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ABSTRACT

This document explains what community consultation and education is, what it does, and how it works; its concern with the prevention of mental illness and the promotion of mental health is examined. More specifically, the document is designed to cast a spotlight upon the preventative and educative services which community mental health centers are pledged to develop. It is also intended to provide center staff and trainees with a concise view of the scope of community mental health consultation and education. Mental health consultation is defined and explored in light of consultation tasks, priorities in the establishment of consultation, authority and power in consultation, the training of consultants, and the recording and evaluation of consultation. The section on mental health education includes training for professional mental health specialists, mental health education for community service personnel and for the lay public, and training of mental health educators. References are included. (Author)

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THE SCOPE OF COMMUNITY MENTAL HEALTH CONSULTATION AND EDUCATION

NATIONAL INSTITUTE OF MENTAL HEALTH

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FOREWORD

Community consultation and education for citizens, agencies, and professionals is concerned with the prevention of mental illness and the promotion of mental health. The purpose of this document is to explain what community consultation and education is, what it does and how it works. More specifically, it is designed to cast a spotlight upon the preventive and educative services which community mental health centers are pledged to develop. It also is intended to provide center staff and trainees with a concise view of the scope of community mental health consultation and education. The material presented here will be included in a larger work scheduled for subsequent publication.

Dr. Saul Feldman, Associate Director of the Division of Mental Health Service Programs, has given constant guidance to staff and consultants of the Mental Health Study Center and the Services Development Branch who have contributed to this document. Drs. Gustave Weiland and Harold Goldstein have given valuable editorial assistance. Helpful suggestions were also received from directors of community mental health centers and other mental health professionals.

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INTRODUCTION

Community mental health centers have two major functions which relate both to prevention and treatment. One is to assess the mental health problems and needs in the community and to plan and develop resources to deal with them. The second is to carry out under their own auspices or in federation with other agencies a wide variety of direct and indirect mental health services.

The concentration of effort on these two functions will vary between centers, depending on their position in the community. A center which is part of a State, county or city department often carries the formal planning responsibility of the local government for the development of community mental health services. This undoubtedly involves the coordination of all public service efforts and may include the delegation of some responsibilities to other mental health specialists and agencies. Some private nonprofit centers, on the other hand, may operate comprehensive services for one catchment within a larger planning area, and take primary responsibility only for direct services while relying on a public agency to provide most of the indirect services. Between these two extremes the distribution of available resources between direct and indirect services will depend at least in part on the role and responsibilities assumed by the center in relation to other institutions in the community. The extent to which the CMHC assumes a creative leadership role depends upon the social and political realities of the particular community, but even more so upon the ingenuity with which center leaders approach their communities.

In the first phase of the centers program, emphasis was placed on assessing needs, reorganizing existing services, and developing new services. However, over the first five years a great excess of demand over potential for service delivery has developed. This has made urgent the need for CMHC's to devise more effective methods of prevention and early treatment of mental health problems and more efficient utilization of already existing and new forms of manpower. The pressure to do so has brought increased recognition of the importance of other community caretakers in maintaining and improving the mental health of the people with whom they work. The task, then, of strengthening and supporting the mental health role of case workers, teachers,

police, family physicians, clergymen, probation officers, and a host of voluntary agencies has become a focal point for increased activity in many CMHC programs. Indeed, the 1970 Amendments (P.L. 91-211) to the CMHC legislation specifically recognize the importance of such services by authorizing special funding for the consultation and education services which centers provide.

As a result, the center's consultation and mental health education program—one of the five essential services—has gained increasing prominence. These services, which are the center's major preventive activities contribute significantly also to assessment of the community's mental health needs, to the development of new resources, and to reshaping of service delivery systems.

The consultation and education services component provides consultation to human service groups and individuals on the mental health dimensions of their work with people. It also includes mental health education and training for staffs of caregiving agencies, and mental health information and education for the general public. Consultation and education are the major means through which the CMHC can share the responsibility for maintaining the mental health of the community with other agencies and with the public, and thus reduce the number of acutely disturbed and chronically ill mental patients who require direct mental health services.

While results are necessarily slow in becoming visible, the long-term rewards for investments in consultation and community education can be enormous. They include: increased collaboration and coordination among service agencies and groups; the development of additional sources of mental health manpower; the creation of effective mechanisms for assuring continuity of care and early intervention in personal crises; an increase in the community's sophistication about mental illness and problems related to mental health; the assurance of a broad base of moral and financial support for the center's work and the enhancement of the community's general mental health.

The rewards of doing consultation can provide much personal and professional satisfaction for the consultant. By discovering new uses for his professional skills his community work becomes more rewarding. The consultant also becomes involved with a broader range of issues than he would encounter in his clinical setting. Furthermore, the consultation experience is often self instructive. Through such consultation experiences the professional increases his understanding of and ability to relate to the catchment area he is serving. (*23, 24, 55, 60*)

MENTAL HEALTH CONSULTATION

Definition of Mental Health Consultation

Mental health consultation is the provision of technical assistance by an expert to individual and agency caregivers related to the mental health dimensions of their work. Such assistance is directed to specific work-related problems, is advisory in nature, and the consultant has no direct responsibility for its acceptance and implementation. Consultation is offered by a mental health specialist either to other mental health workers less knowledgeable in some aspect of mental health, or to specialists in other fields who need assistance in the management of mental health and human relations problems. (*7, 19, 42*)

Mental Health Consultation as a Component of the CMHC Program

Mental health consultation emanating from a community mental health center differs from that offered out of many other settings, such as private consulting firms or a mental health professional's office, in that the purpose and outcome of the consultation has importance for the center's programs as well as for the consultee's. This is so because community mental health centers aim not only to achieve change in the functioning of individual consultees and through them, their clients, but also to assist agencies and institutions to expand and upgrade their roles in the community's mental health maintenance system. This can be achieved through resolving administrative difficulties, increasing the skill of their staffs in understanding and managing mental health problems, and through developing new programs and accepting additional responsibilities which will affect the mental health of the community. Consequently, the disposition of the center's resources for consultation and the selection of consultation priorities are to be consonant with the goals of the center as well as responsive to the demand for consultation by community agencies. (*30, 35, 36*)

Community mental health consultation is not only useful to the center in stimulating agencies to extend heir range of mental health activities and to upgrade their mental health knowledge and skill, but it also provides a vehicle for interagency communication and liaison and for supplementing the center's

knowledge of the changing needs and resources of the community.

