THE ACCEPTANCE OF AN INVENTORY OF PROGRAM OBJECTIVES FOR A COMMUNITY COLLEGE MENTAL HEALTH TECHNOLOGY PROGRAM WITHIN THE SOCIAL AND BEHAVIORAL SCIENCE STRUCTURE

DISSERTATION

Presented to the Graduate Council of the
North Texas State University in Partial
Fulfillment of the Requirements

For the Degree of

DOCTOR OF EDUCATION

By

Marvin Glenn Weber, B.S., M.A.
Denton, Texas

May, 1976

Weber, Marvin Glenn, The Acceptance of an Inventory of Program Objectives for a Community College Mental Health Technology Program Within the Social and Behavioral Science Structure. Doctor of Education (College Teaching--Sociology), May, 1976, 157 pp., 3 tables, bibliography, 81 titles.

The study sought acceptance of an inventory of program objectives for a community college mental health technology program within the social and behavioral science structure. It adapted a set of program objectives, using an inventory from the Southern Regional Education Board, and provided a composite list stated in competency or performance levels and a list of academic requirements showing what fundamental areas of competency or performance would be most germane for a mental health technology graduate. Twenty directors or department heads were used to select a final list of program objectives. A group of core courses was selected from the twenty programs, and experts chose which of the courses were preferred.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

The development and utilization of the position of a mental health associate or technician evolved from a number of factors. To comprehend this aspect of the paraprofessional movement, we need to examine recent history. In 1963 the Federal Government moved from the custodial care concept at centralized hospitals into the community mental health movement, spurred by the Community Mental Health Centers Act of 1963 (17, pp. 551-570).

With the federal funding of the community mental health movement came the realization that the manpower needs in mental health could never be met by using the supply of traditional mental health professionals, particularly since they required extensive periods of training. George Albee, in his book, Mental Health Manpower Trends, concludes that not only was there a critical need for service personnel in mental health, but also that it was important to develop new levels of mental health workers in a shorter span of preparation time (1, p. 13).

Along with this new development of community mental health came the rise of the community college movement in

the United States, especially in the southern states. The philosophy was planned to give emphasis to the educational needs of the regional area served by the community or two-year college (2, pp. 2-22). In time the manpower needs of mental health and the educational roles of community colleges to train people to meet community needs were recognized as appropriate forces. The community mental health agency movement increased the need for locally-based and trained staff (17, p. 56). The community college movement was provided, according to Yolles, a potential local source for the training of mental health technicians to meet manpower needs (17, p. 562). Other dissertations have reported upon training nonprofessional college students to work in mental hospitals (3, p. 14). However, no dissertation to date has been written to seek acceptance of an inventory of program objectives for a community college mental health technology program.

Statement of the Problem

The problem was to seek acceptance of an inventory of program objectives for a community college mental health technology program within the social and behavioral science structure. (Acceptance in this case means that a jury will show approval of certain items found within a set of program objectives. Thus, it was hoped that the judges would make

a favorable response to show acceptance of those items they would like to see used within a community college mental health technology program.)

Purpose of the Study

The primary purpose of the study was to adapt and seek acceptance for a set of program objectives, using an inventory from the Southern Regional Education Board.

1. The research gained acceptance for a projected inventory of program objectives. These program objectives can be used by mental health technology graduates. Through an examination of sources for the program objectives, the study provided a composite list stated in competency or performance levels. The study provided a list of academic requirements showing what fundamental areas of competency of performance would be most germane for a mental health technology graduate.

2. The literature from the field of mental health technology was reviewed for data to be used in the development of the program objectives. Information from journals, workshops, national meetings, etc., provided data to be used in the study.

3. Forty active directors or department heads comprised a jury to seek acceptance for an inventory of program objectives. From this group, twenty were selected

by the use of a table of random numbers. A table of random numbers was used to prevent any bias in the selection of the jury. From program objectives selected, a final list of levels of competency or types of performance found in core courses were retained. This final list of program objectives was matched to the existing curriculum (core classes) of the schools used to ascertain if the curriculum supports the inventory of program objectives. An opinionnaire was developed from the existing curriculum for use by the panel of five experts. (See procedures for analysis of data. Opinionnaire is shown in Appendix B of the dissertation.)

4. A panel of five or more experts was asked to evaluate mental health core classes. These core course samples were taken from the respondent schools participating in the validation. From this evaluation, data were developed regarding which of the courses professionals prefer.

Background and Significance of the Study

In 1966 the National Institute of Mental Health (NIMH) funded an experimental two-year mid-level mental health worker training program at the Fort Wayne Campus of Purdue University (13, p. 1). During the next few years, NIMH funded mental health programs at Blue Ridge Community

College, Weyers Cave, Virginia; Daytone Beach Junior College, Florida; Metropolitan State College, Denver, Colorado; Sinclair Community College, Dayton, Ohio; Jefferson State Junior College, Birmingham, Alabama; Community College of Philadelphia, Pennsylvania; and Greenville Community College, Massachusetts (13, pp. 4-12). Mental health technology programs grew so rapidly that other programs were begun without waiting for an evaluation of the experimental program.

The Southern Regional Education Board (SREB), under an NIMH grant for the "Promotion of Community College Mental Health Workers," (13, p. 3) reacted to the above developments by sponsoring a conference to study the role of the community or junior college in the education of mental health technicians. Data were gathered at the 1972 SREB conference which validated an inventory of program objectives for a community college mental health technology program.

The Southern Regional Education Board reports that "There are 27 active Associate Degree Mental Health Worker programs in the South, and 36 in the planning stages" (10, p. 7). The Southern Region as defined by the Board includes the states of Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina,

South Carolina, Tennessee, Texas, Virginia and West Virginia (10, p. 1).

In the Southern Region the titles of the programs are much more consistent than in the rest of the United States. Below are listed in order the most numerous titles. As one would note, the title of Mental Health Technician (or Technology) is used by thirty-six schools. The numbers indicate how many programs have been given that particular title (10, p. 9).

1. Mental Health Technician (or Technology)--36
2. Mental Health Associate--12
3. Mental Health Worker--10
4. Human Services Aide--5
5. Mental Health Assistant Training Program--5
6. Community Mental Health Assistant--5
7. Psychiatric Technician Program--5
8. Mental Health Aides Training Program--2
9. Mental Retardation Program--2
10. Community Services Technologist--2
11. Social Services Technician--2
12. Mental Health and Retardation Technology--1
13. Mental Health Child Care--1
14. Mental Health Education--1
15. Mental Health Paraprofessional Training Program--1

(10, pp. 52-53).

According to James B. King, Project Director for the Promotion of the Community College Mental Health Workers Program, there were ninety active Associate Degree Mental Health Worker programs in the United States in 1970. In the Southern (SREB) Region, there were twenty-seven active programs in 1970; however, fifty schools were interested in planning such a program (10, pp. 41-43).

In the 1960's "the shortage of skilled manpower has emerged as the salient problem in mental health programming" (6, p. 349). The scholar who first brought attention to manpower needs was George Albee. He states, "Manpower in the mental health profession is insufficient to meet our society's current needs and demands" (1, p. 13). In the research by Albee, the idea to create a new helping para-professional in mental health was first proposed. Albee suggested that

> . . . new kinds of workers who could be trained in a shorter period of time than the traditional six to eight years needed to train professionals in psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing (11, p. 1).

Concurrently with the manpower problem came the significant development of the Community College. The two-year college would offer "a potential local source for training new levels of mental health workers to meet these manpower needs" (11, p. 1).

Limitations of the Study

This study is limited to requirements of an academic nature, derived from a group of twenty schools selected by the use of a table of random numbers. The study will refer to competencies or types of performance levels required for a Mental Health Associate of Arts (A.A.) Degree graduate. Only schools represented at the SREB Conference in 1972 have been used.

Procedures for Collection of Data

One of the procedures for the collection of data was an intensive review of the rather scant literature in the field of mental health workers' training. A study has been made of general and specialized literature. This review will determine what some of the requirements are for the mental health technologist's education.

An excellent source of information comes from the Southern Regional Education Board, which has a professional staff of research associates who spend their time developing educational programs. The Community College Mental Health Worker Project was funded by the National Institute of Mental Health for a period from January, 1968 through January, 1973. The purpose of the program is to help mental health agencies and junior colleges in their regions to establish associate degree level programs in Mental

Health Technology. The Community College Mental Health Worker Project was under the complete direction and control of the Southern Regional Education Board.

Other sources of information are research articles from journals, books, workshops, and national meetings. Information from the National Organization of Human Services (NOHS) will also be used. The NOHS is the professional organization that mental health technology students may join upon graduation.

An inventory has been compiled from information gathered from all these available sources. The research has been divided into two steps. First, it is necessary to understand the role requirements of a mental health worker; the second is to understand the knowledge and performance levels required in order to do a satisfactory job. The second step is presented in Chapter 4 as we study what skills, attitudes, values, and knowledge areas are necessary for a mental health worker to perform his important role functions. This data comes from the validation instrument.

In the collection of data, the method used was the generalist model as developed by the SREB. From this approach the associate degree worker is defined as

> a worker who will be able to work directly with a small number of clients to help them tread through the maze of agency rules and regulations in order

> to allow their clients to solve their psychological or sociological problems (9).

The generalist model, according to the Southern Regional Education Board, has been acclaimed as highly successful (11, pp. 1-4). In 1967 Reissman, using the subspecialist approach, viewed the paraprofessional as "nonprofessionals" or the "NP" (15, p. 103). He felt that the nonprofessional had a role ambiguity due, in part, to the fact that these workers did not have any sort of promotional opportunities. However, in the SREB system using the generalist approach, there is a "system designed for career ladders that will provide more vertical and lateral mobility for the new levels of workers" (9, p. 6). In 1969 Davidoff, Lauga, and Walzer reported that "emotionally mature mothers could be trained as 'mental health rehabilitation trainees'" (5, p. 48). This project did not use the generalist approach. For this reason workers were given duties which the professional would rather not deal with. Davidoff states that "these 'unattractive' cases [to the psychiatrist] . . . can be approached freshly through the addition of 'in-between' specialists, the mental health rehabilitation worker" (5, p. 54). One should be aware that there is a professional disagreement between those who advocate the subspecialist approach and those in the junior college and SREB who prefer to use the

generalist approach in building an inventory of program requirements.

