programs IN **Proceedings, regional conference, Norman, Oklahoma, October 21-24, 1963** (sponsored by the National Institute of Mental Health and the University of Oklahoma). pp. 73-93.

Inservice training is defined in various ways: the training policies of the Western Interstate Commission for Higher Education are listed; and the goals and methods of the Staff Development Program of the Western Council on Mental Health Training and Research are presented. The inservice training programs of the Fort Logan Mental Health Center are described in detail. The nursing service programs use lectures, discussions, role playing, audiovisual aids, case presentations, and demonstrations; nurses are assigned to specific treatment teams within which they are supervised by the team's senior nurse. The department of social services offers training for new staff and general staff. New staff receive one-to-two weeks of orientation; general staff training includes weekly staff meetings, planned visits, and participation in professional organizations and in conferences, institutes, and workshops. Each psychologist has a weekly session with the chief psychologist and all psychologists meet weekly for problem-solving discussions. Departmental research and training meetings are held every two weeks. Weekly didactic meetings are held for the entire staff. The program of the Center for Training in Community Psychiatry at Berkeley is described, and course content and requirements for admission are given. In another training program on social interaction therapy for mental health workers, college graduates who are not experienced in mental health follow a one-year program which offers six months of orientation and six months of supervised experience. **(134)**

LIBO, LESTER M. and CHARLES R. GRIFFITH. Developing mental health programs in areas lacking professional facilities: the community consultant approach in New Mexico. **Community Mental Health Journal** 2:2, Summer 1966. pp. 163-169.

New Mexico uses district consultants to provide mental health services in outlying areas that lack indigenous professional capabilities. The program emphasizes community development, mainly through con-

sultation, inservice training, and interagency coordination. Each multicounty district has a locally based full-time professional consultant—a psychologist, social worker, or mental health nurse—augmented by a part-time traveling psychiatrist. The consultants are given a two-month orientation on community mental health philosophy and method through discussions, readings, and visits to agencies, institutions, and practitioners. During the same period they are oriented to the state and to the district in which they will function. **(135)**

McPHEETERS, HAROLD L. Mental health—the broad picture. IN **The community college in mental health training**. . . . Atlanta, Georgia: Southern Regional Education Board, 1966. pp. 21-26.

The need for associate professionals in mental health is discussed from the standpoint of historical and current changes in mental health. Current changes are cited in treatment, rehabilitation, consultation, prevention, mental retardation, training, research, community development, positive mental health, and Federal Government support. There is renewed interest in training rehabilitation practitioners—vocational counselors, occupational therapists, chaplains, and recreation specialists. Middle level professional workers are being developed—clinical psychologists with master's instead of doctor's degrees, social workers and vocational counselors with bachelor's instead of master's degrees, and mental health workers who attend junior or community colleges. There is also "much more work being done in inservice training of . . . psychologists, psychiatrists, social workers, and nurses." **(136)**

OZARIN, LUCY D. and BERTRAM S. BROWN. New directions in community mental health programs. **American Journal of Orthopsychiatry** 35:1, January 1965. pp. 10-17.

As part of preparation to administer the law concerning community mental health centers, staff of the National Institute of Mental Health visited nineteen facilities which were thought to have characteristics of comprehensive community mental health centers. In addition to other services, all of them offered training for psychiatric residents, student social workers, psychologists, and nurses. All had inservice training for their own staff. Some provided inservice training for community agency staffs or professionals. (Several urban centers provided training for general practitioners, public health nurses, nursing home staffs, police, and social agency staffs.) **(137)**

SCHNETTER, ED and JOHN P. McNAMARA. Central Minnesota Mental Health Center: a clinic designed to serve total community needs. **Mental Hospitals** 14:8, August 1963. pp. 423-426.

This center offers consultation for physicians, for schools, and for social agencies, courts, and other agencies that serve the emotionally disturbed. It holds an eleven-week (two-to-three hours weekly) seminar for family physicians, and it provides inservice training for its own employees and those of other agencies. A one-day workshop for middle management and supervisory personnel is among its efforts to educate the community. Its own staff members are given ten days educational leave each year, and they are encouraged to attend conferences, seminars, and lectures such as are offered at a nearby hospital and university. They also participate in a staff journal club. **(138)**

Training and consultation in aftercare; final report of the pilot project—a training program for aftercare workers. (Sponsored by The Southern Regional Education Board and The National Institute of Mental Health). Atlanta, Georgia: The Board, 1967. 68 pp.

Aftercare is the process of facilitating the return of patients from mental hospitals to their families and communities. "A major emphasis being developed in the provision of care for the mentally ill is the comprehensive community mental health center. . . . A community mental health program requires a well-organized aftercare service." Section I discusses the problem, purpose, background, and need for training and consultation in aftercare. (The term "aftercare" is disputed, with some professionals preferring the larger concept of "continued care" and others insisting that aftercare is a problem requiring a distinct program element.) The training and consultation program reported here attempted to strengthen aftercare programs in the SREB states (1) by providing training for trainers responsible for training programs in each state (The Workshop on Training in Aftercare, January 30-February 4, 1961, Athens, Georgia, is reported in Section II) and (2) by providing a group of consultants from which states might select on the basis of program needs (Improving Aftercare Services Through Consultation and Training, A Planning Workshop, November 21-23, 1966, Atlanta, Georgia, and subsequent visits to states, are reported in Section IV). Section III reports conclusions and experiences in revising original plans for training trainers to planning for training consultation to key persons interested in aftercare programs in the states. A follow-up Seminar on Aftercare Consultation, held June 22-23, 1967, Atlanta, Georgia, is reported in Section V. Appendices include: lists of members of the Aftercare Advisory Panel and the Aftercare Survey Team; participants and consultants; agendas of the two workshops

and the seminar: a sample letter of invitation and a sample letter to the state mental health authority. "Contemporary Approaches to Community Organization," by Robert N. Wilson; "Developments in the Concepts of a Community and Its People," by Charles J. Grigg; and a short bibliography. The report includes an outline of needs of the returned patient; plans and outcomes for consultation with personnel planning community mental health centers; and discussions of aftercare and continuity of care, community-hospital relationships, the question of responsibility, and innovative practices in the states with respect to treatment methods and manpower (including use of allied professionals and nonprofessionals). Recommendations for further regional programs include: training in consultation for mental health professionals; training in the use of community resources and nonprofessional mental health workers; training for lay and professional members of community mental health boards; training for decision makers (particularly legislators); and the use of the current "project consultation" model for other mental health program elements on a continuing basis. **(139)**

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE. OFFICE OF THE UNDER SECRETARY. **Closing the gap . . . in social work manpower** (report of the Departmental Task Force on Social Work Education and Manpower). Washington: U.S. Govt. Print. Off., 1965. 90 pp.