Consultation Tasks

Any of the following activities may be included as the focus of consultation. Consultation is conducted with the consultee regarding the referral or management of an individual, family or client group, or regarding the feelings of the consultee about his client. (*4, 5, 6, 8, 25, 35, 36, 38, 42*)

Consultation also is concerned with administrative and staff organization and relationships. Problems in relationships occur in the organization of an agency, between agencies and the community, between agencies and agencies, and through conflicts between staff members and between administration and staff. Consultation assists individuals or agencies to assess the nature and genesis of mental health problems and the need for new or modified programs. Consultants advise on the planning and development of research, training or service programs, and on the evaluation of a program. Consultants utilize consultation for the transmission of knowledge with regard to general human relations, human growth and development, social organization, and special mental health problems. Consultants transmit skills in treatment, training, research, administration, and evaluation, and in the preparation of written and audiovisual materials. Although consultation may focus primarily on one of these tasks, there may be several shifts in focus even in one consultation session or in regard to one problem. (*3, 10, 19, 20, 28, 30, 31, 35, 36, 39, 43, 44*)

These activities have been variously categorized by writers such as Caplan, and by the Southern Regional Education Board. For the purposes of this document it has seemed most functional to divide these activities into two broad categories—program consultation, and human relations and case consultation. (*7, 46*)

Program Consultation

Program consultation deals with problems concerned with the planning, development, management, evaluation, and coordination of services directly or indirectly affecting the mental health of the community. Participants in such consultations are generally administrators and planning staff. Initiative for seeking consultation may be taken by agencies, departments, associations, institutions in the community, or by the community mental health center. Such consultation may result in the development of new services or policies, in the recommitment or redeploy-

ment of manpower, and in the addition of new functions to an agency. It may assist in the creation of mechanisms for more effective continuous coordination of services and exchange of information, in the provision of training or the development of research and evaluation. Activities may include working with individuals and groups on the development of plans and proposals, ex-officio participation on committees, or advising on the writing of technical materials. As part of its consultation efforts, the comprehensive community mental health center is concerned with the development of mechanisms for comprehensive and coordinated mental health service planning and monitoring. For instance, consultation may be a means of persuading the Health and Welfare Council to establish regular meetings for executives of all local service agencies, or of encouraging a local government to set up a committee to plan preventive and treatment services for children and youth with emotional or behavioral problems. (*10, 16, 17,18, 26, 30, 47*)

Program consultation differs from other kinds of community organization in that the consultant's role remains advisory and he does not take direct responsibility while in that role.

Although the consultant may have much interest in the outcome of the consultation, the initiative for action remains with the consultee. This is in contrast to the direct administrative and program development activities of the center, where the staff may themselves set up a planning committee, organize community activities, or act as equally responsible partners in negotiating interagency collaboration. Some examples of program consultation are: a city demonstration agency director requests consultation and technical assistance in planning the mental health components of a Model Cities program; the head of a city health department seeks advice in setting up a mental health program within his service; a hospital administrator requests help in establishing a psychiatric wing; a personnel director in a factory needs advice on dealing with a high rate of absenteeism; a civic group seeks assistance in organizing preschool nursery programs as an antipoverty measure; or a legislator seeks aid in drafting a mental health service bill. These are among the kinds of program challenges a mental health consultant can expect to meet.

Human Relations Consultation and Case Consultation

Case and human relations consultation is concerned with the day-to-day functioning of an agency or service and its clients, and deals with the interpersonal relations of agency staff and the relationships between the consultees and their clients. In

regard to the latter, focus may be on the feelings and reactions of the consultees, on the needs and management of the clients, or on the interaction between client and consultee. (*1, 3, 4, 19, 34, 38, 39, 42, 44*)

Such consultation arrangements not only assist the consultees to manage day-to-day problems, but also provide a vehicle for liaison between the direct service staff of community mental health centers and other community agencies and for the dissemination of knowledge and skill in regard to mental health matters to the staff of collaborating agencies. Case consultations sometimes stimulate new mental health interests and capacities on the part of other service personnel and overlap into program consultation; for instance when public health nurses after consulting on a number of cases, decide to add to their services after-care for mental patients or a parent education program at the well-baby clinic; or when welfare foster care administrators come to expect some of their foster parents to cope with seriously disturbed youngsters as a result of case consultation and then develop training to increase the competence of their staff.

In case consultation, the consultant is always in an advisory position. However, the fact that the consultant is also a representative of the center, which offers a variety of direct services, may place him in many different roles, and he may in his work with any particular individual or agency find himself having to shift from the role of consultant into some other role. For instance, he may move from advising on referral into accepting the case as an agent of the center or for treatment as the therapist. He may assist in planning training and then become one of the trainers assuming program responsibility. He may advise on program development but later find himself as a collaborator in a joint interagency program endeavor. (*30*)

The consultant at times also seeks consultation from his consultee. For instance, a consultant from a community mental health center to a school principal often takes the opportunity to draw on his consultee's knowledge of the community regarding key leaders or teenage problems. (*7, 21, 42*)

Differentiation between Consultation and Other Activities

There is frequently a very narrow line between consultation and other activities. Consultation differs from supervision in that the supervisor has an administrative responsibility for outcome, must assure that the work is completed, evaluate it, and transmit organizational expectations. The consultant's responsibility is advisory.

The consultant trains through the exami ›blems. He does not take formal responsibility for ıg, ıor does he utilize formal educational arrangements ana methods. although such programs may be the outgrowth of consultation. Training through consultation, because it arises out of what the consultee brings into the sessions, is impromptu in nature. In-service and professional training are more organized. The former, like consultation, is concerned with increasing competence on the job. Professional training prepares potential practitioners for work in a particular discipline. It aims to develop not only knowledge and skiil, but also a professional identity in trainees. (*1, 32, 43, 44*)

Consultation differs from collaboration in that the consultee retains responsibility for the management of the program, situation or case. Collaborators carry joint responsibility. Mental health consultants sometimes find their role changing to that of program administrator and collaborator, once programs have been formulated and responsibility for action allocated. Sometimes it is hard to distinguish when consultation becomes collaboration, as when a consultant is a member of a planning committee or task force which moves from advice-giving to the implementation of proposals for action.

Consultation may resemble psychotherapy and casework very closely when the focus is on the feelings and relationships of the consultees. However, the aim of consultation is always work-related, which sets a clear focus and limit to the discussion. Consultation aims to improve work functioning, and is not primarily embarked on for the private motives of the individual consultee, such as personal advancement or increased enjoyment in the work situation, although these may be secondary gains.

The consultant, as an ex...sion of his role as consultant or trainer, may choose to see a client directly for evaluation purposes, or may develop a demonstration of a particular method in which he includes his consultees as collaborators. However, these arrangements are in fact combinations of consultation and direct services, or of consultation, direct service and training, in which the consultant plays multiple roles.

The Organization of the Consultation Services

A primary decision for the community mental health center is the amount of center resources which will be devoted to consultation. Some centers have made consultation the major vehicle for contact with the community, through which they have endeavored to help existing communities deal with mental health problems. (*13, 24, 25, 26, 30, 35, 36, 37, 47*) These centers have

either been interested in reducing the number of designated patients or in providing efficient service in spite of a shortage of mental health specialists. Through consultation they have mobilized community resources and strengthened existing informal mental health systems. These centers have taken initiative in developing consultation arrangements. At the other end of the scale, centers have seen consultation only as an indirect service to the community to be provided as need arises, and have waited to be called in by community agencies for case and human relations consultation and for training through consultation.