Procedures for Analysis of Data

A preliminary inventory of program objectives was prepared. This inventory was synthesized from several sources. These sources were documents from the SREB prepared by James B. King and Harold L. McPheeters (22 and 23). Further information was also synthesized from remarks made by Ralph Simon in one of his published presentations (48). Also various articles from the Community Mental Health Journal provided data that was used to develop an inventory of preliminary program objectives (2, 8, 12, 14, 45, 55, 59).

The preliminary inventory of program objectives was then made into a questionnaire format and given a pretest. The pretest was held in the conference room of the Western State Hospital. Those involved were training staff who had worked with mental health technicians, and knew something about program objectives. This pretest indicated that a score in the "undecided" column was a negative response. Therefore, the score of -1 was given to this category. After holding an oral critique of those testers (one psychiatrist, two psychologists, one psychiatric nurse and a supervisory mental health technician), a concensus

was reached that the preliminary inventory of program objectives could be used in Louisville as the questionnaire.

The questionnaire was submitted for response to a jury selected from those present at the 1972 National Conference of Mental Health Technology Educators, the National Faculty Development Conference held August 13-16, 1972, at Louisville, Kentucky. This meeting is sponsored annually by the Southern Regional Education Board and funded by the National Institute of Mental Health.

Each inventory of program objectives was numbered by respondents as it was returned. The forty-two department heads or directors had thirty minutes at the start of the convention to fill out the inventory. From the total sample of forty-two, a jury of twenty-one was selected by use of a table of random numbers. The table of random numbers was used to prevent any bias in the selection of the jury. This jury consisted of active directors or department heads listed in the Southern Regional Education Board's latest Status Report. However, the sample also included directors or department heads from other regions if they were listed as part of the program by the Southern Regional Education Board (10, pp. 44-47).

The jury used a Likert-type scale, having these choices: (1) strongly approve, (2) approve, (3) undecided,

(4) disapprove, or (5) strongly disapprove. In the inventory each respondent indicated his response by checking the area indicated. An IBM data card method was used in tabulating a final analysis of evaluation factors. Scoring was accomplished by giving +2 to the "strongly approve" category, +1 to the "approve" category, a score of -1 to the "undecided" category, -2 to the "disapprove" category, and -3 to the "strongly disapprove" category.

A final list of program objectives was retained on the basis of the evaluation dimension holding a plus rating. Therefore, any item with a +0.5 rating was considered favorable and retained on the basis of this score. A mean score of between +2.00 to +1.70 was ranked highly favorable. A score of +1.65 to +1.00 was ranked favorable, while a score of +0.99 to +0.50 was considered low favorable. Those scores from +0.49 to -2.00 were not retained as they were considered unfavorable. In other words, the program objectives under consideration revealed the needed knowledge or types of performance levels required for a worker in a mental health career. This final list of program objectives was then matched to the existing curriculum of the schools used to ascertain if the curriculum supports the inventory of program objectives.

The evaluation of twenty schools was made by a jury of five experts selected from the Southern Regional Education

Board, and related experts. (See Appendix B for copy of opinionnaire.) The opinionnaire holds nineteen course groups developed from the active curriculum of the schools from which the department heads or directors are working at this time.

The opinionnaire listed one area not covered in the validation of an inventory of program objectives. This category was listed as number seven, or "hospital administration, ward supervision for nursing services and medical staff." Since the Mental Health Worker is in essence part of Medical Social Services, this area of curriculum falls properly into an area of medical training. The Mental Health Worker makes the clients welfare his major professional concern. This concern translates itself into helping the client to make maximum use of the helping experience offered by the mental health agency. This question is used as a check and balance to test the jury. (See Appendix C for the Southern Regional Education Board's Program Objectives for Students in the Mental Health Technology Program.)

The units of program objectives from the twenty-two colleges are expressed on the opinionnaire in terms which allow them to interface with the Mental Health Technology Program. The opinionnaire constitutes a representative group of academic course requirements basic to Mental

Health Technology. This list of nineteen items from the respective programs, plus the one unrelated item, were subjected to the same type of analysis as the inventory of program objectives.

The experience of program development at Blue Ridge Community College is recorded in a special section of the dissertation. This section will be called Chapter 3, "Impressions of Program Development in the Field." This section examines the gap between theory and practice. The main data recorded in this section covers the changes made due to the sociological factors which arise to mitigate program development.

In Chapter 5, "Summary, Findings, Conclusions, Recommendations, and Implications," all the data are given a full analysis. The data also provide answers to the following questions:

1. What is the meaning of the directors' responses to the objectives?

2. What is the meaning of the SREB's response to the courses?

3. What elements of likeness(s) emerged?

Each question is given an answer in detail supported by pertinent data where applicable.

CHAPTER BIBLIOGRAPHY

1. Albee, George W., Mental Health Manpower Trends, New York, Basic Books, 1959.

2. Blocker, Clyde E., Robert H. Plummer, and Richard D. Richardson, Jr., The Two-Year College: A Social Synthesis, Englewood Cliffs, N. J., Prentice-Hall, Inc., 1965.

3. Chinsky, Jack M., "Nonprofessional in a Mental Hospital: A Study of the Student Volunteer," unpublished doctoral dissertation, Psychology Department, University of Rochester, Rochester, N. Y., 1968.

4. Cowen, Emory L., Jack M. Chinsky, and Julian Rappaport, "An Undergraduate Practicum in Community Mental Health," Community Mental Health Journal, VI (April, 1970), 91-100.

5. Davidoff, Ida F., Agnes C. Lauga, and Robert S. Walzer, "The Mental Health Rehabilitation Worker: A New Member of the Psychiatric Team," Community Mental Health Journal, V (February, 1969), 48-54.

6. Eisdorfer, Carl and Stuart E. Golann, "Principles for the Training of 'New Professionals' in Mental Health," Community Mental Health Journal, V (October, 1969), 349-357.

7. Gottesfeld, Harry, Rehee Chongik, and Glenn Parker, "A Study of the Role of Paraprofessionals in Community Mental Health," Community Mental Health Journal, VI (August, 1970), 285-291.

8. Hadley, John M., John E. True, and Sherwin Y. Kepes, "An Experiment in the Education of the Preprofessional Mental Health Worker: The Purdue Program," Community Mental Health Journal, VI (February, 1970), 40-50.

9. King, James B., "The Tide and the Westerly Wind: Keynote Address for the Western Interstate Commission for Higher Education," unpublished paper read before the Western Interstate Commission for Higher Education, Denver, Colorado, April 2, 1971. (Multilithed)

10. King, James B. and E. Jo Baker, 1970 Status Report: Community College Mental Health Worker Programs in the South, Atlanta, Georgia, Southern Regional Education Board, 1971.

11. King, James B. and Harold L. McPheeters, Plans for Teaching Mental Health Workers: Community College Curriculum Objectives, Atlanta, Georgia, Southern Regional Education Board, February, 1971.

12. Light, Israel, "Development and Growth of New Allied Health Fields," Journal of the American Medical Association, 210 (October 6, 1969), 114-120.

13. National Institute of Mental Health, Experiments in Mental Health Training: Project Summaries, Washington, D. C., Public Health Service Publication No. 2157 (April, 1971), 1.

14. Rappaport, Julian, "Nonprofessionals in a Mental Hospital: College Students as Group Leaders with Chronic Patients," unpublished doctoral dissertation, Psychology Department, University of Rochester, New York, 1968.

15. Reissman, Frank, "Strategies and Suggestions for Training Nonprofessionals," Community Mental Health Journal, III (Summer, 1967), 103-110.

16. Southern Regional Education Board, "Roles and Functions for Mental Health Workers: A Report of a Symposium on Manpower Utilization for Mental Health," Community College Mental Health Worker Project of the Southern Regional Education Board, Atlanta, Georgia, December, 1969. (Multilithed)

17. Yolles, Stanley F., "The Community Mental Health Center in National Perspective," The Practice of Community Mental Health, edited by Henry Grunebaum, Boston, Little, Brown and Company, 1970.

CHAPTER II

MENTAL HEALTH TECHNOLOGY: THE THEORETICAL BACKGROUND AND RELATED LITERATURE

Introduction

This chapter includes a discussion of the theoretical background of mental health technician roles, and paraprofessional educational models as they appear in the general and specialized literature. These roles may be either formal or informal. The discussion will be based upon the four paraprofessional models listed by Hallberg, Karr and Skrip (16, pp. 30-31). The principal models are programs for "currently enrolled students, the indigenous paraprofessional, the career re-entrant and the career paraprofessional" (16, pp. 30-31).

In attempting to formulate a body of educational knowledge required for the effective performance of mental health technician's functions, it is first necessary to review paraprofessional models, staffing patterns, patient census for mental illness, and role expectations of those who are engaged in such activities. Through understanding educational models and what is expected of a mental health paraprofessional may some determination be made as to the

nature of the academic preparation which would be best suited to the job which needs to be accomplished.

Mental health technology is an enormous complex of interrelated operations, and in recognition of this fact support for the education of allied health professions personnel was initially enacted on November 3, 1966, with the passage of the "Allied Health Professions Personnel Training Act (P. L. 89-751)" (48, p. 33). The need in mental health for more staff is evidenced by a few statistics.

A study of psychiatrists points to a shortage in that specialty. There are only 18,740 psychiatrists in the United States, which is a national ratio of 9.6 psychiatrists per 100,000 population. This figure on paper equals about one psychiatrist for every 10,000 individuals. However, there is a wide variation regarding the availability from state to state, from 1.7 in Idaho to a national high of 22.2 psychiatrists per 100,000 population in New York. Of the sample under study 47 percent of the psychiatrists work in private practice. Some 30.6 percent work one hour or more in an inpatient department of a mental hospital. Another 18.1 percent work 35 hours or more in such hospitals, while 56 percent of the psychiatrists spend no time at all in this work setting (34, pp. 3-17). However, these figures do not take into account

the fact that many psychiatrists work on jobs outside their full time situation.