Part One, Surveying the Social Work Manpower Gap, contains chapters on background of the problem, aspects of supply and demand, and future manpower needs. In Part Two, Current Resources for Meeting Needs, chapters concern education and training, research and demonstration in effective utilization of manpower, sources of support for education and manpower research and development, and recruitment and retention of manpower. Part Three, Closing the Gap, presents a summary and findings. Appendices list federal legislation affecting social work manpower, 1956-65, and selected references. In the section on education and training, information is presented on doctoral programs in social work (including names of schools offering degrees beyond the master's); master's programs; undergraduate programs in social welfare; technical and vocational education (aides, technicians, ancillary workers); inservice training; and other education programs (such as refresher courses for college-educated women returning to work and education to prepare older women for social work service). In the section on inservice training, it is stated: "If personnel are to be recruited to practice directly from the colleges . . . extensive inservice training following employment is necessary. . . . This type of education has not been properly developed in most agencies for various reasons: lack of recognition of training as a legitimate administrative cost, lack of training personnel available, insufficient funds, etc." Notable exceptions are the Social Security Administration's Old-Age, Survivors, and Disability Insurance Program and the Welfare Administration's program (since 1962) for developing inservice training in state and local welfare departments. In 1963, the Council on Social Work Education proposed experimental postgraduate programs under university auspices to further prepare college graduates, but funds and manpower have been lacking. The National Association of Social Workers has been active in "providing opportunities for continuing education of its membership." **(140)**

VISHER, JOHN S. Methods of training in community mental health. **California Medicine** 106:2, February 1967, pp. 117-119.

This comment on comprehensive community mental health programs in California includes a description of training methods used for psychiatrists, psychiatric residents, and clinical psychologists at the Langley-Porter Neuropsychiatric Institute Outpatient Department. Seminars, field experience, consultation with staff members, and special study of research projects are the suggested training methods. **(141)**

WILSON, PAUL T. **Continuing education for psychiatrists: programs and techniques** (paper prepared under Grant MH-09219-02, National Clearinghouse for Mental Health Information, NIMH). 1967. Mimeo. 9 pp.

Presented are the results of the first project undertaken by the Task Force on Continuing Education for Psychiatrists (begun by the American Psychiatric Association, Spring 1966) a study of courses already in existence. The first phase consisted of a questionnaire sent to 2,727 institutions around the country. Represented were thirteen types of institutions, including federal, state, county, and private institutions for the mentally ill, general hospitals with psychiatric units or services; community mental health clinics, universities, APA district branches; mental health associations, mental health departments, and prisons. Courses reported were to be limited to those (1) planned primarily for psychiatrists who have completed their residency training; (2) having a definite curriculum that covers a specific aspect of psychiatry or related disciplines; and (3) scheduled to meet at a definite time. Criteria for **not** including courses were: (1) inservice teaching programs for residents, students, or fellows, (2) regular institutional staff meetings; and (3) formal training exercises leading to psychoanalytic certification. Respondents were to indicate (1) whether they had given such courses during the last two years, (2) whether they had a formal department or administrative position for continuing education; and (3) whether they would send a represen-

tative to attend a national or regional colloquium on continuing education for psychiatrists. For the second phase of the study, a second questionnaire asked for details about the courses themselves, including the group for whom it was intended, the course objectives, how the material was presented, and how the course was financed. Responding institutions totaled 1,847. Of these, only 51 (2.8%) were found to be sponsors, representing a total of seventy-three courses. Formal departments or positions were held in 308 (17%); 1,034 (56%) were interested in attending a colloquium. Universities and the states of New York, California, and Pennsylvania showed higher proportions of sponsors and continuing education positions. Community mental health clinics had a high proportion of the total positive responses in all three categories due to sheer numbers, but only a moderate proportion of the total clinics showed involvement. Topics presented most often related to psychoanalysis (18%), "variety" courses (visiting lecture series, usually) (15%), community psychiatry (10%), psychotherapy (8%), and neurology (7%). Most frequent intended audiences were "psychiatrists plus other mental health workers" (34%), "psychiatrists only" (32%), and "psychiatrists plus other physicians" (25%). Other results given relate to course objectives, duration, setting, formal structure, evaluation, and financing. More information is needed about other aspects of continuing professional education before designing courses needed to supplement them: (1) institutional staff conferences, working meetings, and rounds; (2) postgraduate programs leading to formal certification (usually in psychoanalysis); and (3) the whole spectrum of continuing education carried on unintentionally, i.e., informal group discussions, supervision, reading, informal conversations, and daily professional experiences. **(142)**

WILSON, PAUL T. **Continuing education in psychiatry: preliminary report of a voluntary respondent questionnaire** (paper prepared under Grant MH-09219-02, National Clearinghouse for Mental Health Information, NIMH). 1967. Mimeo. 4 pp.

A questionnaire studying the information needs of psychiatrists was given to voluntary respondents at the 1966 annual meeting of the American Psychiatric Association. Presented is data relating to continuing education. Of the 2,800 members attending the meeting, 264 (9%) completed usable questionnaires, suggesting a highly biased sample. The following percentages are based on the total responses: 116 respondents (46%) had taken or were taking a continuing education course in psychiatry. Teaching techniques used were lectures (59%), seminars (54%), case presentations (26%), and clinical demonstrations (26%). Fifty-seven percent felt the course had been of great usefulness (39% felt it was moderately useful, 4% reported it of little or no use). Fifty-nine percent judged quality of the course to be excellent, 40% adequate, and 1% poor. When asked to characterize a course "made to order," responses for characteristics were: 24% expressed a primary interest in community psychiatry, 20% in a specific therapeutic technique, 12% in problems in psychiatric administration, and 10% in the use of drugs. Sixty-five percent preferred seminar formats, 29% preferred lectures, 26% preferred panel discussions, 19% preferred programed instruction, and 18% preferred clinical demonstrations. Ninety-two percent preferred direct (in person) communication as the medium. Nineteen percent were for televised presentations, and 14% for films. Sixty-six percent preferred small groups (2-10), 27% chose larger groups (more than 10), and 3% chose home or office for the setting. Thirty-six percent preferred weekly presentations, 30% monthly, and 27% twice a month. Wednesday was the most preferable day (41%). Monday and Friday were the least preferable (17% each). Evening (7-11 p.m.) was the preferred time of day (50%), with percentages for midmorning (9-11 a.m.) and late afternoon (4-5 p.m.) running 17% and 12% respectively. **(143)**

TRAINING–RESIDENCY AND ACADEMIC CREDIT

Psychiatrists

BERLIN, IRVING N. Training in community psychiatry: its relation to clinical psychiatry. **Community Mental Health Journal** 1:1, Spring 1965. pp. 19-22.