Centers have been divided as to whether consultation should be conducted by a separate staff or combined with direct services such as the outpatient program. The advantages of the latter arrangement are that where programs are decentralized, travel is reduced and consultation provides a vehicle for case referral, for intimate understanding of local agencies and their programs, and for the development of close relationships between center and agency staff. It is also possible to better understand when clients are referred, whether the problem lies with the patient or the agency. Case and human relations consultations also demand many of the same skills as those utilized in diagnosis and treatment, and there are advantages in integrating programs which combine consultation, training, and treatment in response to specific problems. For instance, in addressing the mental health problems of foster care, a child mental health specialist can consult with social service personnel, train foster parents, and treat children whose problems have been identified in consultation as requiring more than care from foster parents and schools. However, program and administrative consultation, undertaken between administrative personnel, may demand skills not always possessed by clinical staffs, and it makes sense in some situations to differentiate organizationally between program consultation and human relations and case consultation. In small centers, shortage of staff often will necessitate a combined program. In all situations, responsibility for the coordination of consultation should be assigned to one staff member. (*16, 17, 35, 36, 30*)

Consultation services may be offered directly by center staffs, or they may be contracted for with individuals or groups who work as independent professionals, or as members of federated or collaborating agencies. Occasionally, if a consultation is particularly designed to confront an agency or part of an agency with the need for change which may arouse anger, it may be helpful to employ a consultant who is not a member of a community agency, but who can enter from outside to stimulate changes and accept the negative reaction which does not jeopardize local rela-

tionships. Other times, working through conflicts brings agency staffs closer together. (*24*)

Another organizational difference lies between consultants who specialize in working with a particular kind of agency, such as the clergy or the schools, and those who are generalists and who, particularly at the local level, attempt to use consultation as a medium for increased interagency communication or for coordination of community efforts related to particular problems. Consultants working with a particular agency become expert in problems of that agency and can utilize special knowledge in the consultation. However, it may well serve to reinforce agency separateness, a big problem in most communities. (*5, 16, 19, 26, 30, 38, 40, 47*)

Priorities in the Establishment of Consultation

When a center begins to consider the development of a consultation program, enough information must be obtained to give the center some idea of the major problems in the community and the resources available to deal with them. The center should know the nature of the community, its physical layout, population composition, institutional structures and dynamics, and the specific mental health values and problems of its community. Decisions regarding which consultations to develop will be conditioned by the directions of the overall program, for consultation is one of the resources through which the center tackles mental health problems, as well as a service it offers to the community. For instance, if the population in the catchment area consists largely of families with very young children, it will likely be desirable to place more emphasis on consultation with well-baby clinic, day care center and elementary school staffs than with high school staffs, if a choice has to be made.

The center also will need to determine how it plans the role of consultation in its program so that it can select consultees through whom the maximum impact can be achieved. If the center wishes to concentrate a major effort in prevention, working with principals and teachers in the schools may be more effective than working with special pupil services which deal only with the child who is identified as a problem. If the center wishes to affect the administration of a system, it usually is not helpful to consult only with line personnel.

The center also must obtain a picture of the most urgent needs which are expressed by the agencies and citizens and plan its program so that it can be responsive to these. In beginning a program, it is very important that the first efforts succeed. Conse-

quently, consultees should be selected who are interested and accepting of consultation. (*35, 36*)

The Consultees

There is a mental health and human relations dimension to all human activities; consequently, almost anyone in the community may seek consultation from a community mental health center. Choice of consultees will depend on their interest and willingness, and on the priorities of the community and the center. The most frequent consultees are community service personnel such as school staffs, clergymen, physicians, public health nurses, vocational and occupational workers, welfare workers and court and correctional staffs. Other professionals such as policemen, firemen, recreational and youth group workers, sanitarians and agricultural extension agents also have extensive community contacts where consultation programs could be developed.

However, many others may seek consultation or be sought out as consultees. Lawyers, for instance, have access to partners in marital conflict and many people who are suffering from bereavement. Executive and legislative members of the government play very important roles in the promotion of mental health and the prevention of mental illness. They set policies and priorities, facilitate the development of service, and appropriate money. Mental health associations, PTA's, and other citizen organizations are influential in obtaining community support, in keeping the public informed on mental health problems and resources, and in the formation of public opinion on central community mental health issues. They may seek consultation on the direction or implementation of their programs. Employers and employment agencies, real estate developers and property managers, labor organizations, and public utility planners all structure and maintain situations and climates which will facilitate or impede community mental health. They often also must make decisions about the mental health problems of their personnel or clientele and may seek consultation and guidance on these matters. Administrative and program staff of radio and TV stations can affect the quality of programs relating to mental health issues.

Employment policies regarding opportunities for job satisfaction and advancement may have great effect on the mental health of the community. The capacity to spot a worker's state of tension may prevent accidents. The skilled management of disturbed employees may enable them to stay on the job. The policies and practices of property and resident managers may determine the fate of a neighborhood. They are key people in the reduction of conflict in changing communities. They are often called on to deal

with personal crises, such as suicide threats, a death in the family, or a case of drug taking. The physical relationships between services and people may be crucial in the mental health climate of a town. Transportation is sometimes the greatest barrier to service delivery. Consequently, planners of public utilities and zoning regulations may seek mental health consultation. Some individual citizens such as bartenders, cab drivers, CAP workers may be very important members of the informal mental health maintenance system of a community. Bartenders, for instance, are frequently the first line of defense in the treatment of alcoholics. All workers who have to deal with crowds in the course of their work, such as ball park and amusement park attendants, policemen, movie house managers, and rock festival managers may need both consultation and education on group dynamics and the management of mental health problems.

Citizen organizations concerned with special problems or age groups also may seek expert assistance in developing their programs. Youth groups, senior citizen organizations, parent associations or self-help groups may require consultation on their special needs.

Consultation may be offered also to mental health professionals and nonprofessionals in other mental health agencies whether affiliated with the center or not. These consultations may be related to advanced techniques, special methods, or intra-agency conflicts.

Consultation may be conducted with individuals or groups of individuals, the latter belonging to the same organization or to a number of organizations. They may be of the same rank or of varying ranks. Group consultation has both advantages and limitations. It provides opportunity for the development of a nondefensive problem-sharing atmosphere in which learning from one situation can be carried over into others. It provides opportunities for cooperative planning and communication and for the resolution of interlocking and conflict-ridden relationships. Groups reduce the use of the consultant as a weapon between staff members. On the other hand, some consultants lack the skills to understand and manage group interaction and certain consultees may have difficulty speaking freely in a group. Some administrative situations could not appropriately be examined in a group setting. When problems discussed have high relevance for all group members, then group consultation saves considerable time; however, when there is low relevance, it may be less expensive to work with consultees individually. In group—as in individual—consultation, the consultant is not responsible for the administrative arrangements of the consultation. Staff remain re-

sponsible for effective utilization of the consultant's time and skills. (*2*)

Even when the initiative for consultation originates with a consultee agency or organization, the choice of specific consultee does not need to rest solely with that agency. A consultant is always a party in deciding how, with whom, and on what he will consult. When an approach is made by a staff member in an agency, it may be very important also to consult with the supervisor and administrator either in a group or separately, or at least to meet these officials and have free access to them. When an administrator seeks consultation on a problem, it may be necessary to bring in the line personnel. These are matters which the consultant considers in developing a contract with his consultee agency. He has to devise some way of getting to know the organization well enough so that he can make informed decisions. Initial success is important, so every effort should be made to ensure that the consultants who initiate a center's program are able to relate to the particular consultees who have been selected and that the first problems are not too hard to solve. (*10*)

Gaining Access (*11*)

Consultation does not begin spontaneously, but arises out of perceived needs and competences. Initiative for establishing an arrangement may be taken by consultant or consultee. Consultants take several factors into consideration in the development of program. Who sponsors the center in the community will be important. Too speedy alliances may block off access to relationships which may later be very desirable. Historical accounts, community agency reports, census data and other statistics, and newspaper articles all will be useful in offering background information on the community. If staff are new to the area, a series of meetings with community agencies to become acquainted and to learn about their programs and problems probably will be very profitable. Community agencies are usually very knowledgeable about the community even though they undoubtedly will define the needs and problems in terms of their own perspectives. Independent professionals and citizens' associations may be useful informants. Initial consultation probably will be invoked on the basis of expressed agency and community needs. As center staff talk with agencies, useful areas for consultation will become apparent. Each consultation should be clearly defined between consultant and consultee, and care taken that access to and consent from all relevant parties has been obtained. For instance, if administrators are not aware that their line personnel are receiving consultation, they may become antagonistic and obstructive at

a later date, and the consultant may be vulnerable to being used as a tool in battles between administration and staff. If administrators impose consultation on line staff, they may subtly sabotage it and allow it to wither away. The maintenance of multilevel relationships is complicated by problems of communication and sanction to which the consultant needs to be particularly sensitive.