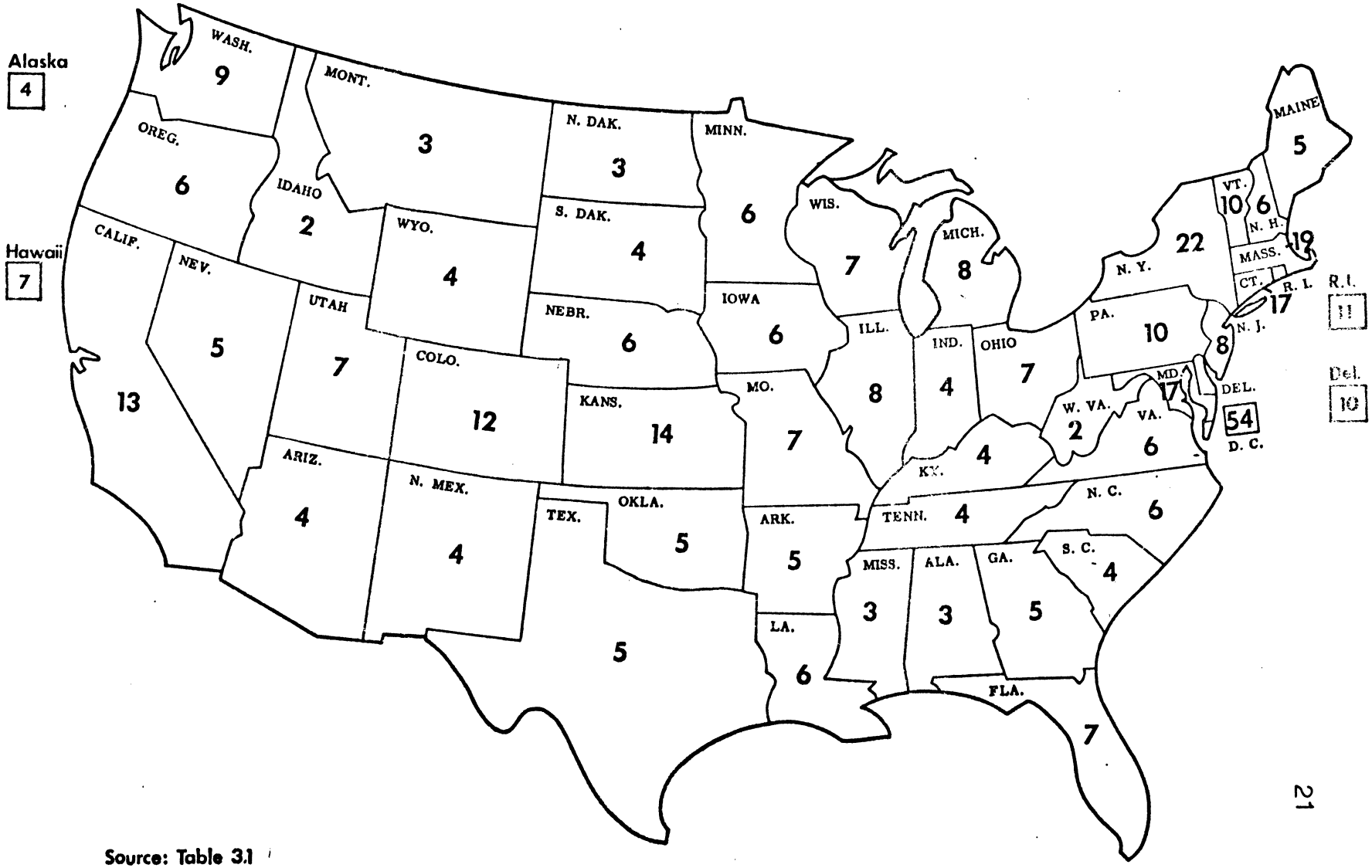
The number of psychiatrists is low in the stated served by the Southern Regional Education Board. In this region the availability of psychiatrists range from a low of 2.0 per 100,000 in West Virginia to a high of 17.0 for Maryland. (See Figure 1.) One assumption that seems valid is that the lack of availability for psychiatrists may be part of the general trend in the lack of staff for the entire region. The population for the region according to the U. S. Census is 29 percent while the region has only 22 percent of the nation's mental hospitals.

The southern region also has fewer private mental hospitals. There are 33 private mental hospitals in the southern region out of a total of 149 hospitals in the United States. This suggests that southern states could provide a larger share of state-supported facilities for treatment (35, p. 2). For example, the states of Arkansas, Louisiana, Oklahoma, and Texas have only 4.2 beds per 100,000 United States population, which is less than two-thirds the national average of 7.2 beds in private mental hospitals (34, p. 3).

The Biometry Branch of the Public Health Service, Health Services and Mental Health Administration, has predicted that by 1975 some 21,558,800 persons of all ages will need care. In order to give maximum care (optimum

(34, p. 27)

FIGURE 1
NUMBER OF PSYCHIATRISTS PER 100,000 STATE POPULATION, 1965



Source: Table 3.1

conditions) to these persons there would need to be 143,725 clinical psychiatrists, 86,235 psychologists, 287,451 social workers, and 86,235 nurses (33, p. 19). This data is based on the assumptions that present trends continue and that the rate of "patient care episodes that existed in 1968 would remain constant over the period 1968-1980" (30, p. 1). However, the projected manpower pool does not meet the projected maximum care figures listed above. By 1975 there will be only 30,000 psychiatrists, 30,000 psychologists, 25,400 social workers, and 35,900 nurses to care for those in need of services (33, p. 22). By using the traditional methods of training mental health professionals, therefore, a shortage of staff is projected for 1975.

The result of this distribution of staffing patterns was the subject of a study prepared by the Survey and Reports Section of the Biometry Branch. This report made a study of "Staffing of State and County Mental Hospitals." In this report three significant patterns emerged.

1. Over half the total staff time is provided by nursing and attendant staff followed by non-professionals, who account for 36 percent and then professionals who provide 12 percent.

2. Only 11 percent of the nursing and attendant staff time was provided by registered nurses. Of the remaining 89 percent, on the basis of previous surveys, the greater proportion of staff time is provided by custodial type staff of which licensed practical nurses comprise less than ten percent.

3. Of the total manhours worked by the four core disciplines, registered nurses provided 54 percent, followed by social workers, 20 percent, psychiatrists, 17 percent, and psychologists, nine percent (39, p. 2).

The above data tends to indicate that much of the work in publicly supported mental hospitals is now performed by custodial and nonprofessional staff. Such a staffing pattern seems to be the trend of the future, if present shifts continue and projected statistics are correct.

Another recent study seems to confirm this trend. In federally funded community mental health centers the A. A. degree mental health worker is starting to fill the gap in the area once labeled custodial or nonprofessional level work. While data is still rather scant, some 1,457 A. A. level workers were in the fields as of January, 1972 (27, p. 15). There are an average of 4.9 such workers per community mental health center (37, p. 16), who contribute a total of 39,608 scheduled staff hours for a sample week as compared to 15,181 staff hours for psychiatrists (37, p. 20). With this small sample of data the trend seems clear. The A. A. degree mental health worker seems to help in providing needed services when traditional forms of manpower are in short supply.

The growth in numbers of A. A. level mental health workers has been dramatic. In 1968 a total of 2,263 mental health facilities reported that there were 13,000 nonprofessional level vacancies for budgeted positions (36, p. 3).

The number of graduates from two-year Associate Degree Mental Health Programs in that year, however, was a total of 99 students. Projections for graduates in 1972 are 2,600 students. Projections estimate that by June, 1976, there will be 14,500 graduates to fill vacant nonprofessional positions (54, p. 5). Francine Sobey stated in 1970,

> The figures have been even more alarming for social work and nursing services. Particularly in mental health institutions and public welfare and correctional settings, the gap between the demand for highly trained professional staffs and the supply has steadily widened. The lowest ratios of professional mental health personnel to all employees (one to ten) have been found in public hospitals for the mentally ill. Of necessity, then, large numbers of supporting nonprofessionals have had to be recruited to maintain adequate hospital services for the mentally ill (51, pp. 17-18).

Sobey felt that in 1970 the need for professional manpower in mental health was in a crisis stage.

As shortages of professional mental health manpower increase, the need for new paraprofessionals with new levels of competence will be utilized. The utilization of paraprofessionals falls into four models. These models will be given a brief review regarding the theoretical and historical background.

The Currently Enrolled Student

This model deals with what Hallberg, Karr and Skrip call "Peer Counselors." They are "typically students who become involved in activities such as tutoring, orientation and work/study projects with fellow students" (16, p. 30).

Sinnett and Niedenthal feel that "indigenous volunteers may provide a supplementary source of help to their emotionally disturbed peers" (50, p. 2). In their program the volunteers were used as role models. The volunteers were from a cross-section of the student population who had a genuine desire to be of service. No real effort was made to turn these students into "junior therapists" (50, p. 4).

In a study by Walker, Wolpin and Fellows students were assigned to work at Camerillo State Hospital under the supervision of a psychologist. Students from any academic area could enroll in two three-unit psychology courses. The major motivation for this project was to provide students with an experience more meaningful than that found in the general classroom lecture (59, p. 186). Again, the aim was not to train a student to become a mental health worker but to provide experience for him and to offer patients direct contact with a "normal" role model (58, pp. 186-187).

Students have also been used as peer counselors in the community college setting. According to Pyle and Snyder, training students "focused largely on how to help selected students translate their natural concerns into a round helping process" (43, p. 260). In this study the peer counselors were paid and reported the problem of role ambiuity not found in the case of volunteers. This program

was credited with the general reduction of frustrations and tensions found in previous semesters (43, p. 262). While the students were given 30 hours of training, no additional long range education was given; thus this program meets the criteria for this first model.

The Indigenous Paraprofessional

Hallberg, Karr and Skrip state that the "indigenous paraprofessional is often a member of a minority group in the community . . . not a student" (16, p. 31). The indigenous paraprofessional is selected from the environment which the agency is trying to offer its services. The theory is that these paraprofessionals need to be members of the community served, must be part of the outreach philosophy, and must work within their own areas. Examples of these types of workers are "public school aides, social service representatives, police community relations aides, and community organization aides" (16, p. 31).