The community psychiatry programs, in response to national need, have begun to train psychiatrists who are not given much basic clinical psychiatry training. This poses some serious problems. The community psychiatrist does not usually function in immediate relationship to the people with whom he is concerned. It is thus easier to dehumanize people and see them as a mass to be manipulated. Clinical training, with continued clinical work, not only sensitizes one to transference and countertransference problems of individuals and group psychotherapeutic work vital to self-awareness in all interpersonal situations, but it also keeps one focused on the individual human being and his needs and reactions to programs and process. It also makes it possible to utilize clinical acumen in all of one's interpersonal relations at all levels. **(Community Mental Health Journal)** **(144)**

BERNARD, VIOLA W. Education for community psychiatry in a university medical center (with emphasis on the rationale and objectives of training). IN Bellak, Leopold (ed.). **Handbook of community psychiatry and community mental health**. New York: Grune & Stratton, 1964. pp. 82-122.

Training for community psychiatry should give the trainee more than a body of knowledge and specialized skills. It must orient him in his attitudes and frame of reference to a community approach. Because curricula of three-year residency programs at most training centers are filled to capacity, a fourth and fifth year of training are suggested for those who are going into community psychiatry. An outline of the training program at the Columbia-Presbyterian Medical Center describes the core curriculum in community psychiatry. This curriculum is made up of seminars, courses, reading, and field assignments. Programs for the nonspecialist in community psychiatry–medical students or students in the School of Public Health–are also described. In addition to the program, both full-time and half-time, one-year, nondegree traineeships are available. **(145)**

BERNARD, VIOLA W. Roles and functions of child psychiatrists in social and community psychiatry: implications for training. **Journal of the American Academy of Child Psychiatry** 3:1, January 1964. pp. 165-176.

Columbia University's combined academic training for child psychiatry and community psychiatry is described, and the need for reoriented training to facilitate impending role changes is pointed out. Among the activities concomitant to these new roles are preventive intervention, changing patterns of public care by working with government officials, and case consultation on matters of social policy. **(146)**

BERNARD, VIOLA W. Some aspects of training for community psychiatry in a university medical center. IN Goldston, Stephen E. (ed.). **Concepts of community psychiatry: a framework for training** (Public Health Service Publ. No. 1319). Washington: U.S. Govt. Print. Off., 1965. pp. 56-67.

To cultivate interest and competence in community psychiatry, traditional psychiatric residencies with their intramural settings should introduce programs more integrally related to the network of community mental health services. The Columbia-Presbyterian Medical Center program for residency and postresidency training in community psychiatry is carried out by an interdepartmental Division of Community Psychiatry, which allows access to wider facilities and permits greater flexibility for individualizing programs. It is intrinsic to this program that residents work in close conjunction with both medical and nonmedical agencies concerned with mental health. The focus of training should be on the processes of interaction at the interfaces between environment and the human organism, for which reason training methods that involve practical experience under supervision are most effective. Close study of case histories in terms of dynamic connections between the individual patient and the community is also a useful teaching exercise. Training in community psychiatry should be included in a general residency and also offered more intensively in special programs. The Division of Community Psychiatry permits first or second year residents with the interest to enter a four-year sequence of training which

combines both the general residency and a degree program in community psychiatry. **(147)**

BERNARD, VIOLA W. A training program in community psychiatry: integrating trends in public health and administration. **Mental Hospitals** 11:5, May 1960. pp. 7-10.

The rationale of Columbia University's training program in community psychiatry is described, and the following programs (besides a degree program leading to the M.Sc. degree) are listed: a four-year combined psychiatric residency with training in community psychiatry and public health; a postresidency, two-year traineeship in administration, public health, and community psychiatry, leading to either an M.P.H. or an M.Sc. degree; and a one-year, full-time or half-time, nondegree, postresidency traineeship (or fourth-year residency) in community psychiatry. **(148)**

BRANCH, C. H. HARDIN. Preparedness for progress. **American Psychologist** 18:9, September 1963. pp. 581-588.

The psychiatric profession is characterized as unprepared to adequately adapt to community mental health programs. New kinds of mental health personnel must, therefore, be developed or new skills must be developed in the personnel we now have. A discussion of improvements that might be made in teaching psychiatrists concludes that any changes made will be in curriculum content or in the setting of the training; these possibilities are enlarged upon and suggestions regarding each are offered. **(149)**

CAMERON, D. EWEN. Training of psychiatrists. **Comprehensive Psychiatry** 6:4, August 1965. pp. 227-235.

Psychiatry departments are now expected to train students in several new subspecialties such as community psychiatry. Today's psychiatrist must be trained in many settings, including community clinics. He must be taught to work with the community resources. Teaching methods may include lectures, seminars, discussions, tutorials, conferences, ward rounds, journal clubs, sociodrama, and home visits. **(150)**

COLEMAN, J. V., C. S. THOMAS, and B. J. BERGEN. A teaching program in public health psychiatry. **American Journal of Psychiatry** 122:3, September 1965. pp. 285-289.

The teaching program in public health psychiatry at Yale is examined from the standpoints of unmet psychiatric need, particularly in the lowest socioeconomic classes; the paths to treatment; and the new area of community organization and coordination of community resources. **(151)**

DANIELS, ROBERT S. Community psychiatry a new profession: a developing subspecialty, or effective clinical psychiatry? **Community Mental Health Journal** 2:1, Spring 1966. pp. 47-54.

The experiences of the staff of a community mental health center form the basis of the presented analysis. (Such a center avoids direct patient contact whenever possible and evaluates by using information from a referring agency or person.) The development of community psychiatry is examined, its place in the history and practice of psychiatry is assessed, the additions and modifications that its residency training programs need are explored, and the influences that it exerts on psychiatric theory and practice are suggested. From this consideration it is found that more psychiatrists will be spending more time in community psychiatry and some will become specialists in community psychiatry. **(152)**

DANIELS, ROBERT S. and PHILIP M. MARGOLIS. The integration of community psychiatric training in a traditional psychiatric residency. **Mental Hygiene** 49:1, January 1965. pp. 17-26. Also published in Golston, Stephen E. (ed.). **Concepts of community psychiatry: a framework for training** (Public Health Service Publ. No. 1319). Washington: U.S. Govt. Print. Off., 1965. pp. 69-77.