In developing community mental health programs, center staffs usually see themselves as having the primary responsibility for mental health efforts in the community, but others, such as welfare councils, county and State health departments, and mental health associations may already view themselves in a similar role. When a new structure is created, existing roles and territories have to be taken into consideration. Other groups already may be active as consultants. For instance, school psychologists may act as mental health consultants to the school system and may view center staff as undesirable competition. In such a situation center staff seek to work out a relationship so that each reinforces the other.

Each agency also has its own priorities. Consultee staff have to perform their primary functions. They are interested in the community mental health center to the extent that it can help them improve their program, solve their problems, or take their problems off their hands. They have limited time and resources and try to use these to most advantage. A successful consultant relates to their needs as well as to his own and modifies his approaches accordingly.

Non-mental health people are often uneasy with mental health specialists. Effective community mental health consultants, while demonstrating their expertise and usefulness, respect their consultees and take care not to present themselves as superior. The relationship should be that of colleagues, with authority based on knowledge and expertise. Time is often needed before consultees will feel confident enough to reveal their needs and the fruits of a relationship may not be immediately apparent.

Consultees often have preconceived ideas of the roles and functions of mental health specialists, and these may need redefinition before a useful working relationship can develop. Generally, the first request from clinical personnel is for direct treatment because this is what the community understands. It is useful for the consultant to be able to provide direct service back-up from his agency if this is necessary and appropriate, but he has the prerogative of determining whether this is the most appropriate management of the problem and the most effective use of his time. He often has to sell his program. Consultation often has developed

out of the conduct of specific training programs or mental health education, just as the need for these is often identified in consultation.

The choice of consultees will depend on the goals of the consultation. The organization of the consultee agency and the functions of staff are taken into consideration. Thought is given as to whether supervisors or line staff or both will be most effective consultees. Such decisions, however, usually are not made unilaterally but in collaboration with the consultee organization. Sometimes, several organizations or groups may have to be involved if the purposes of consultation are to be achieved.

The Course of Consultation

Consultation is essentially a dynamic process which is carried out through the establishment of a relationship between the consultant and his consultees. Each consultation arrangement, as it is established, should declare its purposes, focus, frequency, duration, expectations, and responsibilities of consultant and consultee. Essentially a contract is established. This undoubtedly will require redefinition and review from time to time. The beginning phase then is concerned with the establishment of the contract, the setting of goals and objectives, the development of initial trust and an acceptance of the need for change. As the consultation develops, the body of the consultation will be occupied with the sharing of ideas, identification of problems, consideration of alternatives, and coming to grips with possible solutions. Throughout the consultation arrangement there may be changes in focus, from process to content and from client to consultee, to administrative arrangements or to an examination of the nature of the program. Some consultations will concentrate in one area, others may fluctuate.

The speed with which a consultation develops will depend on the defensiveness of the consultee and the skill and capacity to inspire confidence on the part of the consultant. Because consultation is also a process, a relationship has to be developed between consultant and consultee and time is required before trust and confidence is established. Consultation is normally conducted within a positive relationship and at a level of support, guidance and clarification similar to casework. Consultation directed towards major changes in institutions or programs or the development of staff may take several years to achieve its ends. As a consultation arrangement draws to a close, achievements should be evaluated and decisions made as to whether to terminate, renew or to reorganize the arrangement.

The aim of consultation is to enable the consultees to function

independently in a more efficient manner so that long-term dependency should not be fostered. However. it may well be that long-term interagency collaboration will be an important aspect of the community mental health network and consultation between staffs may be of continuing duration although varying in nature over time.

Because consultees become attached to their consultants, attention is always paid to the resolution of the emotional aspects of the relationship at termination. Often the consultees experience a sense of loss. If a transfer is contemplated, they may be reluctant to establish a new relationship, just as in psychotherapy or in private life. Successful consultation is based on a relationship of mutual trust and confidence, and consultants are not immediately interchangeable. This is important to recognize, for many CMHC's are plagued by staff turnover, and new consultants have the task of reestablishing agency relationships.

Authority and Power in Consultation

In most consultations, direct authority rests with the consultees. The consultant's power to influence rests in his expertise and his ability to be of help, in his need to demonstrate his competence and in the consultee's wish to vest him with capacity for assistance. However, in some situations the consultant's organization well may have authority to veto or approve programs or to recommend funding, in which case the consultant's opinions and advice are extended from a base of direct authority and power. In these situations, the consultant needs to be particularly sensitive and responsive to his consultee's opinions and feelings.

Consultant Goals

The consultant's task is to help consultees in one or more of the following ways:

1. To *understand* the mental health dimensions of their program and problems. This includes their own and other people's intrapsychic and interpersonal reactions and the appreciation of appropriate mental health alternatives for action, both in specific and general work situations.
2. To *resolve* interpersonal conflicts and program crises on the job.
3. *To acquire and improve skills* in dealing with the mental health dimensions of their work.
4. *To research, plan, develop, and evaluate* programs related to mental health.

General Knowledge and Skills

A consultant must possess basic professional skills before he attempts to become a consultant. Just as importantly, he should be able to exude an aura of confidence, competence and concern for his consultees. Prior experience as a supervisor is useful so that the mental health professional is already able to gain understanding of individual, family, and group behavior at second hand and to transmit this understanding to others. Consultants need to be knowledgeable about the identification and treatment of mental health problems relevant to proposed areas of consultation. They also should be able to analyze the organizational structure of the consultee agency and understand the process of program development and decision making in order that their advice and opinions can be relevant and useful to the consultees.

A competent consultant is responsive to the needs of consultees. He analyzes and appraises his consultee's position, his mandate, his needs, his capacities and resources, his power, and his particular biases. He presents his knowledge in a way which is usable by the consultees and he can "speak their language." In developing a program, an experienced consultant knows how to gain access to and acceptance by a consultee and is able to develop a relationship of trust. He also understands his own biases and reactions in the variety of situations where he will serve as consultant.

A consultant possesses techniques for quickly acquiring knowledge about the community, the institutions and the population with which he is concerned. If he is responsible for program development, he sets program priorities and considers strategies for the development of the program. He needs to know how to present himself and whom to contact for what purposes. In the consultation itself, whether it is case or program consultation, he must listen and question in order to be able to extract the essence of the problem and help his consultees examine and deal with it.

The Training of Consultants

Specific training for consultants should teach how to assess consultation needs and how to manage a consultation relationship.

1. *The Community*

If a consultant is moving into a new community for the first time, he takes time to get to know something of the area, its vital statistics, its physical layout, the people and situations in the news. It is a good idea to drive and walk around in the area to get a feel for it, to see what the houses, stores, and amusements are like, to shop and eat in the neighborhood. He explores with members of the community how they see their needs.