The most definitive article on this subject is by Riessman, who states,

> While nonprofessionals may be selected because of certain characteristics they possess, such as informality, humor, earthiness, neighborliness--in other words some of the "positive" characteristics of the resident population--the other side of the coin cannot be ignored, that is, they may possess characteristics of low-income populations that interfere with effective helper roles (45, p. 104).

Riessman goes on to make the point that efforts need to be made to "train out" the less desirable qualities in the indigenous worker (45, p.104).

This paraprofessional group is found most often in antipoverty agencies (45, p. 109). For this reason they may have a low level of education and as a result have anxiety regarding their role ambiguity and lack of role identity, career lines, and requisite skills (45, pp. 104-110). All of these problems have also been reviewed by other authors (17, 44, 6, 11, 25, 56).

Another problem regarding the indigenous nonprofessional, who is, after training, especially skillful in relating to and helping others of his race and social class, is that he often loses this valued rapport over several years as he absorbs the values of his co-workers and is socialized into the middle class. One opinion is that society will benefit, assuming that this indigenous nonprofessional can be replaced (25, pp. 95-96).

The Career Re-Entrant

Hallberg, Karr and Skrip refer to a "paraprofessional who is changing careers or is embarking on an initial career in his middle years," as a career re-entrant (16, p. 31). Training programs for such workers tend to deal with emotionally mature older women. One such project by Davidoff, Lauga and Walzer reports that the "authors were aware of

the number of emotionally mature mothers, no longer involved in child-rearing duties, who wanted gratifying work in community service . . ." (8, p. 48). The major assumption underlying this model is that mature women can easily be trained to care for patients since they have cared for families of their own for many years (16, p. 31). The career re-entrant seems to be found most often in the roles of teacher aide or mental health worker.

Lefkowity states that teacher aides were introduced into public education during the Michigan Project in 1948 (24, p. 546). The purpose of aides at that time was to relieve the shortage of teachers and increase class size. By 1970 approximately one teacher in four had the services of a teacher aide. According to Lefkowity, paraprofessionals are used primarily in elementary schools (24, p. 547).

Many teachers perceive aides as a threat to their professional authority in the classroom and give their aides only menial tasks to perform. On the other hand, Lefkowity states that there is increasing evidence that some teachers have allowed teacher aides to teach entire classes. He deplores the lack of adequate training to develop a team teaching method between the professional teacher and the paraprofessional aide in order to clarify the role of each in the classroom (24, p. 547).

On the more positive side, Michael believes that aides can be used effectively but that definitions of teacher and teacher aide competencies should be formulated according to specific behaviors and outcomes rather than list of functions (31, pp. 548-549). Michael states that in considering such issues as professional versus nonprofessional, teaching versus non-teaching, certified versus noncertified, graduate versus dropout, we are overlooking the fact that we need individuals who will help to humanize our schools by helping both students and teachers. He continues that no one has suggested that teacher aides replace professional teachers; rather that they assist the teacher in many ways according to their own individual abilities. In short, teacher aides can help the classroom teacher achieve the desired educational goals (31, pp. 548-549).

The Career Paraprofessional

In this model we find a paraprofessional who is prepared or committed to work within the mental health field, after graduation from an Associate of Arts degree (A.A.) program in Mental Health Technology, from a community college. The first model program was the Purdue University project. This project was founded in 1965 by the National Institute of Mental Health (14, p. 40).

One of the most significant constraints encountered to date is resistance to this new paraprofessional by existing

workers in the field of mental health. In his article True refers to this as "the professional mystique." The elements of this attitude cluster around the thought that "only we professionals can do it." Certainly there have been benefits to the professional in status and pay. Benefits have also been given to the public in terms of better service. It is the position of the Purdue program that one way to increase these service benefits is to add paraprofessionals to the staffing pattern, and thus allow trained professionals to concentrate their efforts on more highly sophisticated treatments. The trained professional is free to concentrate his efforts on supervision, consultation, program planning, in-depth therapy, and research. It is frequently difficult to make this point effectively to those professionals who have been preoccupied with upgrading traditional roles. Such a preoccupation makes it difficult for other professionals to accept the fact that paraprofessionals can often perform a variety of functions adequately (14, pp. 40-50).

In the study by Gottesfeld, Rhee and Parker regarding the utilization of paraprofessionals in ten New York institutions, research indicates favorable use of staffing patterns. The actual work roles described by administrators varied from unskilled to highly skilled but more often were the latter. The majority of administrators, supervisors,

and clinicians perceive the paraprofessional's work as at least partially overlapping the work of the professionals (12, p. 286).

> In relationships with professionals, somewhat more than half of the paraprofessionals felt that the relationship was one of equals, that they worked together and made joint decisions on patients. Somewhat less than half felt that their role was subordinate to the professional, that the paraprofessional assisted the professional but the professional made the final decision. Relationships between professionals and paraprofessionals seemed generally informed and friendly. However, a substantial minority of paraprofessionals felt that some professionals looked down on paraprofessionals (12, p. 289).

One point this study makes is that the mental health technician differs from the psychiatric aide, although there is still a great deal of confusion over these two roles. The psychiatric aide in most cases has less than a high school education and performs work under the supervision of the nursing service. The literature abounds with data on how to train an aide in full-time preservice courses of study ranging in length from eight to 32 weeks. Most education, however, is on-the-job training as a result of staff shortages (57, 42, 15, 9, 7).

In contrast to the psychiatric aide, the mental health worker usually has an A. A. degree. While 100 percent of the mental health workers had two years of college, only 7.9 percent of the aides had this much college training and 42.3 percent of them were less than high school graduates (40, pp. 9-11). Therefore, psychiatric aides seem to fit

the model for the indigenous paraprofessional rather than that of the career paraprofessional (25, p. 95).

Another big difference between psychiatric aides and mental health workers is work settings. The Federal study states, "seventy percent of the aides were employed in a hospital with 2,000 or more patients" (40, p. 6). While the mental health worker is sometimes found working in hospitals, he also works in mental health centers and other community agencies. The aide on the other hand is limited to hospital-level nursing services and has only a custodial role within the mental health system (40, p. 6).

Due to their training, A. A. degree mental health workers can be found in a variety of settings. In his report Simon lists some of the following agencies:

1. Community Mental Health Centers
2. General Hospital (Psychiatric Section)
3. Speech and Hearing Centers
4. Institutions for the Mentally Retarded
5. School Systems
6. Rehabilitation Institution for the Blind
7. Tuberculosis Hospitals
8. Nursery Schools
9. Children's Homes
10. State Mental Hospitals
11. Daycare Centers

12. Psychiatric Hospital (Social Service Department)
13. Crisis Intervention Centers
14. Public Health Departments
15. Variety of Federal Agencies (49, p. 4)

In his report Simon feels that he has enough evidence to support the opinion that "persons with less than full professional training can provide meaningful, useful, and effective mental health services" (49, p. 2).

The biggest complaint that professional psychologists have concerning paraprofessionals is the quality of service that the paraprofessional renders. Arnhoff agrees with this position and states, "we must protect the population from being promised a great increase in 'service' when in reality they may be 'served' by someone with little knowledge or skill . . ." (1, p. 164). On the other hand, Greenfield is more interested in the related issue of the quality of those who train paraprofessionals because he feels ". . . little information is available on the qualifications possessed by teachers . . ." (13, p. 79).

The quality of service is a problem in person-to-person contacts, which the psychologist will perform very often. In many cases complex decisions are necessary in order to help the patient. The professional psychologist feels that the paraprofessional, without having the needed six to ten years of training, would make the wrong decision. Of course,

there is no guarantee that the decisions of professionals are always correct. Blau states, ". . . psychologists can oppose the use of nonprofessionals, specifying chapter and verse about possible negative effects, the same psychologist could be extremely helpful in establishing the standards and guidelines . . ." (4, p. 29). Blau goes on to state that problems can be controlled through the use of standards, proper supervision, "longitudinal evaluation," and control of the quality of educational programs (4, pp. 29-30).

The most recent study to date indicates that the judgments of paraprofessionals ". . . differed very little from the professional in terms of either reliability, scope of utilization, magnitude of judgments, or judgmental confidence" (55, p. 157). The one area of difference was that the paraprofessionals "conceived of mental health and mental illness primarily in terms of deviant, or socially disapproved behavior . . ." (55, p. 175). However, through training and understanding, the supervisors of paraprofessionals from diverse backgrounds could control some of their negative attitudes (55, p. 176).

Despite these criticisms of paraprofessional mental health workers, there has been an increase in their use in the past six years. To meet this demand, as reported by Young, True, and Packard, there are now more mental health

community college training programs in the United States (59, p. 1). These programs train generalists, ". . . that is, people who are familiar with numerous mental health intervention methods and who are able to provide or arrange for a large number of services . . ." (59, p. 1). Sobey reports that 70 percent of these generalists are used to "provide informal sustaining relationships to patients and clients" (51, p. 150). In another 66 percent of projects studied, mental health workers were used to "relieve the professional of tasks not requiring professional expertise" (51, pp. 150-151). The study went on to show that 60 percent of the same projects used these workers because "they felt they could communicate better with the patient-client groups or reduce . . . social distance . . ." (51, p. 151). The statistic that was the most surprising was that only 40 percent reported that mental health workers were used "to provide services which would be better provided by professional staff if enough were available (51, p. 151). The most often quoted major reason for the use of paraprofessionals has been in response to the professional manpower shortage; in the Sobey study we find a multiple use basis for paraprofessionals that one would not expect.

There is some difference of opinion as to whether such paraprofessionals should be trained as subspecialists or as generalists. Several important studies call for the former.

Mitchell, for example, states that nonprofessionals should become involved in "Amicatherapy" and their volunteers should become trained in this type of therapeutic intervention (31, p. 307). Bertheson, on the other hand, feels that trained volunteers should be used to supplement treatment by professionals (3, p. 266). Epstein feels that casework assistants should be used to achieve maximum use of professional staff (10, pp. 67-68). Hollander feels that more clergymen should be given mental health training and placed in agencies as part of the treatment staff (18, pp. 221-229). All of these concepts move toward a subspecialist model.