All psychiatrists have community responsibilities whether they decide to become community specialists, part-time community psychiatrists, or merely informed citizens. Some of the training needs for community psychiatry can be met by taking advantage of opportunities in existing residency programs. The inpatient service, for example, may be viewed as a small community through which the resident can become aware of family and group dynamics while he is evaluating and diagnosing an individual with a serious psychiatric illness. He must learn to cooperate with a team of experienced and inexperienced collaborators who can provide data relevant to his case. He observes and participates in critical incidents when patients enter the unit. He learns to utilize nonprofessionals and community facilities for the future welfare of his patient. He is introduced to the relationship between psychiatry and law, and in emergencies he tests his spontaneity, skills, and resources under stress. Many inpatient services send teams of people from different specialties to help individuals or families in crisis, through which the resident can participate in problem-solving at the level of origin. The

consultation or liaison service offers the resident an opportunity to acquire experience in psychiatric consultation with patients on the individual level. Again he must cooperate with a team and take advantage of community facilities. During outpatient service, the resident is taught comprehensive diagnosis and individual psychotherapy with the help of a supervisor. Child psychiatry service familiarizes the resident with psychologic illness at its inception and requires the psychiatrist to study the child's family and environment. These situations can be extremely valuable when they are supervised by an individual who interprets the connection of these training experiences to community psychiatric practice. Didactic material of great value is research and theory in social, cultural, environmental, preventive and therapeutic factors, and study of epidemiology and biostatistics. **(153)**

Education and training of psychiatric residents in state service: conference of those responsible for psychiatric resident training programs in state service, Windsor, Connecticut, November 8-11, 1964 (conducted by the Connecticut State Department of Mental Health). 140 pp.

Among the contents of this booklet are the following articles: "Resident Education in the Medical Specialties: an Historical Review," by Aldwyn Stokes: "Development of Formal Residency Training and the Emergence of Current Problems," by J. Sanbourn Bockoven: "The State Hospital Residency Picture," by Henry Brill: "Changing Trends in Psychiatric Education," by Francis Braceland; "Medicine and Psychiatry," by Samuel Silverman; and "Training in Community Psychiatry," by Eugene A. Hargrove. **(154)**

FELIX, ROBERT H. The preparation of a community-oriented psychiatrist. **American Journal of Psychiatry** 122:12, supplement, June 1966. pp. 2-7.

Comments about Franklin G. Ebaugh's influence on community-oriented psychiatry are followed by a discussion of "community knowledge" expected of a psychiatric resident. The curriculum of a community health program is described, and the responsibilities and skills of psychiatrists of the future are outlined. **(155)**

GOLDSTON, STEPHEN E. (ed.). **Concepts of community psychiatry: a framework for training** (Public Health Service Publ. No. 1319). Washington: U.S. Govt. Print. Off., 1965. 211 pp.

Four regional training institutes in community mental health were held in 1963 and 1964. The major papers presented were: "Community Psychiatry Introduction and Overview," by Gerald Caplan; "The Psychiatric Evolution," by Leonard J. Duhl; "Selected Sociological Perspectives," by Leo Srole; "Theory and Practice of Community Psychiatry Training in the Medical School Setting," by Melvin Sabshin; "Some Aspects of Training for Community Psychiatry in a University Medical Center," by Viola W. Bernard; "Community Psychiatry Training in a Traditional Psychiatric Residency," by Robert S. Daniels and Philip M. Margolis; "Community Psychiatry Training: A Public Health Approach," by Howard M. Kern, Jr.; "Problems of Training in Mental Health Consultation," by Gerald Caplan. "Epidemiology and Psychiatric Training," by Ernest M. Gruenberg and Alexander H. Leighton; "Community Psychiatry and the Legal Process," by (1) Abraham S. Goldstein (2) Hon. Justine Wise Polier; "Planning and Evaluation of Community Mental Health Programs," by Hyman M. Forstenzer; "Is This Psychiatry?" by Frank Kiesler; "Effects of a Community Psychiatry-Oriented Hospital Program on the Training of Psychiatric Residents," by Alvin M. Mesnikoff; "Current Issues Relating to the Training of Psychiatric Residents in Community Psychiatry," by Gerald Caplan; and "Training in Community Psychiatry: A survey Report of the Chairmen of the Medical School Departments of Psychiatry," by Stephen E. Goldston. There is a list of definitions and a brief bibliography. **(156)**

GROUP FOR THE ADVANCEMENT OF PSYCHIATRY. COMMITTEE ON MEDICAL EDUCATION. **Education for community psychiatry** (Vol. VI, report no. 64). New York: Group for the Advancement of Psychiatry Publications Office, 1967. 56 pp.

This publication clarifies the role of community psychiatry in the total field of psychiatry and explores its impact on current residency programs in relation to the need for trained personnel to carry out the various programs envisaged under the Community Mental Health Centers Act of 1963. It offers recommendations for organizing the curriculum and residency programs to provide multidisciplinary training for community psychiatry as an extension of clinical psychiatry; for faculty selection; and for integration of community psychiatry programs with general psychiatry. Described in an appendix are training programs in community psychiatry at sixteen institutions. **(157)**

HEATH, ROBERT G. Psychoanalytic training and community psychiatry. IN Masserman, Jules H. (ed.). **Communication and community** (Vol. VIII of **Science and Psychoanalysis**). New York: Grune & Stratton, 1965. pp. 268-277.

The Tulane University community psychiatry program is based in both the Department of Psychiatry

and the School of Public Health, and is given to residents in general psychiatry and child psychiatry, as well as to specialists in community psychiatry. "Psychodynamics is considered a basic science of human behavior from which numerous therapeutic and research techniques evolve." The following aspects of practice (in addition to conventional clinical training) are emphasized: community organization, program administration, mental health education, consultation, applied research, forensic psychiatry, group dynamics, supervision, and special methods for inservice training. **(158)**

HOLLAND, BERNARD C. and ROBERT A. PORTER. The education and training of physicians and psychiatrists for community psychiatry. **Kentucky Medical Association Journal** 62:4, April 1964. pp. 286-288.

Acceptable instruction of resident psychiatrists will create in them openminded attitudes regarding social problems, give them an extensive knowledge of social service organizations, and develop their capability of applying their clinical knowledge to social problems. The methods of teaching usually employed to accomplish these goals are social research, consultation with agency staffs, direct contact with agency clients, supervision of agency staff members whose work involves clients who have mental or emotional problems, and exposure to the power struggles, conflicts of interest, and budget problems which affect any program of care. **(159)**

KERN, HOWARD M., JR. Community psychiatry training—a public health approach. IN Goldston, Stephen E. (ed.). **Concepts of community psychiatry: a framework for training** 1965. pp. 79-87.

The Maryland training program is a joint venture of the state and local health departments and the university, state, and private training centers. To participate, a resident psychiatrist must have at least two years of clinical experience. Each resident then spends one working day a week in a rural county for at least one year, acting as psychiatric director of the county mental health clinic. This training experience is in addition to other training at the parent institution. An overriding consideration of the program is to encourage the trainee to develop his own capacity for leadership, and therefore the supervisor functions as a consultant rather than as a senior supervisor in the field. The trainee, confronted with immediate clinical problems, learns that there are factors in the county situation that make the traditional orthopsychiatric team approach obsolete. He must draw upon the practical knowledge of health officers and public health nurses, he must work directly with social workers in community agencies, he must work to develop an entire mental health program, and he must learn to cooperate with his own and community personnel. When he realizes the magnitude of the community's mental health needs, he is compelled to seek out a variety of practical and applicable solutions. **(160)**

KERN, HOWARD M., JR. and JANE BRADSHAW HESS. Preparing the psychiatrist for leadership in a changing society. **American Journal of Orthopsychiatry** 35:4, July 1965. pp. 795-798.