2. *The Population*

If the consultation is concerned with a subculture with which the consultant is unfamiliar, he will read any materials available on that population, talk with people who are familiar with the group, meet with indigenous workers, and take part in activities where such a population is active.

3. *The Institutions*

A consultant who is setting up a new program in an area, makes contact with the key people in the agencies and institutions and determines how they see the needs and resources of the community. Combined with his knowledge of the community, he will begin then to set some priorities and to work out consultation arrangements which are related to pressing community needs. A beginning consultant has to learn how to assess agencies and institutions and to make appropriate contacts. He will study their tables of organization and try to find out who has formal and informal power and responsibility. If a community mental health center has an ongoing relationship with an agency or institution, it usually is possible to create a learning situation for the beginning consultant and to arrange for him to observe his future consultees at work. He accompanies a Public Health Nurse on some visits, reads cases and sits in on some case presentations.

In a school setting he may be permitted to observe in the classroom, sit with a counselor and attend building conferences. At first, he only observes. When he begins to understand what is going on, he gradually joins in and makes comments. Lunching informally with staff members, he becomes aware of the areas of difficulty, the concerns of the staff members and to understand their particular styles. At the same time, he will learn how to analyze the institution, and to explore the functions and roles of different staff members. He will read the current literature related to his field of interest. If a novice consultant has to create a new consultative relationship, he may need assistance in learning how to make access.

Training in the Art of Consultation

The consultant must be able to develop a relationship of trust with his consultees, to understand and manage group phenomena, to recognize that there is an ongoing process from beginning to termination. He learns how to utilize his basic professional skills, to facilitate the expression and identification of problems, clarify confused feelings, lead the consultees toward relevant and appropriate solutions and to generalize from specific situations. The beginning consultant should familiarize himself with basic theories of consultation and use the literature to gain from other consultants' experiences. Where possible, it may be helpful for the

novice to act as a coconsultant where he can observe a senior consultant at work. An ongoing workshop on consultation where beginners may present their programs is a most useful vehicle for learning as it serves both for assistance and support and as a model of a consultation from which the participants can learn. If the new consultant is part of a larger program, then he can participate in meetings where senior staff are present and analyze their problems in consultation. Wherever possible, regular supervision, or at least consultation, should be provided for the beginning consultant. (*33*)

Selection of a Consultant

Probably most important in the selection of consultants is the basic personality and competence of the consultant, his capacity to relate to people, to enable them to develop trust and confidence in him in order that he may be of assistance to them. However, other factors may have to be taken into consideration. Sometimes a consultee will have strong feelings about the profession, religion, race, age, or sex of a consultant. It may be important to have a consultant from the same profession or to have a consultant who is or is not an M.D. Sometimes the consultant must be from the same ethnic group. Most times this is irrelevant. Some people find it easier to accept advice and assistance from a man; others from a woman. Most frequently these initial preferences can be overcome by a competent consultant. Very occasionally a consultation cannot be begun unless the qualifications are those predetermined by the consultee.

Occasionally more than one consultant will work together on a consultation. This is expensive for the center but it sometimes can be justified. It may be a useful device for training an inexperienced consultant. Two consultants from different disciplines or who have special expertise occasionally can provide through a team approach exactly the assistance required by the consultee.

It should be noted that as consultation is a dynamic process, the ways in which consultees relate to two consultants are not identical and the consultants are not interchangeable. Consideration also must be given to the relationship between the consultants for, as with cotherapists, consultants may work well or poorly together.

Locus, Duration and Frequency of Consultation

Consultation may be undertaken in any setting: at the office of the consultant or consultee, in a neutral setting, over a meal, in a car, over the telephone. Most regular consultations are held in

one place. Sessions held in the consultee's agency have the advantage of keeping the consultant in touch with that agency's changing climate. Some interagency consultations rotate between agencies. Consultations may be offered ad hoc for one or two sessions to deal with a specific nonrecurring problem or crisis. They are most frequently conducted regularly over a set and limited period of time, although consultation does sometimes develop into a permanent service offered by one agency to another, or even by a staff member of one department to another within the same agency. The "permanent" consultant is particularly useful when there is high turnover in the consultee agency, and the consultant assumes the added role of staff trainer. He is sometimes retained on an "as needed" basis to assist in the management of specific problems when they arise. Most consultation arrangements seem to be conducted on a weekly, twice monthly, or monthly basis. Length of session varies from a few minutes to a stay of several days or even months to study a particular problem. Some consultants visit outlying localities for a day every three or four weeks and carry out several consultations within that day. However, the average community mental health consultation session probably lasts one or two hours.

Payment of Consultation

While some community mental health center consultations are paid for out of continuing local or state appropriations as an ongoing and permanent service to the community, many community mental health services are only partially or even temporarily funded out of public monies. Preferential funding for consultation is included in the 1970 CMHC Amendments (P.L. 91-211). However, the problem of obtaining payment for consultation services is a very real one for most centers. When a need is rapidly perceived by the consultee and the consultant is clearly acknowledged as an expert, there is generally no problem, even if it only means a transfer of funds between two public agencies. Most frequently, the need has to be established and the expertise demonstrated before the consultee agency will pay for this service. Under these circumstances, it may be useful to offer a time-limited service stating clearly the center's financial position. If the need becomes established and the consultee can obtain funds, then the question remains to be settled whether consultation will be bought from the center or elsewhere. Centers, having obtained recognition of the need for consultation and demonstrated its usefulness, may be content to encourage the utilization of private resources if they are available. Thus, the center's consultants can turn their attention to the development of new areas.

The Recording and Evaluation of Consultation

(17, 18, 27, 30, 45)

All community mental health center programs make an effort to keep adequate records. Consultation records are no exception. It is essential to know what was intended and what has taken place, in order to monitor and control for cost of the ongoing services and to evaluate their effectiveness and efficiency. (*30*)

Consultation has impact on two populations, the consultees and their clients. For completeness, an initial description is written on each consultation arrangement delineating the purposes and goals for both populations and plans for the conduct of the consultation. A regular record is then kept of contacts, of attendance, of consultees, and brief notes of the problems presented. A summary is made from time to time of the progress of consultation. Records are kept on individual clients considered in consultation and a method devised for following them if they enter the direct service delivery system. In evaluating the effectiveness of consultation, it is necessary to ask whether the purposes of individual consultation arrangements are achieved, and whether they actually contribute to the mental health of the community. If consultation is offered on case management, are decisions carried out, and do they resolve the problem? If there is staff or organizational conflict, is this worked out? If the purpose of the consultation is directed toward increasing the skills and knowledge of the consultee does this happen, and if so, does it increase the impact of the consultee on his clients? If the purpose of consultation is to change institutional systems, does this happen, and if so, does it decrease the problems or improve the mental health of the community? If a network of consultation, with or without direct service, is designed to reduce a particular mental health problem, does this happen? Is consultation less expensive and more effective than training or direct treatment for a particular kind of problem or population? These are questions which must be addressed in the evaluation of a program of community mental health consultation. Only an adequate recording and monitoring system can permit such analysis and refinement of the program. No program is perfect initially, and the capacity to learn from mistakes is one of the hallmarks of a successful program.