The most salient literature regarding the A. A. degree mental health technologist, however, has been composed by the Southern Regional Education Board (2, 19, 20, 21, 22, 23, 26, 27, 28, 29, 30, 46, 53, 54). The SREB was the first agency to initiate research and demonstration programs in this field. The major theme in SREB publications is that the product of mental health training should be a generalist. In one symposium the report stated,

> In the course of the symposium we repeatedly heard that the client in distress or need is already at the mercy of too many specialists and agencies. Especially in complex urban areas the client and his family are shunted from specialist to specialist and agency to agency, each with its different policies, procedures, and eligibility limits. The client--usually a person in distress and with limited abilities--finds himself confused by the maze, intimidated by the specialists' jargon and

> manner and rebuffed by the system's rules and regulations. What poor people and people in distress need is not more specialists, or even worse, a proliferation of subspecialists, but a single person whom they can trust and through whom they can relate to all of the specialists and agencies (28, p. 32).

This "generalistic" concept is found also in the work of Baker (2, p. 281), McPheeters and King (22, p. 9), McPheeters (30, p. 3), and Young, True and Packard (59, p. 1); the last named study argues that generalist training creates ". . . people who are familiar with numerous mental health intervention methods and who are able to provide or arrange for a large number of services to clients and families . . ." (59, p. 1). This model seems to offer the most flexible alternative to the staffing pattern yet found by the mental health movement.

Roles and Functions of the Mental Health Technician

As evidenced by the literature, we have seen a great change within the major fields of specialization in mental health. Each field has a great fund of knowledge, skills, and abilities; yet their roles are less distinct than in the past. We now find members of any one of the professional disciplines being used as educators, consultants, or outreach workers.

A "generalist," as the model was developed, was to have some of the following specific characteristics:

1. The generalist works with a limited number of clients or families (in consultation with other professionals) to provide "across the board" services as needed by the clients and their families.

2. The generalist is able to work in a variety of agencies and organizations that provide mental health services.

3. The generalist is able to work cooperatively with all of the existing professions in the field rather than affiliating directly with any one of the existing professions.

4. The generalist is familiar with a number of therapeutic services and techniques rather than specializing in one or two areas.

5. The generalist is a "beginning professional" who is expected to continue to learn and grow (22, p. 10).

The generalist is, most often, the person who works as the client's advocate, in planning and working with the client to help him through the maze of services. Mental health workers are to play whatever roles are found necessary. They refer patients only when it is not possible to serve the patient directly.

The roles through which these functions could be performed are listed by the Southern Regional Education Board as

1. Advocate
2. Administrator
3. Behavior Changer
4. Broker
5. Community Planner
6. Consultant
7. Data Manager
8. Evaluator
9. Mobilizer
10. Outreach Worker(23, pp. 13-14).

As of this date there are only two evaluative articles that deal with the effectiveness of this generalist role pattern (59, p. 48). However, evaluative components were built into all National Institute of Mental Health funded A. A. degree mental health worker programs (49, p. 5). This scant body of data tends to confirm the roundness of the generalist role pattern.

Out of the sample taken by Baker, "seventeen workers were employed in state hospitals, two in educational settings, five in mental health centers, three in children's agencies, and two in general hospitals . . ." (2, p. 283). The job functions of graduates also tended to support the goal of the generalist role pattern. For example, Baker found that the "highest percentage of functions performed were 'indirect client services,' which includes interacting with relatives, other members of the staff, or other agencies and services on the client's behalf" (2, p. 284). Baker also noted that with regard to stated objectives of their training data supported evidence "which suggests that the objectives within this category are being met" (2, p. 287). Baker concludes by calling for more task analyses "before a determination can be made of the type and level of training required to perform to given criteria" (2, p. 290). No research to date has been prepared on the history and development of the mental health technology movement.

CHAPTER BIBLIOGRAPHY

1. Arnhoff, Franklyn N., and others, "The New Mental Health Workers," Manpower For Mental Health, edited by Franklyn N. Arnhoff, Chicago, Aldine Publishing Co., 1969.

2. Baker, E. Jo, "The Mental Health Associate: A New Approach in Mental Health," Community College Mental Health Journal, 8 (November, 1972), 281-291.

3. Bertleson, Chad M., "Helping Personnel: The Use of Trained Volunteers in the Treatment of Mental Patients in a Community Psychiatric Clinic," American Journal of Orthopsychiatry, 34 (1964), 260-267.

4. Blau, Theodore H., "The Professional in the Community Views the Nonprofessional Helper," Professional Psychology, 1 (November, 1969), 25-30.

5. Bouhoutsos, Jacqueline C., "The Nontraditionally Trained Mental Health Worker: Fad or Future?," Professional Psychology, 1 (Fall, 1970), 455-459.

6. Christmas, Jung Jackson, "Group Methods in Training and Practice: Nonprofessional Mental Health Personnel in a Deprived Community," American Journal of Orthopsychiatry, 36 (April, 1966), 410-419.

7. Cochran, M. A. and Kelly E. Steiner, "Evaluation of an Inservice Training Program Using the SREB Information Test," American Journal of Mental Deficiency, 70 (May, 1966), 913-917.

8. Davidoff, Ida F., Agnes C. Lauga, and Robert S. Walzer, "The Mental Health Rehabilitation Worker: A New Member of the Psychiatric Team," Community Mental Health Journal, 5 (February, 1969), 48.

9. Ellsworth, Robert, Arthur Bryant, and Grace Butler, "Psychiatric Aide In Service Training: An Experimental Approach," Nursing Research, 9 (Winter, 1960), 12-16.

10. Epstein, Laura, "Differential Use of Staff: A Method to Expand Social Services," Social Work, 7 (1962), 67-72.

11. Gordon, Jesse E., "Project Cause, The Federal Anti-Poverty Program and Some Implications of Subprofessional Training," American Psychologist, 20 (May, 1965), 334-343.

12. Gottesfeld, Harry, Cohongik Rhee, and Glenn Parker, "A Study of the Role of Paraprofessionals in Community Mental Health," Community Mental Health Journal, 6 (August, 1970), 285-291.

13. Greenfield, Harry I., Allied Health Manpower: Trends and Prospects, New York, Columbia University Press, 1969.

14. Hadley, John M., John E. True, and Sherwin Y. Kepes, "An Experiment in the Education of the Preprofessional Mental Health Worker: The Purdue Program," Community Mental Health Journal, 6 (February, 1970), 40-50.

15. Haid, Doris M., "Teaching of Psychiatric Aides," Teaching and Implementation of Psychiatric Mental Health Nursing, edited by Mary N. Redmond and Margery E. Drake, Washington, D. C., The Catholic University of America Press, 1958.

16. Hallberg, Edmund C., Ben Karr, and Cathy Skrip, "Paraprofessionals as Counselors," Community and Junior College Journal, 43 (October, 1972), 30-31.

17. Hallowitz, E. and Frank Riessman, "The Role of the Indigenous Nonprofessional in a Community Mental Health Neighborhood Service Center Program," American Journal of Orthopsychiatry, 37 (1967), 776-778.

18. Hollander, Fred, "A Mental Health Training Program For Clergymen," Mental Health Program Reports--No. 2, February, 1968, Department of Health, Education and Welfare, Public Health Service Publication No. 1743, Superintendent of Documents, Washington, D. C., U. S. Government Printing Office, February, 1968.

19. King, James B., "The Black and White Issues," a position paper from the project director, Community College Mental Health Workers Project, Atlanta, Georgia, Southern Regional Education Board, 1972.

20. King, James B., "The Tide and the Westerly Wind: Keynote Address for the Western Interstate Commission for Higher Education," unpublished paper read before the Western Interstate Commission for Higher Education, Denver, Colorado, April 2, 1971. (Multilithed)

21. King, James B. and E. Jo Baker, 1970 Status Worker Programs in the South, Atlanta, Georgia, Southern Regional Education Board, 1971.

22. King, James B. and Harold L. McPheeters, Plans for Teaching Mental Health Workers: Community College Curriculum Objectives, Atlanta, Georgia, Southern Regional Education Board, February, 1971.

23. King, James B. and Harold L. McPheeters, Roles and Functions for Mental Health Workers, Atlanta, Georgia, Southern Regional Education Board, December, 1969.

24. Lefkowitz, Leon J., "Paraprofessionals: An Administration/School Board Conspiracy?," Phi Delta Kappan, LIV (April, 1973), 546-547.

25. Levinson, P. and J. Schiller, "Role Analysis of the Indigenous Nonprofessional," Social Work, 11 (July, 1966), 95-101.

26. McPheeters, Harold L., "Faculty Relationships to Graduates," a position paper prepared for the 1972 National Faculty Development Conference, Community College Mental Health Workers Project, Atlanta, Georgia, Southern Regional Education Board, August 13-16, 1972.

27. McPheeters, Harold L., "Faculty Responsibilities Regarding the Introduction and Use of Mental Health Worker Graduates in Agencies," a position paper from the commission on Mental Illness and Retardation, Atlanta, Georgia, Southern Regional Education Board, 1973.

28. McPheeters, Harold L., Manpower Utilization in Social Welfare: A Report Based on a Symposium on Manpower Utilization in Social Welfare Services, Atlanta, Georgia, Southern Regional Education Board, June, 1970.

29. McPheeters, Harold L., "Recommendations for Mental Health Workers Upon Entering Employment in a Mental Health System," a position paper from the commission on Mental Illness and Retardation, Atlanta, Georgia, Southern Regional Education Board, 1973.

30. McPheeters, Harold L., "Some Considerations in Introducing New Mental Health Workers," a position paper from the commission on Mental Illness and Retardation, Atlanta, Georgia, Southern Regional Education Board, 1973.

31. Michael, Elizabeth B., "No Conspiracy, But Let's Use Paraprofessionals Wisely," Phi Delta Kappan, LIV (April, 1973), 548-549.

32. Mitchell, William E., "Amicatherapy: Theoretical Perspectives and an Example of Practice," Community Mental Health Journal, 2 (1966), 307-314.