The Maryland training program in community psychiatry tries to stimulate senior psychiatric residents to seek leadership in community mental health programs. Working one day a week in rural health departments, trainees are forced into contact with the community and to see the magnitude of the problem, which demonstrates that the traditional methods of psychiatric treatment do not suffice. Supervision and guidance are handled through weekly seminars, individual sessions with program directors, and monthly meetings in which training program consultants of various disciplines participate, and at which activities are discussed and compared. **(161)**

KNIGHT, JAMES A. and WINBORN E. DAVIS. **A manual for the comprehensive community mental health clinic**. Springfield, Illinois: Charles C. Thomas Publishers, 1964. 184 pp.

This outline of a program for a comprehensive community mental health clinic stipulates that all available and appropriate resources of the community should be mobilized for prevention, diagnosis, treatment, and rehabilitation. The Center for Training in Community Psychiatry at the University of California at Berkeley is described. There is a discussion of the role of the Church and volunteers in community mental health. It is hoped that the comprehensive mental health clinics will enter strongly into a cooperative training effort with the university educational programs. **(162)**

KOLB, LAWRENCE C. Academic and community psychiatry. **Mental Hospitals** February 1963. pp. 61, 64-65, 66, 71.

This address, presented at the 14th Mental Hospital Institute, and intended to stimulate discussion, mentions the manpower problem, location of residency training, the amount of training that academic programs offer in community psychiatry, and models for community psychiatry training programs. Discussion following the address touched on inservice training, nonprofessionals, mental health workers, and general practitioners. **(163)**

MASON, EDWARD A. and GERALD CAPLAN. Working with the Peace Corps: a training opportunity in social psychiatry. **Mental Hygiene** 48:2. April 1964. pp. 172-176.

Presented is a description of a training program devised for psychiatric consultants to the Peace Corps who help the organization in its selection and training services. A manual formulating some principles and practical steps which might guide the psychiatrists in this new role was prepared in 1962. Also, each participating consultant was invited to attend a two- or three-day training institute at which besides being given orientation background, certain anticipated problems were discussed. This new role of the psychiatrist in the Peace Corps calls for him to "encourage trainees to confront reality," and many of the principles of community mental health are used in this role. "Work with the Peace Corps is a high-status opportunity for psychiatric residents to be trained for the developing field of social psychiatry." **(164)**

The medical school and the community mental health center. Report of a conference, Atlanta, Georgia, December 13-15, 1966. Sponsored by the Southern Regional Education Board and the National Institute of Mental Health (Public Health Service Publ. No. 1858). Washington: U.S. Govt. Print. Off., 1968. 46 pp.

This conference focused on the problems of planning a community mental health center as part of the teaching resources of a medical school. Participants were from departments of psychiatry and psychology, faculty from schools of social work and nursing, deans of medical schools, and representatives of local agencies and state mental health departments. Presentations were made on the obligation of the medical school; problems encountered in planning; programming the services (clinical, nonclinical, children, and adolescents); the teaching of other disciplines besides psychiatry; research; financing and administration; and relationships of the center with the university, the community agencies, and the state mental health authority. **(165)**

MESNIKOFF, ALVIN M. Effects of a community psychiatry-oriented hospital program on the training of psychiatric residents. IN Goldston, Stephen E. (ed.). **Concepts of community psychiatry: a framework for training** (Public Health Service Publ. No. 1319). Washington: U.S. Govt. Print. Off., 1965. pp. 159-164.

The community-oriented psychiatry program at the New York State Psychiatric Institute has evolved beyond the traditional psychoanalytic model. They first established a closer working relationship with patients in a general hospital, then began to emphasize a broader range of patients and continuous care in the local community. Finally, the hospital ward was developed into a small therapeutic community itself. Their training program for psychiatric residents focuses on the patient's adaptation to the community, which requires a problem-oriented, pragmatic approach. The policy of continuous care emphasizes the successes and defects in previous therapeutic formulations, and confronts the resident with the realities of mental illness as manifested in the local community. Community-orientation emphasizes the psychiatrist's central responsibility for his patient, requires the organization of an entire treatment and care program, and forbids the shifting of a difficult patient to other agencies. Responsibility and continuous care demand reinvestigation and restudy, which sharpen the psychiatrist's skills. This new training program has made community psychiatry more attractive to psychiatric residents. **(166)**

OZARIN, LUCY D. Experiences in teaching community psychiatry to residents. **American Journal of Psychiatry**, vol. 120. September 1963. pp. 271-273.

Fifty-one psychiatric residents attended two workshops on community psychiatry and public health–mental health. Didactic presentations took up the first two days: the public health approach to disease; epidemiology; social science in relation to health; the practice of community psychiatry; and community resources were among subjects of the presentations. A day was spent at the Psychiatric Receiving Center in Kansas City. The last day presentations on mental health centers were heard. There were also problem-solving sessions, and the trainees evaluated the program when it was finished. It is suggested that similar training experiences could be incorporated into existing residency programs. **(167)**

REECE, S. A. Social work participation in psychiatric training related to intake work. **American Journal of Psychiatry** 121:12, June 1965. pp. 1183-1189.

Social work participation in psychiatric training has been limited generally to didactic seminars, case consultations, and informal teaching. In the Children's Service of the Langley Porter Neurophychiatric Institute of the University of California School of Medicine, however, the social workers participate in the teaching of the intake process to psychiatric residents. Each resident is assigned to a social worker who discusses intake policies and related social work principles. The resident sits in on the social worker's intake interview, which they later discuss in detail. The resident then does an intake interview while the social worker sits in, and

this is discussed. Both the social workers and the psychiatrists have to overcome the usual problems related to learning and teaching, but the consensus of the social work and psychiatric staff is that this learning experience by demonstration is valuable to the resident in enhancing his knowledge of intake and of the social work profession. **(Abstracts for Social Workers)** **(168)**

Review of psychiatric progress, 1964. **American Journal of Psychiatry** 121:7, January 1965. pp. 627-719.