MENTAL HEALTH EDUCATION

Mental health education is the dissemination of knowledge related to issues and behaviors which contribute to individual and community mental health and mental health breakdown; and knowledge of resources and skills for the achievement of mental health and the management of mental illness. Mental health education includes both theory and practices; general knowledge and training in specific job or task-related skills. It can be offered to professional and nonprofessional mental health specialists, to personnel engaged in other human service fields and to the lay public. (*59*)

Mental Health Education and Training for Professional Mental Health Specialists

Although the comprehensive community mental health center is not generally responsible for formal professional mental health education and training, it can provide supervised field experiences in the various service components of the center. The center appropriately plays a part in the continuing education of community mental health specialists through offering seminars and workshops on aspects and methods of community mental health, such as the assessment of community mental health needs and resources, administration of community mental health centers, crisis and group treatment, consultation, citizen involvement, evaluation of community mental health programs, and the supervision of nonprofessionals and volunteers.

The center will provide as a matter of course in-service training and education for its own staff to increase their understanding of community mental health theory and practice. New staff to the center require orientation to the community, its composition, strengths, problems and resources and also orientation to the philosophy of the center, its services and methods. The center usually will provide at least entry training for its nonprofessional mental health workers.

Mental Health Education for Community Service Personnel

Mental health education is also a prime component in the community mental health center's efforts to prevent and manage

mental health breakdown; to promote sound mental health attitudes in the community and to gain public support for community mental health services. Education and training are offered to human service personnel and mental health specialists in the community as part of the center's program.

In the development of community mental health, all community service personnel are regarded as part of the manpower force which must work together to meet the mental health needs of the community. This is true whether they are working as independent professionals such as general medical practitioners, lawyers, psychiatrists, private nurses, or within agencies and institutions such as schools, welfare agencies, churches, family casework agencies. As these agencies and individuals accept this role and organize to develop comprehensive community mental health services, they often wish to sharpen their skills so that they can add new depth to old roles and functions, and plan to take on new roles. They then become aware of the need for further education and training. Their needs may be for a deepening of their awareness of the meaning of human behavior, or of the dynamic forces operating in the groups with which they work in the handling of special problems. School teachers may request additional training in understanding the dynamics of their classes and the behavior of their students. They may require help with the human relations problems in intergroup education. Some clergy wish to know more about family relations. Most want to become more capable of identifying problems in their early stages and in the day-to-day management of minor difficulties. Many raise questions about the normal problems inherent in specific life situations. Public health nurses may wish to become adept in coping with the psychological problems of pregnancy or in identifying chronic schizophrenic patients who are in need of psychiatric treatment. Doctors and nurses often request assistance in the psychological management of acute and chronic illness and death, as do policemen, neighborhood workers, and lawyers in coping with family crisis. Community service personnel may enlarge their roles, learn new methods, and take on new functions. School psychologists and guidance counselors may decide to develop group treatment for students with learning and behavior problems. Welfare departments may train some of their foster parents to run therapeutic group homes for disturbed children. Clergy and other human service personnel in outlying communities may run their own crisis management or emergency service aided by telephone consultation with mental health specialists. Pediatricians and nurses in well-baby clinics or teachers in nursery school may add a family life education component to

their service. The management of alcoholics is one aspect of the bartenders' work, as well as that of policemen and hospital residents on emergency service duty. Volunteers may be trained for a variety of roles as assistants in hospitals, as links in the transition back into the community, in providing support and caring for individual patients, in adding additional services drawn from their own specialties. All these people benefit from institutes, workshops or seminars geared to their special needs.

Mental Health Education for the Lay Public

Mental health education for the lay public serves three basic purposes. One is to improve the capacity of people living in the community to develop satisfying relationships and roles for themselves in their everyday lives. A second purpose is to ensure that people are informed about the mental health resources which are available to them in the community and know how to use them in the management of problems which arise in their own lives, or in the lives of those with whom they are closely associated. A third purpose is to keep the population aware of the mental health problems and needs current in the community, to obtain support for the legislation, funding and location of resources in the community, and to prevent the stigmatization and ostracism of people suffering from mental disorders.

1. *The improvement of the lay population's capacity to develop satisfying relationships and roles for themselves in their everyday lives.*

A vast array of activities fall under this heading, many of which well may be carried out by other than mental health specialists and community mental health workers. The center may choose to carry out some, may demonstrate some, and then train others to undertake the service, or may stimulate the development of a program by others through its consultation. These activities include all kinds of family life and human relations education, whether carried out in clinics, schools, family agencies, agricultural extension services or sponsored by lay organizations such as PTA's and Mental Health Associations, or developed in radio and TV programs or magazine articles. Mental health specialists may develop or design a program of human relations education for a school system; lead parent-child study groups; demonstrate premarital counseling workshops to be taken over later by the clergy; create an orientation program for older people about to retire; or lead a series of human development sensitivity training groups for people interested in improving the quality of their day-to-day living. Mental health educators may train audiovisual

experts to be more sensitive to the community mental health implications of advertising or soap operas.

Mental health education designed to improve the quality of day-to-day life may also be directed toward the examination of social mores which play a crucial part in the mental health of the community. Institutes and TV panels may be held on such issues as youth-adult relationships as expressed in the generation gap; race relations; accommodation to a rapidly changing modern world; male-female stereotypes and sexual mores; the mental health implications of poverty in the midst of affluence; attitudes toward cigarettes, alcohol and drugs.

2. *Mental health education* includes the development of programs to inform the public about the nature of mental illness and its management, helps them understand how to cope with special problems such as epilepsy, drug-taking, alcoholism, suicidal attempts, and how to obtain expert assistance. It also includes informing the public about existing resources for the management of mental health problems, about the existence of the community mental health center and how to use its facilities.

3. *Support for mental health programs* involves working with the public about what is needed, what efforts are being and should be made to meet these needs, and what part the public can play. This raises the issue of the nature of citizen involvement in the identification of mental health needs, the setting of priorities and in decisions regarding the nature and organization of service delivery. Two-way communication of information and opportunities for participation in decision-making will ensure that services are relevant, accessible and utilized. Communities and individuals will vary in the degree to which they will wish to get involved in decision-making. When people are well-informed and services are satisfactory the general public feels little need to become involved in their day-to-day direction. However, interest must be maintained if mental health services are to compete for money and resources in short supply. Insurance companies may be drawn in as allies, bankers and the members of Chambers of Commerce and influential fraternities and orders kept informed of changing needs. Neighborhood leaders, both formal and informal, need to be drawn in significantly. This means stimulating interest in those who would be able to become active as legislators, volunteers, board members, financiers and in general those who are influential in the neighborhood. If new resources such as half-way houses or residential treatment centers are to be brought into the community, then public support must be obtained for their acceptance, or neighborhoods will protest their location; licenses may be denied or residents excluded from local facilities. Local residents

should be consulted about program priorities, whether services are meeting their needs, or if they could be offered at more convenient times and places. Public communications media play an important part in forming public opinion on mental health issues and a partnership with the center profitably can be developed.

The Organization of Mental Health Education

Mental health education is a vital though much neglected part of the community mental health center's program. Inevitably most staff include education in their other activities, whether they are treating patients, collaborating or consulting with other service personnel or planning new programs. However, all centers should have one member at least who has special competence in mental health education and who takes responsibility for developing and coordinating this component.

Some centers have developed separate departments for the mental health education of community caregivers or for the information and education of the lay public. Sometimes public relations, citizen participation, and the recruitment and training of volunteers may all be combined with the education of the public. Sometimes functions are disseminated throughout the center. All too frequently mental health education is tokenly represented. In some very interesting programs mental health education, community organization, consultation and treatment are combined to address specific problems. Mental health education, like all other services, should be developed in terms of the specific needs and priorities of the community.