33. National Institute of Mental Health, Memo: Estimates of Unmet Needs with Respect to Mental Health Services, August 28, 1970. (Mimeo. copy)

34. National Institute of Mental Health, The Nations' Psychiatrists, Public Health Service Publication No. 1885, Superintendent of Documents, Washington, D. C., U. S. Government Printing Office, 1969.

35. National Institute of Mental Health, Private Mental Hospitals, 1969-1970, Department of Health, Education and Welfare Publication No. HSM 72-9089, Superintendent of Documents, Washington, D. C., U. S. Government Printing Office, 1972.

36. National Institute of Mental Health, Staffing Patterns in Mental Health Facilities, 1968, Public Health Service Publication No. 5034, Superintendent of Documents, Washington, D. C., U. S. Government Printing Office, 1970.

37. National Institute of Mental Health, Survey and Reports Section, Biometry Branch, Descriptive Data on Federally Funded Community Mental Health Centers 1971-1972, Second Edition, Rockville, Maryland, May, 1973.

38. National Institute of Mental Health, Survey and Reports Section, Biometry Branch, Staff and Manhours in Mental Health Facilities in the United States, Department of Health, Education and Welfare Publication Statistical Note 51, Superintendent of Documents, Washington, D. C., U. S. Government Printing Office, May, 1971.

39. National Institute of Mental Health, Survey and Reports Section, Biometry Branch, Staffing of State and County Mental Hospitals, Department of Health, Education and Welfare Publication No. HSM 72-9012 (Statistical Note 52), Superintendent of Documents, Washington, D. C., U. S. Government Printing Office, June, 1971.

40. National Institute of Mental Health, Training and Manpower Resources Branch, The Psychiatric Aide in State Mental Hospitals, Department of Health, Education and Welfare Publication No. PHS 1286, Superintendent of Documents, Washington, D. C., U. S. Government Printing Office, March, 1965.

41. North, Robert, "Micro-Lab Training of Mental Health Workers," a position paper prepared for the 1972 National Faculty Development Conference, Community College Mental Health Workers Project, Louisville, Kentucky, August 14-16, 1972.

42. Pryer, Margaret W., M. K. Distefano, and Mary B. Poe, "Effects of Training Programs on Psychiatric Attendants," Mental Hygiene, 50 (January, 1966), 66-70.

43. Pyle, Robert R. and Fred A. Snyder, "Students as Paraprofessional Counselor at Community Colleges," The Journal of College Student Personnel (July, 1971).

44. Richan, W. C., "A Theoretical Scheme for Determining Roles of Professional and Nonprofessional Personnel," Social Work 4 (October, 1961), 22-28.

45. Riessman, Frank R., "Strategies and Suggestions for Training Nonprofessionals," Community Mental Health Journal, 3 (Summer, 1967), 103.

46. Sanders, Richard, "Training a New Breed of Mental Health Worker," Mental Health Program Reports--3 January 1969, Department of Health, Education and Welfare, Public Health Service Publication No. 1876, Superintendent of Documents, Washington, D. C., U. S. Government Printing Office, January, 1969.

47. Schulman, Eveline D., "The Four W's of the Mental Health Technologist's Field Work Placement," a position paper prepared for the 1972 National Faculty Development Conference, Community College Mental Health Workers Project, Louisville, Kentucky, August 13-16, 1972.

48. Senate Report of the Health Facilities, Manpower, and Community Mental Health Centers Act of 1972, 92nd Congress, 2nd Session, No. 1014, Washington, D. C., August 16, 1972.

49. Simon, Ralph, "The Paraprofessionals are Coming! The Paraprofessionals are Coming!," a paper presented at the 78th Annual Convention, American Psychological Association, Miani Beach, Florida, 1970.

50. Sinnett, E. Robert and Linda K. Niedenthol, Research Report Number 1: The Use of Indigenous Volunteers in a Rehabilitation Living Unit for Disturbed College Students, Student Health Service, Kansas State University, September, 1967.

51. Sobey, Francine, The Nonprofessional Revolution in Mental Health, New York, Columbia University Press, 1970.

52. Sobey, Francine, The Nonprofessional Revolution in Mental Health, New York, 1970.

53. Southern Regional Education Board, "Roles and Functions for Mental Health Workers: A Report of a Symposium on Manpower Utilization for Mental Health," Community College Mental Health Worker Project of the Southern Regional Education Board, Atlanta, Georgia, December, 1969. (Multilithed)

54. Southern Regional Education Board, Summary Analyses of National Survey, Atlanta, Georgia, 1973.

55. Summers, David A., Ted Faucher, and Sue B. Chapman, "A Note on Nonprofessional Judgments of Mental Health," Community Mental Health Journal 9 (Summer, 1973), 169-177.

56. Truax, Charles B., "The Training of Nonprofessional Personnel in Therapeutic Interpersonal Relationships," American Journal of Public Health, 57 (October, 1967), 1778-1791.

57. Vaugn, Rufus, Stanley Teitlebaum, and Helen Kempman, "A Research Project in Psychiatric Aide Training," American Journal of Psychiatry, 119 (December, 1962), 555-559.

58. Walker, C. Eugene, Milton Wolpin, and Lloyd Fellows, "The Use of High School and College Students as Therapists and Researchers in a State Mental Hospital," Psychotherapy: Theory, Research and Practice, 4 (November, 1967), 186-187.

59. Young, Carl E., John E. True, and Mary E. Packard, "A National Survey of Associate Degree Mental Health Programs," accepted for publication by the Community Mental Health Journal, January, 1974. (Reprint)

CHAPTER III

IMPRESSIONS OF PROGRAM DEVELOPMENT IN THE FIELD

Introduction

The Blue Ridge Community College is located in the Shenandoah Valley area of Virginia. The College is near the intersection of Interstate 80 and State Highway 256, one mile south of the City of Weyers Cave on U. S. Route 11. The College serves primarily those who live in the August and Rockingham Counties. However, specialized statewide associate degree curricula are available to all qualified students.

As a comprehensive institution of higher education offering programs of instruction generally extending not more than two years beyond the high school level, the College is committed to the following functions:

1. Occupational-Technical Education.
   The occupational and technical education programs are designed to meet the increasing demand for technicians, semi-professional workers, and skilled craftsmen for employment in industry, business, the professions, and government. The curricula are planned primarily to meet the needs for workers in the region being served by the College.

2. University Parallel-Transfer Education.
The university parallel-college transfer programs include college freshmen and sophomore courses in arts and sciences and pre-professional education designed to meet standards acceptable to Baccalaureate Degree Programs in four-year colleges and universities.

3. General Education.
The programs in general education encompasses the common knowledge, skills, and attitudes required by each individual to be effective as a person, a worker, a consumer, and a citizen.

4. Continuing Education.
Programs are offered to enable the adults in the region to continue their learning experiences and include both degree and non-degree credit hours offered during the day and evening hours.

5. Special Training Program.
Arrangements can be made through the Division Chairman for Business and Engineering Related Programs for special on- or off-site training and retraining of industrial employees. These programs can be subsidized for industries which will provide new or expanded employment opportunities for this region. The provisions for special training are part of Virginia's efforts toward economic expansion and toward meeting the needs of its employers.

6. Developmental Studies.
Developmental Studies are offered to prepare individuals for admission to an occupational-technical curriculum or to a university parallel-college transfer curriculum in the community college programs.

7. Specialized Regional and Community Services.
The facilities and personnel of the College are available for specialized services to provide for the cultural and educational needs of the region served by the community college. This service includes non-classroom and non-credit programs, cultural events, workshops, meetings,

> lectures, conferences, seminars, and special community projects which are designed to provide needed cultural and educational opportunities for the citizens of the region (2, pp. 20-21).

The Mental Health Technology Program at Blue Ridge Community College was developed in part to meet the staffing needs for mental services of the Commonwealth of Virginia. The course curriculum was proposed as a pilot program in Virginia. As such, this program is the only existing program of its type in the Commonwealth of Virginia at present. The first year of operation was the 1971-1972 academic year. Under the support of the National Institute of Mental Health Grant MH 12772-01, the program funding ended in January of 1973. The College arranged to take over the program using state funds when federal support was discontinued. The total money to be spent over the seven-year life of the pilot program is $328,000. (See Program and Grant Application in Appendix .)

The Mental Health Technology Program at Blue Ridge Community College requires a minimum of ninety-seven quarter credits for graduation. On a full-time basis a student should be able to complete all of his required study in two years. At the end of six quarters the degree of Associate in Applied Science is conferred upon successful graduates. The curriculum of the Mental Health Technology

Program was approved on December 14, 1970, by the Blue Ridge Community College's Local Board (1, pp. 71-73).

One part of the Mental Health Technology curriculum reflects the statewide policy for general education courses. These general education courses are Economics, English, Government, Orientation, Psychology, and Physical Education. A second part is coordinated practice at Western State Mental Hospital. The third part is courses in Introduction to Mental Health, Coordinated Practice, Advanced Mental Health, and Seminar and Project; these courses constitute the basic program for Mental Health Technology. The college plan to substitute a gradually increasing amount of coordinated practice for a gradually decreasing amount of academic studies. (See Curriculum in Appendix C.) It is from this core that the inventory of program objectives was developed for this dissertation.

The program does not now have a definite written set of objectives other than to train students to work in the mental health setting. Each community mental health agency seems to have its own ideas regarding the type of person it would like to see emerge from the degree program.

Open Admissions vs. Selective Screening

It is common knowledge that the community college holds what is called an open door policy (10, p. 29; 7, p. 150). According to Clark, ". . . the junior college is expected

to admit all applicants, without regard to ability, type of curriculum completed in high school, or any other aspect of background" (4, p. 45). This point of view allows students unrestricted choice in the selection of a major occupation or field of study. The Carnegie Commission on Higher Education found this policy widely adopted in their often quoted study on The Open-Door Colleges: Policies for Community Colleges (3). It is not the object of this chapter to question this philosophy, simply to report on the consequences when it is carried to extreme limits.

In the first year of operation the Mental Health Technology Program at Blue Ridge Community College admitted all students into the program on an open admissions policy. The result was that the program seemed to attract those with personality disorders. Out of a total of 20 first year students, eight had problems that had been discovered by staff members. There were two active chronic male alcoholics, one female mental patient who was being treated by a mental health clinic, two female sociopaths, one man convicted of abducting a child, one inmate on parole from a state prison, and one female with adjustment problems. In addition there were also a female student who was an ambivert and a female "couple" who were alleged to be lesbians. While most of these personality patterns did

not interfere vicibly with the education program, a number of questions did arise.