The last of an annual review of literature includes articles on social psychiatry, psychiatric social work, psychiatric nursing, outpatient and community psychiatry, and psychiatric education. It also summarizes literature on the manpower problem, on training in community psychiatry, and on continuing education. **(169)**

SABSHIN, MELVIN. Theory and practice of community psychiatry training in the medical school setting. IN Goldston, Stephen E. (ed.). **Concepts of community psychiatry: a framework for training** (Public Health Service Publ. No. 1319). Washington: U.S. Govt. Print. Off., 1965. pp. 49-56.

If community and social psychiatry are to attract high quality individuals, the traditional psychiatric residency must give way to a more varied and experimental curriculum. Promising residents should have individualized programs from the beginning, including greater concentration on activities germane to community psychiatry. While some first-year residents are currently benefitting from carefully supervised work in Emergency Service, some also might profit from work in community center after-care programs, walk-in clinics, and rehabilitation efforts. The program at the University of Illinois, which will hopefully become a center for research and training in community psychiatry, currently has a field project on the south side of Chicago where research efforts and clinical operations are integrated under the direction of three competent psychiatrists whose training has been other than the traditional psychoanalytic program. When the psychiatric residency accommodates itself to carefully supervised variations and experimentations, which are constantly assessed and evaluated for effectiveness, all of the career lines will be strengthened. **(170)**

SCHWARTZBERG, ALLAN Z. Training for community psychiatry. **Medical Annals of the District of Columbia** 34:12, December 1965. pp. 587-588.

One day of training per week over a six-month interval would be the minimum necessary to acquaint the average resident with the basics of community psychiatry. Reasons are cited for including this training in psychiatric residency programs, the goals are given, and probable course content is discussed. Informal seminars, conferences, lectures, and readings, in conjunction with supervised field experiences, are suggested as teaching methods for such a program. **(171)**

Training in psychiatry. IN Mental health news digests. **Mental Health Digest** (National Clearinghouse for Mental Health Information). August 1967. p. 34.

Psychiatry and medical education was the subject of a March 1967 conference in Atlanta, Georgia, among psychiatrists, sociologists, psychologists, anthropologists, deans of medical schools, and chairmen of departments of psychiatry. All aspects of the teaching of psychiatry were assessed especially with respect to changes that have occurred in the theory, practice, and role of psychiatry in medicine during the past two decades in America. A report of the conference will be published early in 1968. **(172)**

YOLLES, STANLEY F. Trends in federal legislation and their effect on university departments of psychiatry. Reprint of speech delivered at the meeting of the Northeastern Professors of Psychiatry, Onchiota Conference Center, Tuxedo, New York, April 2, 1967. 15 pp.

In 1946, when the Training Support Program of the National Institute of Mental Health was authorized by Congress, relatively few medical schools had independent departments of psychiatry. Today, every medical school in the country has one. These schools must now train students in community mental health, child psychiatry, and in treatment of alcohol and drug abuse. They should encourage private psychiatrists to take advantage of continuing education, and they should encourage faculties to emphasize teaching rather than research. **(173)**

Psychologists

BINDMAN, ARTHUR J. Problems associated with community mental health programs. **Community Mental Health Journal** 2:4, Winter 1966. pp. 333-338.

The organizational plans and the administrative and fiscal policies of community mental health programs vary; proliferation of community programs often interferes with the flow of services; conflicts flare between individual professional interests and community needs; new attitudes toward mental health are needed in many professional workers. Inservice training can ameliorate

these problems by reshaping professionals for new roles. Such inservice training can use state-level staff and university and other consultants to direct and execute training through institutes and workshops. (Medical schools and schools of public health could help by relating their training programs to existing community mental health activities.) Massachusetts, for instance, has training in public health aspects of mental health, in mental health consultation, and in administration of community mental health programs. Psychologists are interested in new developments in community psychology. A transfusion of attitude and orientation toward community mental health may be accomplished by inservice education and postdoctoral specialty programs. (174)

CARTER, JERRY W., JR. The training needs of psychologists in community mental health programs at state and local levels. IN Strother, Charles R. (ed.). **Psychology and mental health.** ... Washington, D.C.: American Psychological Association, Inc., 1956. pp. 21-40.

A review of the organization and scope of activities in community mental health programs, at state and local levels (including the amount of money appropriated by certain states), indicates the growing demand for psychologists in these programs and suggests areas of competency needed by them. The psychologist's roles in the areas of diagnosis, treatment, consultation, education and training, and research and evaluation are discussed. Additional training in group and community organization and action techniques is needed. Ways in which training institutions might develop their faculties for contributing to current mental health programs are: encouraging interchange of opinion and practice regarding specific teaching techniques; encouraging participation in mental health professional meetings and conferences; granting leave for postdoctoral training; holding intra- and interdisciplinary seminars on community mental health problems; granting sabbatical leave for work in other programs; exchanging duties with mental health program staff for limited time periods; holding short-term national, regional, or local institutes; encouraging faculty members to serve on intra- or interdisciplinary advisory committees or as consultants; giving teaching appointments to psychologists in state or local mental health programs; and encouraging graduate students to study community programs as thesis projects. A final comment on training methodology warns that "the present tendency to create an intellectual system which ... suppresses curiosity for the sake of 'efficient' education robs modern society of the true scientist and teacher it needs." (175)

Community mental health, individual adjustment or social planning: a symposium. Ninth Inter-American Congress of Psychology, 1964 (Public Health Service Publ. No. 1504). Washington: U.S. Govt. Print. Off., 1966. 82 pp.

A general view of community mental health was presented by U.S. psychologists before an inter-American audience interested in psychology and allied disciplines. The topics were theory, practice, research, and training. Discussions were carried on by delegates from Latin America. Four papers are included: "Community Mental Health: A Movement in Search of a Theory," by J. R. Newbrough; "Community Mental Health Services: For What and To Whom," by A. J. Simmons; "The Community Mental Health Center and the Study of Social Change," by James G. Kelly; and "Graduate Training in Community Mental Health," by John C. Glidewell. The training article presents an analysis of community mental health programs in university psychology departments in 1964. These programs received little more attention than was found by Golann in 1962. The survey results are presented from the standpoints of objectives and philosophy, curricula, professional practice, research activities, and professional and scientific opportunities. (176)

FELSINGER, JOHN M. VON and DONALD C. KLEIN. Professional training for the mental health field. **Mental Hygiene** 46:2, April 1962. pp. 203-217.

One objective in developing a community mental health training program for psychologists, psychiatrists, and social workers was the precise specification of suitable teaching and training. Relevant general principles and main training areas are identically suitable for the three professions. Each needs to think of the health or sickness of entire populations rather than of individuals and to understand that health and sickness are as two points in the same continuum. On the other hand, each must be aware of those current circumstances that support or threaten an individual's stability and of the social environment whose tensions are mirrored in the symptoms of the individual. Finally, each needs skills in change-oriented work in the community—with emphasis on related networks of persons rather than individuals. Training was divided into seven categories: clinical training, mental health consultation, group methods, communication and public education, administration, community organization, and research. The program for the psychologist included clinical experience with case and staff consultation, a one-year seminar, observation of groups, work with a group, group meetings, field experience in communication, exposure to administrative procedures, research, and field experience in the community. (177)

GOLANN, STUART E., CAROLYN A. WURM, and THOMAS M. MAGOON. Community mental health content of graduate programs in departments of psychology. **Journal of Clinical Psychology** 20:4, October 1964. pp. 518-522.