Methodology

Many different modalities are used for mental health education such as lectures, seminars, workshops, institutes and mass communications media. Teaching and training methods include didactic, experiential and sensitivity groups, role playing, use of audiovisual aids, reading materials, emphasis on process or content. There is need to assess the effectiveness of different approaches and exposures. Care must be taken to adapt materials for different populations so that language is understandable and examples relevant. There is considerable use today of both the patient population and outside experts to assist in training and in the development of teaching materials.

Access and Payment

Mental health education may be requested by the community, agency or individual trainee. It may be offered directly by the

center or it may arise out of program development or consultation activities. Education and training of community service personnel may take place within the context of consultation.

Payment for education and training is easily obtained from the start if the need is well recognized. However, the need may have to be demonstrated to the training target and funds obtained from some outside source such as State or federal grants and contracts or from private foundations. The expertise of community mental health personnel also may need to be established through demonstration before their services are accepted and paid for. Sometimes training is more easily accepted if it can be cosponsored by an agency or college where credit is granted the trainee for his participation. Sometimes a center may see a need but expertise is lacking. Limitations must be recognized and programs directed accordingly.

Evaluation

Evaluation of the effectiveness of mental health education should be planned before services begin as an integral part of the program. As with other evaluative efforts, a decision has to be made as to how extensive the evaluation will be. Minimally, this should include the definition of the goals of the program, some assessment of the state of knowledge, attitudes and skills of the population at the beginning and end of the program, a description of the actual educational effort, and some assessment of whether the required effects were achieved.

Some types of education are easy to evaluate, for instance, education designed to increase the public's knowledge and use of a program. However, others may be very difficult, for instance, efforts to change the acceptance of ex-mental patients in the community or a teacher's management of interpersonal dynamics in the classroom.

Mental Health Educators

The qualifications of mental health educators will vary depending on what they plan to do. For instance, those planning to undertake sensitivity training in regard to general human development must be fully qualified mental health professionals with special training in group dynamics and management. However, a staff member who is charged with informing the public on the services of the center or on the management of specific mental health problems, will need highly developed publicity and mass communications skills and familiarity with technical matters related to educational materials and the transmission of infor-

mation. Whatever they do, they should be expert in their particular specialization and should know their population and community.

Ideally, the mental health educational specialist charged with program responsibility at a center should be a mental health professional, an educator and a communications expert. At this point in time, there are few individuals combining these skills and the specialist probably will have to draw on other resources than his own.

Training

Mental health educators must first be knowledgeable, experienced and competent in regard to the issue, problem or method about which they plan to educate others. Mental health educators, like consultants, should give consideration to the setting in which they work, their target population, and the prerequisites for putting into practice what they advocate or teach. Mental health educators also need to learn methods of teaching and training, resources for obtaining teaching materials, and principles of curriculum design and use.

At present, there are almost no programs which specifically train mental health educational specialists and there is a need for these. There is almost no literature on the education and training of mental health educators. Nor is there literature on the mental health education component in community mental health centers, although the literature which relates to specific subjects is vast. Readers should refer to the literature of each subject area. However, some annotated bibliographies on training and other relevant Public Health Service publications have been included among the references in this pamphlet. (*13, 49, 50, 51, 52, 53, 54, 55, 56, 57*)

SELECTED REFERENCES

(1) Adams, R. S., Wernick, H. M. Consultation: An In-service Training Program for the School. *Journal of the American Academy of Child Psychiatry. 5*, 3: 479–489, 1966.

(2) Altrocchi, J., Spielberger, C., & Eisdorfer, C. Mental Health Consultation with Groups. *Community Mental Health Journal. 1*, 2: 127–134, 1965.

(3) Argyris, C. Explorations in Consulting-Client Relationships. *Human Organization. 20*, 3: 121–133, 1961.

(4) Berlin, I. N. The Theme in Mental Health Consultation Sessions. *American Journal of Orthopsychiatry. 30*, 4: 827–828, 1960.

(5) Berlin, I. N. Mental Health Consultation in Schools as a Means of Communicating Mental Health Principles. *Journal of the American Academy of Child Psychiatry. 1*, 4: 671–679, 1962.

(6) Bindman, A. J. Mental Health Consultation: Theory and Practice. *Journal of Consulting Psychology. 23*, 6: 473–482, 1959.

(7) Caplan, G. *The Theory and Practice of Mental Health Consultation.* New York: Basic Books, 1970.

(8) Caplan, G. Types of Mental Health Consultation. *American Journal of Orthopsychiatry. 33*, 3: 470–481, 1963.

(9) *Gaupp*, P. G. Authority Influence and Control in Consultation. *Community Mental Health Journal. 2*, 3: 205–210, 1966.

(10) Gibb, J. R. The Role of the Consultant. *The Journal of Social Issues. 15*, 2: 1–4, 1959.

(11) Glidewell, J. C. The Entry Problem in Consultation. *The Journal of Social Issues. 15*, 2: 51–59, 1959.

(12) Golann, S. E. *Coordinate Index Reference Guide to Community Mental Health.* New York: Behavioral Publications, 1969.

(13) Goldston, S. E. Mental Health Education in a Community Mental Health Center. *American Journal of Public Health. 58*, 4: 693–699, 1968.

(14) Haylett, C. H. Evolution of Indirect Services. In H. R. Lamb, D. Heath, & J. J. Downing (Eds.), *Handbook of Community Mental Health Practice.* San Francisco: Jossey-Bass, 1969, 289–304.

(15) Haylett, C. H. Issues of Indirect Services. In H. Lamb, D. Heath & J. J. Downing (Eds.), *Handbook of Community Mental Health Practice.* San Francisco: Jossey-Bass, 1969, 305–321.

(16) Haylett, C. H., & Rapoport, L. Mental Health Consultation. In L. Bellak (Ed.), *Handbook of Community Psychiatry and Community Mental Health.* New York: Grune & Stratton, 1964, 319–339.

(17) Hunter, W. F., & Ratcliffe, A. W. The Range Mental Health Center: Evaluation of a Community-Oriented Mental Health Consultation Program in Northern Minnesota. *Community Mental Health Journal. 4*, 3: 260–267, 1968.

(18) Iscoe, I., Pierce-Jones, J., Friedman, S. T., & McGehearty, L. Some Strategies in Mental Health Consultation: A Brief Description of a Project and Some Preliminary Results. In E. L. Cowen, E. A. Gardner

& M. Zax (Eds.), *Emergent Approaches to Mental Health Problems.* New York: Appleton-Century-Crofts, 1967, 307–330.

(*19*) Kane, R. F. Social Work Consultation to the Priest. *Catholic Charities Review. 50*, 8: 4–10, 1966.

(*20*) Karowe, H., Lofchie, S, Sullivan, G., Sweetser, E., & Wysocki, W. The Clinic and Community Relations. *Mental Hospitals. 14*, 5: 289–293, 1963.

(*21*) Kazanjian, V., Stein, S., Weinberg, W. L. *An Introduction to Mental Health Consultation.* U.S. Public Health Service Publication No. 922, Public Health Monograph No. 69. Washington, D.C.: U.S. Government Printing Office, 1962, p. 13.

(*22*) Latimer, N., *et al. The Protection and Promotion of Mental Health In Schools.* U.S. Dept. of HEW, NIMH, Bethesda, Md., 1964.