The first question was obviously how would the collective and individual conditions of the students effect the patients that they worked with in field training? Unfortunately, no answer is forthcoming, as no data is available to answer the question.

One short example will indicate the severity of the problem. Both male alcoholic students went on what was called by the local population as a "bender," a long-term "drunken behavior" pattern (6, p. 1), which lasted four weeks, during which the two students did not attend class or report to their field work station at the state hospital. Upon return, both students expected passing grades, making the assumption that open admission indicated automatic graduation.

The second question raised is what level of mental stability is needed in order to enter the field of mental health. No criteria are available to answer this question. Even if there were some, unfortunately, it is difficult for a state-supported institution to prevent a student from taking any tax-supported program he selects.

The third question raised is how does the college "counsel out" or drop a student from the program. In the case of Blue Ridge Community College, like other schools

of its type, there are no procedures established for this. This again is part of the open-door policy.

It should be noted that selection criteria were imposed by the Federal Government. These controls, created under the Protection of Human Subjects clause from the National Institute of Mental Health, were intended to prevent injury to a patient or a student. This regulation provided an incentive for screening students. There were few controls placed upon the staff, however, to abide by the regulation. In any event, the second group of students showed a marked increase in stability.

Types of Students in Mental Health Technology

The enrollment at public two-year colleges has increased from 551,760 in 1959, to 2,051,493 in 1969 (8, p. 3). In his research Harbin has called the community college "People's Colleges" because they tend to serve all the people in an area or community (5, p. 43). What types of students did we find in the Blue Ridge Community College Mental Health Technology program? Harbin lists four types of students who find junior colleges especially attractive: those who

1. Wish to qualify as rapidly as possible for job.
2. Have family obligations and can't leave home.

3. Are disadvantaged and need to overcome their earlier neglect.

4. Are ambitious but financially poor (5, p. 47).

From a review of academic records it was determined that all students in the Blue Ridge program fit into one or another of these categories. Ten students were former aides at the local state hospital and were on fellowships from the state.

All of the students in the program were interested in training, not education. The major question asked of the faculty was: "When I get my degree, what can I do with it?" Thus, pressure was on the faculty to prepare these students for one type of job, while theory stated they should be trained as generalists.

Although the students were not in a transfer type of program, many of them wanted to use the program for this purpose. Those students on fellowships from the state were prevented from taking liberal arts courses not listed in the catalog under required subjects (9, p. 182). Such problems took a great deal of time away from program development.

Role of the Advisory Committee

At most community colleges an occupational advisory committee helps with the development of each program. According to Riendeau,

> . . . the function of the occupational advisory committee is to advise junior college administrators regarding instructional programs in specific . . . occupations. This committee should be concerned with the particular occupational educational area which it represents as it relates to the overall educational program (13, p. 28).

In the document A Guide for Health Technology Program Planning, the authors call for collaboration with accrediting organizations and for the organization of a general advisory committee (11, pp. 16-18). Blocker, Plummer, and Richardson state, "Advisory committees have been a part of two-year colleges for many years" (1, p. 191). Thornton adds, "such committees in any instructional field are useful adjuncts to administration" (14, p. 122).

The program at Blue Ridge Community College, however, did not have an advisory committee meeting in its first year of operation. In the second year of operation an advisory committee was created on paper but was never authorized to meet. This fact alone hindered program development.

The reason the advisory committee did not meet was role conflict between two state institutions. The state hospital had trained an earlier group of mental health workers on an "on the job training" pilot program. Later, the state asked the community college to help write a grant request through the state hospital. It was feared by the college faculty that if the mental health committee

ever held any meetings, the program would go back to the state hospital. This jealousy prevented cooperation between agencies, prevented the program from attaining any of its stated goals, and jeopardized all future operations. In addition, curriculum development was inhibited. Reynolds states, "the development of the junior college curriculum depends on those innovative and inventive people who discover better ways of doing things and are able to expand fields of service . . ." (12, p. 119). But innovation was stifled at Blue Ridge because there was no functioning agency to which improvements could be suggested.

This problem had several further ramifications. One, in particular, exacerbated the already poor relations between the state hospital and the college. The state hospital did not have the space or staff to offer field experience to all the students. Consequently, the program head had to go to the Virginia School for the Deaf and Blind, the Department of Social Services, the Department of Public Health, and the Sheltered Workshops of the Division of Mental Retardation to arrange for the needed extra field work. He also had the problem of finding agencies that would hire graduates. In an ordinary situation the directors of these agencies would be on the advisory committee, and if the program was adequate and

the students successful, would take an interest in and employ these students. Since there had not been much advance planning by the two feuding organizations, the state hospital did not have the funds to hire all of the first-year graduates. The faculty hoped that the four other state agencies would provide jobs for the students who had done their field work with them. And, indeed, the Virginia School for the Deaf and Blind wanted to use as house parents some of the students who would gain their experience in field work at that institution. This arrangement would also fall into the generalist model that the SREB has supported since 1966. Hence, four months after planning began, all students were placed, some at the state hospital and the rest at the other four institutions. The college was satisfied with the placements.

By the time the program actually got under way, however, the situation at the hospital had changed drastically; it now had a shortage of aides to cover many of its wards. The program head was called to an organization meeting at the state hospital. At this meeting the state hospital said that it would take all the students, that it would use them to cover the wards that were short of staff, and that the state hospital staff did not think the other agency placements were adequate.

The faculty, on the other hand, felt that the students should not be on the wards without supervision. The college retained its original plan and thus further alienated the state hospital.

A second related outgrowth of the lack of cooperation between college and hospital was program staffing and teaching patterns. In the past the state hospital had provided occasional lectures for the college program; these lectures had been paid out of the grant. At the start of the 1972-1973 school year the college ended this practice. The reason given was as follows: "This is now our program, and we should have total control over it."

There were still further consequences of the poor relationship between the college and the hospital. The students, who were placed at the state hospital for an 11-week period of an academic term, were asked by hospital officials to work over exam week. When this was made known to the college, the question was asked: "Who runs this program, the state hospital or the college?" Since the college felt it was its program, students were advised not to do their fieldwork during exam week. This created additional bad feeling.

Despite the social dysfunction that was evident between these two state agencies, a set of program objectives was developed. (See Appendix A.) However, the

college's insistence on establishing role primacy over the state hospital did not facilitate positive patterns of interaction. The resulting antagonism had negative results upon social events, modes of behavior, and the status structure for mental health technicians. In the last analysis, the worst of these outcomes was that the status of the students was made inconsistent. This re- resulted in the types of anxiety that were alluded to in an earlier chapter.

In summary, the experience at Blue Ridge Community College indicates that every effort should be made to prevent extraneous variables from intervening in operations. Curriculum development and program development, according to Reynolds, are administrative responsibilities, with the control resting with the faculty (12, p. 201). When time-tested methods of operation are circumvented, trouble is sure to come.

CHAPTER BIBLIOGRAPHY

1. Block, C. E., Robert Plummer, and Richard C. Richardson, The Two-Year College: A Social Synthesis, Englewood Cliffs, N. J., Prentice-Hall, Inc., 1965.

2. Blue Ridge Community College, Bulletin, 1971-1972 Blue Ridge Community College, Weyers Cave, Virginia, 1971.

3. Carnegie Commission on Higher Education, The Open-Door Colleges: Policies For Community Colleges, New York, McGraw-Hill, 1970.

4. Clark, Burton R., Open-Door College, New York, McGraw-Hill, 1960.

5. Fort Hays Kansas State College, The Community Junior College, a report of an institute for faculty, administrators, and trustees of community colleges, held June 18-July 28, 1973, Hays, KS, 1973.

6. Glaser, Daniel and Vincent O'Leary, Parole Decision-Making Report, JD-5003, Office of Juvenile Delinquency and Youth Development, The Alcoholic Offender, Washington, U. S. Government Printing Office, 1968.

7. Kellery, Win and Leslie Wilbur, Teaching in the Community Junior College, New York, Appleton-Century Crofts, 1970.

8. Koltai, Leslie and Alice S. Thurston, "The Community Colleges," American Junior Colleges, Eighth Edition, Edited by Edmund J. Gleazer, Jr., American Council on Education, Washington, D. C., 1971.

9. Medsker, Leland L., "Community College Education," The Encyclopedia of Educational Research, Fourth Edition, Edited by Robert L. Ebel, a project of the American Educational Research Association, London, Macmillan Co., 1969.

10. Moore, William, Jr., Blind Man on a Freeway, Jossey-Bass, Inc., Publishers, 1971.

11. Report of the American Association of Junior Colleges and the National Health Council Ad Hoc Committee: A Guide For Health Technology Program Planning, Washington, D. C., 1967.

12. Reynolds, James W., The Junior College, New York, Center for Applied Research in Education, 1965.

13. Riendeau, Albert J., The Role of the Advisory Committee in Occupational Education in the Junior College, American Association of Junior Colleges, Washington, D. C., 1967.

14. Thornton, James W., The Community Junior College, New York, John Wiley and Sons, Inc., 1960.

CHAPTER IV

PROGRAM OBJECTIVES FOR MENTAL HEALTH TECHNOLOGY: ACCEPTANCE, PROGRAM EVALUATION AND SUMMATION

Chapters one and two described the factors used by the Southern Regional Education Board in constructing its list of program objectives for mental health technology. In Chapter three we examined one program in this area. The present chapter will outline the procedures used to seek acceptance for the inventory of objectives and correlate it with the evaluation of a representative group of academic course requirements basic to Mental Health Technology.

Description of Sample

For this study forty-two department heads or directors of mental health technology programs were given thirty minutes at the start of the National Faculty Development Conference to fill out the inventory. From the total sample of forty-two, a jury of twenty-one was selected by use of a table of random numbers (1, pp. 113-134). This jury was selected from a list compiled by the order in which the inventory documents were turned in to the

researcher. This added mix was a further control over the descriptive research. (See Table I.) The sample was comprised of active directors or department heads listed in the "College Participants" section of the roster for the August 14-16, 1972, National Faculty Development Conference for the Southern Regional Education Board's Community College Mental Health Workers Project.