Relatively few departments of psychology offer much explicit instruction in community mental health concepts or techniques--according to responses to a questionnaire sent to the chairmen of 61 departments offering doctoral programs in clinical or counseling psychology. There is a discussion of possible new roles for which the psychologist will have to be trained. Changes that could be instituted in doctoral training in clinical and counseling areas are suggested. **(178)**

JONES, MARSHALL R. and DAVID LEVINE. Graduate training for community clinical psychology. **American Psychologist** 18:4, April 1963. pp. 219-223.

The graduate training program at the University of Nebraska has been trying for some time to train clinical psychologists who can fit into the sorts of roles that are demanded by the community mental health center approach and who can be flexible enough to develop with the field as it progresses. The paper reviews some of the basic principles underlying the training of psychologists for professional careers in mental health, examines these principles in relation to the developments that have occurred in the field since World War II, explores the implications of these factors for graduate training in psychology in general and in clinical psychology in particular, and describes a training program in which an attempt has been made to apply these principles. The program involves conferences, observation of supervisors dealing with problems, and participation in field experience under supervision. It concentrates on teaching the use of psychological tests as an aid to understanding peoples' problems. Staff conferences are attended by all students in the clinical training program as an important part of practicum training. Students are involved in seminars and research projects and the writing of reports on their work. An important advantage noted in this program is that the contact students have with a wide variety of community agencies and personnel furnishes an excellent basis for teaching professional conduct and ethics in terms of concrete, live situations in which the students themselves are often involved. **(179)**

ROSSI, ASCANIO, DONALD C. KLEIN, JOHN M. VON FELSINGER, and THOMAS F. A. PLAUT. A survey of psychologists in community mental health: activities and opinions on education needs. **Psychological Monographs** 75:4. Whole No. 508. 1961. 38 pp.

This is a description of a survey carried out in order to make a beginning step in overcoming the training lag of psychologists involved in community mental health. "In addition to gathering data on the activities of psychologists interested in community mental health, it was also the purpose of this survey to learn the opinions of these psychologists concerning the education and training needs of those involved in community mental health activities." The results of the survey are presented under eight headings: Descriptive Data, Present Activities, Future Activities (anticipated), Desired Content Areas (for inclusion in education and training programs), Level for Education and Training, Locus for Predoctoral Training, Locus for Postdoctoral Training, Influences in the Development of Interest in Community Mental Health, and General Comments by Respondents. Approximately sixty percent of the respondents had some inservice education duties, and this sixty percent spent an average of only 7.2 hours a month in this activity. This group of respondents was asked to answer two subquestions: "Setting for inservice education?" and "Audience for in-service education?" The tabulations of the replies to these subquestions are presented in Tables 18 and 19. The most noteworthy finding in Table 18 is that only four percent of these respondents provided in-service education within social agencies. It was expected from the literature that this percentage would be much higher than it was. Seventy-seven percent of those engaging in in-service training provided this service to non-mental health personnel. The authors conclude that from the data, it would appear that the majority of psychologists interested or engaged in community mental health are chiefly characterized by two activities: consultation and administration. **(180)**

WATCHEL, ANDREW S. A comprehensive community clinic. **Mental Hospitals** 13:12, December 1962. pp. 653-655.

The activities of the Oak Ridge Mental Health Center (Tennessee) include provision for a psychology trainee from the department of psychology of the state university, and training in the Oak Ridge school system and in a rehabilitation center. There is also a program for formal and informal psychiatric training of general practitioners in the area. The success of these activities indicates that clinical service and training are not only compatible, but augment each other. **(181)**

Psychiatric Social Workers

Advanced social work in community mental health. **American Journal of Public Health** 56:8, August 1966. p. 1217.

A new training program, called Post-Master's Education in Social Work, will prepare social workers for specialist and leadership roles in the field of community mental health. This program will be under the direction of Lydia Rapoport and Robert Z. Apte at the School of Social Welfare, University of California at Berkeley. Its purpose is to help practitioners make the transition from direct clinical services to nonclinical methods of social work. The curriculum emphasizes administration and policy development, mental health consultation and education, community organization, demonstration and evaluative research, and modes of preventive intervention. It uses relevant courses from the master's and doctoral programs of the School of Social Welfare, from the School of Public Health, and from other university departments. Concurrent field experience stresses development of specific innovative projects. Admission requirements have been set. Graduate credit for one academic year will be given. **(182)**

FURMAN, SYLVAN S. **Community mental health services in Northern Europe** (Public Health Service Publ. No. 1407). Washington: U.S. Govt. Print. Off., 1965. 210 pp.

General observations on mental health programs in Northern Europe are followed by a discussion of comprehensive mental health programs (including training) in general and mental hospitals and health departments in England, Scotland, The Netherlands, Denmark, and Sweden. Various special programs such as those for problem families and habitual offenders and programs for the prevention and alleviation of stress are discussed in Chapters III and IV. Chapter V describes mental health research and social work training in Great Britain. The National Institute for Social Work Training, established in 1959, is a kind of "staff college" which supplements the universities and technical colleges. Seven broad functions of the Institute, not all of which are as yet fully operational, are: to provide a center where senior workers in health-and-welfare fields can gather to consider policy and practice; to provide a center for research, experiment, and demonstration in social-work training; to train experienced social workers to teach their profession; to provide advanced refresher courses; to pioneer new courses in general work; to develop teaching materials and publications; and to develop a specialized library in social work and serve as an information center about research projects in social work and related fields. Maudsley Hospital's Institute of Psychiatry (London) is the dominant teaching facility for undergraduate and postgraduate psychiatric studies for Great Britain and the British Commonwealth. The volume includes a glossary of British terms and abbreviations as well as a bibliography. Training methods mentioned throughout the book include: field experience, seminars, case conferences, job-rotation, short courses, ward meetings, lectures, and problem-solving discussions. **(183)**

MAGNER, GEORGE W. and THOMAS L. BRIGGS (eds.). **Staff development in mental health services.** New York: National Association of Social Workers, 1966. 126 pp.