(*23*) Levenson, A. I., & Brown, B. Social Implications of the Community Mental Health Center Concept. In J. Zubin & F. A. Freyhan (Eds.), *Social Psychiatry.* New York: Grune & Stratton, 1968, 117–127.

(*24*) Levenson, A. Organizational Patterns of Community Mental Health Centers. In L. Bellak & H. H. Barten (Eds.), *Progress in Community Mental Health 1*, New York: Grune & Stratton, 1969, 67–90.

(*25*) Libo, L. M. Multiple Functions for Psychologists in Community Consultation. *American Psychologist. 21*, 6: 530–534, 1966.

(*26*) Libo, L. M., & Griffith, C. R. Developing Mental Health Programs in Areas Lacking Professional Facilities: The Community Consultant Approach in New Mexico. *Community Mental Health Journal. 2*, 2: 163–169, 1966.

(*27*) Lippitt, G. L. A Study of the Consultation Process. *Journal of Social Issues. 15*, 2: 43–50, 1959.

(*28*) Lippitt, G. L. Operational Climate and Individual Growth; The Consultative Process at Work. *Personnel Administration. 23*, 5: 12–19, 43, 1960.

(*29*) Lippitt, R. Dimensions of the Consultant's Job. *Journal of Social Issues. 15*, 2: 5–12, 1959.

(*30*) MacLennan, B. W. The Systematic Development of a Consultation Program in a Comprehensive Community Mental Health Center. Paper presented at St. Elizabeth's Medical Society Annual Institute, Washington, D.C., 1968.

(*31*) MacLennan, B. W., Montgomery, S. L., & Stern, E. G. The Analysis and Evaluation of the Consultation Component in a Community Mental Heaith Center. Laboratory Paper No. 36, Adelphi, Md., Mental Health Study Center, NIMH, 1970.

(*32*) Magner, G., & Briggs, T. Staff Development in Mental Health Services. *National Association of Social Workers*, New York, 1966.

(*33*) Mannino, F. V. *Consultation in Mental Health and Related Fields. A Reference Guide.* Chevy Chase, Md., NIMH, 1969.

(*34*) Mannino, F. V. Developing Consultation Relationships with Community Agents. *Mental Hygiene. 48*: 356–362, 1964.

(*35*) Mental Health Study Center Annual Report—July 1, 1967 to June 30, 1968. Mental Health Study Center, Adelphi, Md., NIMH, HEW, 1968.

(*36*) Mental Health Study Center Annual Report—July 1, 1968, to June 30, 1969. Mental Health Study Center, Adelphi, Md., NIMH, HEW, 1969.

(*37*) Muhich, D. F., *et al.* Professional Deployment in the Mental Health

Disaster, The Range Mental Health Center. *Community Mental Health Journal. 1*, 2: 205–207, 1965.

(*38*) Murphy, L. B. The Consultant in a Day-Care Center for Deprived Children. *Children. 15*, 3: 97–102, 1968.

(*39*) Newman, R. G. *Psychological Consultation in the Schools.* New York: Basic Books, 1967.

(*40*) Nitzberg, H., & Kahn, M. W. Consultations with Welfare Workers in a Mental Health Clinic. *Social Work. 7*, 3: 84–93, 1962.

(*41*) Parker, B. *Psychiatric Consultation for Non-Psychiatric Professional Workers.* Public Health Monograph, No. 53, Washington, D.C., U.S. Department of Health, Education, and Welfare, 1958.

(*42*) Rapoport, L. (Ed.) *Consultation in Social Work Practice.* New York. National Association of Social Workers, 1963.

(*43*) Scheidlinger, S., & Sarcka, A. A Mental Health Consultation-Education Program with Group Service Agencies in a Disadvantaged Community. Paper presented at the American Orthopsychiatric Association, Chicago, 1968.

(*44*) Seashore, C., & Van Egmond, E. The Consultant-Trainer Role in Working Directly with a Total Staff. *Journal of Social Issues. 15*, 2: 43–50, 1959.

(*45*) Singh, R. K. Janmeja, & Thompson, D. Evaluation of a Program of Community Mental Health. Flint, Mich. Community Mental Health Services, 1969. (mimeo)

(*46*) Southern Regional Education Board. *Definitions of Terms in Mental Health, Retardation, and Alcoholism Programs.* (2nd Ed.) Definitions and Classification Committee, Southern Regional Conference on Mental Health Statistics, Atlanta, Ga. 1970.

(*47*) Spielberger, C. A Mental Health Consultation Program in a Small Community with Limited Professional Mental Health Resources. In E. L. Cowen, E. A. Gardner, & M. Zax (Eds.). *Emergent Approaches to Mental Health Problems.* New York: Appleton-Century-Crofts, 1967, 214–238.

(*48*) Stringer, L. A. Consultation: Some Expectations, Principles and Skills. *Social Work. 6*, 3: 85–90, 1961.

(*49*) U.S. Dept. HEW. Annotated Bibliography on Inservice Training for Key Professionals in Community Mental Health, Public Health Service Publication No. 1900, Washington, D.C., U.S. Government Printing Office, 1969.

(*50*) U.S. Dept. HEW Annotated Bibliography on Inservice Training for Allied Professionals and Non-Professionals in Community Mental Health, Public Service Publication No. 1901, Washington, D.C., U.S. Govt. Printing Office, 1969.

(*51*) U.S. Dept. HEW. Annotated Bibliography on Inservice Training in Mental Health for Staff in Residential Institutions, Public Health Service Publication No. 1902, Washington, D.C., U.S. Govt. Printing Office, 1969.

(*52*) U.S. Dept. HEW. Training Methodology Part I: Background Theory and Research, An Annotated Bibliography, Public Health Service Publication No. 1862, Part I, Washington, D.C., U.S. Govt. Printing Office, 1969.

(*53*) U.S. Dept. HEW. Training Methodology Part II: Planning and Administration, An Annotated Bibliography, Public Health Service

Publication No. 1862, Part II, Washington, D.C., U.S. Govt. Printing Office, 1969.

(54) U.S. Dept. HEW. Training Methodology Part III: Instructional Methods and Techniques, An Annotated Bibliography, Public Health Service Publication No 1862, Part III, Washington, D.C., U.S. Govt. Printing Office, 1969.

(55) U.S. Dept. HEW. Training Methodology Part IV: Audiovisual Theory, Aids, and Equipment, An Annotated Bibliography, Public Health Service Publication No. 1862, Part IV, Washington, D.C., U.S. Govt. Printing Office, 1969.

(56) U.S. Dept. HEW. The Comprehensive Community Mental Health Centers Program, Grants for Construction and Staffing, Washington, D.C., U.S. Govt. Printing Office, 1969.

(57) U.S. Dept. HEW. Selected Sources of Inexpensive Mental Health Materials. Public Health Service Publication No. 1911, Washington, D.C., U.S. Govt. Printing Office, 1968.

(58) U.S. Dept. HEW. Mental Health Consultation to Programs for Children: A Review of Data Collected from Selected U.S. Sites, Public Health Service Publication No. 2066, Washington, D.C., U.S. Govt. Printing Office, 1970

(59) Webster, T. G. Changing Continuing Education in Mental Health. National Conference Continuing Education in Mental Health, Chicago, Ill., 1967.

(60) Yolles, S. F. Past, Present and 1980: Trend Projections. In L. Bellak and H. H. Barten (Eds.), *Progress in Community Mental Health, I.* New York: Grune and Stratton. 1969. 3-23.

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