These papers, selected from among those presented at six regional institutes and from a survey of the major issues discussed on staff development for social workers in psychiatric inpatient facilities, include: "Social Change and Its Implications for Training," by Norman V. Lourie; "In-Service Staff Education," by Walter L. Kindelsperger; "Basic Principles of Staff Development and Their Implementation," by Dorothy Schroeder; "Concepts of Staff Development and Impact of Institutional Environment," by Samuel Finestone; "Social Service Staff Development in Mental Health Installations," by John Wax; "Mobilization of Institutional Resources for Change," by Fernando G. Torgerson; "Changing Dimensions of Social Work Practices in the Mental Health Field," by Jerome Cohen; "Major Issues—A Survey of the Institutes," by George W. Magner and Thomas L. Briggs. An appendix entitled "Resources and Methods of Staff Development Used in Mental Health Facilities," discusses community resources (area professional and undergraduate schools, professional meetings and conferences, specific resource people from the community, collaborative case conferences, and field trips) and resources of the social work department (provision of social work supervision; social work staff meetings—including administrative staff meetings, social work seminars, and supervisory or staff development meetings; specific case aide or trainee staff development projects; journal clubs; provision of funds and/or time off for attendance at conferences and institutes; consultation; provision of funds for graduate training; provision for a staff development or training position; and general institutional resources such as the professional library, the film library, interdiscipline committees for training purposes, coordinated lecture series, joint or coordinated orientation programs, interdiscipline teaching staffs, attendance at lectures and seminars held by other disciplines, and specific institution-sponsored projects such as annual conferences). **(184)**

BROCHURES AND CURRICULUM OUTLINES*

Community mental health. San Francisco, California: The Langley Porter Neuropsychiatric Institute. n.d. 5 pp.

The Langley Porter Neuropsychiatric Institute of...s an advanced training program of one or two years' education for psychiatrists and psychologists interested in specializing in community mental health. Training methods include three weekly seminars (consultation, crisis theory, administration, community organization, mental health education, program planning, evaluation and research, and epidemiology of psychiatric disorders); community experience (direct observation of urban environments, attendance at professional and lay meetings, consultation to agencies or organized groups); multidisciplinary consultation (discussion with members of other disciplines); and special studies (mental health aspects of delinquency, adoption, alcoholism, acculturation, poverty and unemployment, or criminality and the law). Completion of a three-year residency in psychiatry or the Ph.D. in psychology, are the requirements. Fellowships are available from the National Institute of Mental Health for psychiatrists and from the California Department of Mental Hygiene for some psychologists. Psychiatrists are officially registered as postgraduate students and receive a certificate upon completion of the program. Application instructions and a list of staff and clinical faculty conclude the brochure. (185)

Continuing education in community health: tentative curriculum. Cincinnati, Ohio: University of Cincinnati Department of Psychiatry. n.d. 6 pp.

The Department of Psychiatry of The College of Medicine, University of Cincinnati, and the Ohio Department of Mental Hygiene and Correction have embarked upon a joint pilot educational project in continuing education for professionals in community mental health. "The plan of implementation is to select mental health professionals from The Ohio Department of Mental Hygiene and Correction and related agencies and bring them in groups of approximately twenty each to the Cincinnati complex (composed of major mental health and university facilities) for a period of approximately four weeks, for an intensive seminar-workshop-demonstration educational experience in comprehensive mental health programs. The attendee time will be allotted on the basis of part-time classroom work and part-time site-practicum experience. Resource persons, discussion leaders, and lecturers will be obtained from throughout the country." Presented are a tentative curriculum, a statement of philosophy, a list of major objectives, and members of the joint policy committee. Major sections of the tentative curriculum are: program orientation; current social and psychological concepts; social change; changing role of the state hospital; changing roles of community, state, and federal agencies in the provision of the mental health services; public health approaches; current treatment programs; orientation to mental health facilities in Cincinnati; mental retardation programs; evaluation projects in current treatment programs; manpower crisis; concept of primary prevention; community organization of mental health; mental health consultation, high priority considerations; community planning; education and coordination of community services; community mental health education and information, and administration. (186)

Educational program in community mental health of the Laboratory of Community Psychiatry of the Department of Psychiatry, Harvard Medical School (Brochure). November 1966. Mimeo. 38 pp.

The one-year, full-time educational program of the Laboratory of Community Psychiatry offers graduate students subjects bearing on community mental health administration, education, planning, and research. Full-time students may be psychiatrists who have completed three years of approved residency; psychologists with the Ph.D. degree and at least three years of postdoctoral experience; social workers with the master's degree and at least five years of experience in clinical, community, and supervisory settings; nurses with the Ph.D. in psychiatric nursing or a master's degree and extensive supervisory experience in the public health-mental health field; and occasional students with backgrounds in social science, administration, law, public health, or theology. Part-time programs are offered students of the Harvard Medical School, psychiatric

*These are selected examples of the kinds of materials that are often available from various training centers and graduate institutions for the four key professions.

residents of Harvard teaching hospitals, faculty of other universities, and professional personnel of the Massachusetts Department of Mental Health. Admission requirements and resume's of courses and research projects are provided. **(187)**

Langley Porter Neuropsychiatric Institute of the San Francisco Medical Center. San Francisco, California: The Institute, April 1964. 14 pp.

This general informational booklet for prospective resident physicians describes services, departments affiliated institutions, educational programs, research, types of residency appointments, kinds of financial support available, methods of application, and officers of the Institute. The Center for Training in Community Psychiatry is an affiliated institution which offers eight courses on nonclinical aspects of community psychiatry. Part-time and full-time training are provided. Two summer session courses, full-time for two weeks, cover (1) laws, legal procedures, and probation practices involving psychiatric patients and (2) the development and utilization of community resources in behalf of psychiatric patients. At the Institute, the Community Mental Health Training Program has a permanent staff that includes a member of each of the four key mental health professions. Participants in the program (psychiatric residents—third year usually—clinical psychology fellows, and nurses) are involved in field experience at the community level. A seminar on community mental health related to the practice of child psychiatry is offered in the two-year advanced program in child psychiatry. The full-time training program in community psychiatry includes consultation with agencies; familiarization with the broad matrix of community programs; supervision of residents; participation in continuing research projects; and collaboration with social workers, psychologists, and public health nurses. Didactic and literature seminars on community organization, epidemiology, and preventive measures are offered. **(188)**

TALLMAN, FRANK F., J. ALFRED CANNON, and STANLEY C. PLOG. **A curriculum in social and community psychiatry.** 1965. Mimeo. 16 pp.

A number of concepts upon which the Social and Community Psychiatry Training Program of the University of California, Los Angeles, is based are described. The terms "mental health" and "social psychiatry" are defined and the focus of community and social psychiatry is given. Turning to training, the necessity for a truly interdisciplinary program is stressed. The curriculum of the program for 1964-65 is outlined, and each course is described. Major areas include social and community psychiatry, public health methods, administration, consultation, group dynamics, and mental health patterns of social and ethnic groups. The program lasts two full years. **(189)**

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