TABLE I

A CONSECUTIVE LISTING OF SCHOOLS SUCCESSFULLY COMPLETING AND SUBMITTING THE INVENTORY OF PROGRAM OBJECTIVES FOR DATA ANALYSIS

*1. Walters State Community College, Morristown, Tennessee
2. Amarillo College, Amarillo, Texas
*3. Hinds Junior College, Rayond, Mississippi
4. Utah Technical College, Provo, Utah
5. Flathead Valley Community College, Kalispell, Montana
6. Gadsden State Junior College, Gadsden, Alabama
*7. Jefferson State Junior College, Birmingham, Alabama
*8. Corning Community College, New York
9. Floyd Junior College, Rome, Georgia
*10. Midlands Technical Education Center, Columbia, South Carolina
*11. Daytona Beach Community College, Daytona Beach, Florida
12. Palm Beach Junior College, Lake Worth, Florida
*13. Wayne Community College, Goldsboro, North Carolina

TABLE I--Continued

14. Southeast Community College, Cumberland, Kentucky

*15. Sheppherd at Enoch Pratt Hospital Community College of Baltimore

16. Catonsville Community College, Catonsville, Maryland

*17. Clockamos Community College, Oregon City, Oregon

*18. Maricopa Technical College, Phoenix, Arizona

19. Delgado Junior College, New Orleans, Louisiana

20. Central Piedmont Community College, Charlotte, North Carolina

*21. North East Alabama State Junior College, Rainsville, Alabama

*22. Virginia Western Community College, Roanoke, Virginia

23. Santa Fe Community College, Gainesville, Florida

24. John C. Calhoun State Technical Junior College, Decatur, Alabama

25. Community College of Philadelphia, Pennsylvania

*26. Western Piedmont Community College, Morgantown, North Carolina

*27. Jefferson Community College, Louisville, Kentucky

28. Chemeketa Community College, Salem, Oregon

29. Anchorage Community College, Anchorage, Alaska

*30. Nebraska Western College, Scottsbluff, Nebraska

*31. Sinte Gleska College, Rosebud, South Carolina

*32. Rio Honda College, Whittier, California

*33. Durham Technical Institute, Butner, North Carolina

*34. St. Gregory's College, Shawnee, Oklahoma

TABLE I--Continued

35. Golden West College, Huntington Beach, California

36. Metropolitan State College, Denver, Colorado

37. Los Angeles City College, Beverly Hills, California

38. American River Community College, Sacramento, California

*39. Greenville Technical, Greenville, South Carolina

40. Craven Technical, New Berm, North Carolina

*41. University of Maine, Bangor, Maine

42. Mt. Hood Community College, Gresham, Oregon

*College Selected in Random Numbers Sample

The jury used a Likert-type scale, having these choices: (1) strongly approve, (2) approve, (3) undecided, (4) disapprove, or (5) strongly disapprove. In the inventory each respondent indicated his response by checking the area indicated. An IBM data card method was used in the analysis of evaluation factors. Scoring was accomplished by giving +2 to the "strongly approve" category, +1 to the "approve" category, and -3 to the "strongly disapprove" category. After a pretest the scoring was arbitrarily selected in the manner indicated.

The final list of program objectives was retained on the basis of the evaluation dimension holding a plus rating. Therefore, any item with a +0.5 rating was considered favorable and retained on the basis of this score.

A mean score of between +2.00 to +1.70 would be ranked highly favorable. A score of +1.69 to +1.00 would be ranked favorable, while a score of +0.99 to +0.50 would be considered low favorable. Those items with scores from +0.49 to -3.00 would not be retained as they would be considered unfavorable.

Analysis of Data

Each item in the inventory of program objectives was examined by the IBM process regarding the response to each item. Out of 217 items, 21 were rejected. Another 36 items were ranked in the highly favorable category. In the favorable category 130 items were retained. As a check on consistency, item 185 was repeated and both items received an exact score of +1.62. It was felt that this test-retest reliability would indicate if individuals were reading the items with care or simply checking of items at random. As it turned out it indicated that respondents were reading the items. The last area in which any items were retained was the low favorable category, which included 31 items.

The Highly Favorable Category

1. (Item 19) Identify the psychological methods..non-directive methods (client centered) +1.71
2. (Item 21) Counseling +1.71
3. (Item 23) Group methods +1.70

4. (Item 30) Identify community intervention methods.. consultation +1.81
5. (Item 31) Community planning +1.76
6. (Item 32) Public education +1.76
7. (Item 33) Legislative and administrative process (especially at local community levels) +1.71
8. (Item 121) Construct and study one's self concept +1.81
9. (Item 122) One's abilities +1.81
10. (Item 123) One's personality +1.81
11. (Item 124) One's values +1.76
12. (Item 125) One's philosophies +1.71
13. (Item 126) One's competencies +1.81
14. (Item 127) One's experiences +1.86
15. (Item 128) One's interpersonal style +1.86
16. (Item 129) One's disabilities +1.81
17. (Item 130) One's limitations +1.86
18. (Item 131) One's reaction patterns +1.86
19. (Item 132) One's motivations for mental health work +1.76
20. (Item 133) Skill in interviewing normal and disabled persons..have skill in talking with people comfortably and productively +1.76
21. (Item 134) Have skill in obtaining information "reading" the feeling tones of what people say, and observing and reporting behaviors people exhibit in interviews +1.76

22. (Item 136) Have skill in sensing the impact of self on the person being interviewed, and responding appropriately +1.76
23. (Item 137) Skills in observing and recording..have skill in observing behaviors, emotions, and physical characteristics of people and settings +1.75
24. (Item 138) Have skill in using ordinary check forms to record observations +1.70
25. (Item 139) Have skill in recording observations and interview data in simple descriptive fashion (graphic descriptions of exactly what the person is saying and doing) +1.70
26. (Item 144) Competence in interpersonal skills..non-possessive warmth--the ability to establish a caring but not a consuming relationship with other persons +1.81
27. (Item 145) Have skill in dealing with other mental health workers in various role relationships +1.85
28. (Item 187) Conviction that the mental health worker can help bring about improvements +1.71
29. (Item 188) Considerable intention to work to bring about improvements +1.75
30. (Item 190) Thorough conviction that no person shall be treated in demeaning, patronizing, condescending, or arbitrary ways +1.71

31. (Item 196) Considerable respect and tolerance for different individual and cultural life styles +1.76
32. (Item 203) Considerable awareness of various value systems and of own value system regarding race and racism +1.71
33. (Item 204) Basic awareness of various value systems and own value and attitude regarding human life and death +1.70
34. (Item 206) Awareness of own attitudes and possible implications in work with clients +1.71

The Favorable Category

35. (Item 1) Knowledge of personality theory and function +1.00
36. (Item 5) Identify common personality patterns and behaviors +1.55
37. (Item 6) Knowledge of abnormal psychology +1.24
38. (Item 7) Identify abnormal behaviors +1.24
39. (Item 8) Identify psychopathologic conditions related to children, etc. +1.29
40. (Item 9) Identify behaviors +1.37
41. (Item 10) Knowledge of the conceptual basis for various theories of intervention +1.58
42. (Item 11) Identify the various models for individual client intervention +1.24

43. (Item 12) Identify the principles of treatment, supportive care, rehabilitation, partial disability, etc. +1.40
44. (Item 13) Differentiate between the concepts of prevention, positive health promotion, social systems in intervention, anticipatory guidance, etc. +1.33
45. (Item 14) Identify and compare the methods of intervention with individuals +1.10
46. (Item 20) Psychotherapy (identify psychoanalysis) +1.24
47. (Item 22) Short term eclectic methods +1.62
48. (Item 24) Behavior therapy +1.52
49. (Item 25) Rehabilitation +1.60
50. (Item 26) Therapeutic use of self +1.52
51. (Item 27) Milieu therapy +1.48
52. (Item 28) Activity therapies +1.52
53. (Item 29) Therapeutic community +1.48
54. (Item 40) Recite what to do in the event of abuse of untoward effects +1.29
55. (Item 41) Identify the educational backgrounds, roles, and functions of status considerations of the mental health technologist +1.38
56. (Item 42) List basic information about the related mental health professions +1.67

57. (Item 43) List basic information about the middle-level mental health workers +1.57
58. (Item 45) Identify organizational...structures +1.05
59. (Item 48) Identify concepts in vocational rehabilitation +1.57
60. (Item 49) Identify agencies in corrections, parole, and probation +1.52
61. (Item 50) Identify agencies in public welfare +1.52
62. (Item 51) Identify agencies in community action programs +1.43
63. (Item 52) Identify volunteering agencies +1.43
64. (Item 53) Identify the roles and functions of school counselors, marriage counselors +1.24
65. (Item 54) Identify the roles and functions of private practitioners of medicine and psychiatry +1.29
66. (Item 55) Same as above for clergymen +1.29
67. (Item 56) Identify resources for public agencies--local and statewide +1.62
68. (Item 57) Identify voluntary agencies +1.62
69. (Item 58) Identify private resources for the mentally disabled +1.62
70. (Item 59) Identify the following concepts in sociology +1.20
71. (Item 60) Culture +1.24
72. (Item 61) Socialization +1.24

73. (Item 62) Organization +1.19
74. (Item 63) Definition of groups +1.10
75. (Item 64) Primary and secondary groups +1.10
76. (Item 65) Persistence of primary groups +1.10
77. (Item 66) The power of large organizations +1.19
78. (Item 67) Voluntary associations +1.10
79. (Item 68) Bureaucracies +1.24
80. (Item 69) Effects of organization on the individual +1.43
81. (Item 70) Collective behavior +1.24
82. (Item 71) Characteristics of collective behavior +1.19
83. (Item 72) Crowds, mass behavior and the public +1.05
84. (Item 73) Stratification +1.25
85. (Item 74) Social Stratification +1.25
86. (Item 75) Class rank, determinants, hierarchy, social mobility +1.11
87. (Item 76) Urbanization +1.10
88. (Item 77) Transition from a rural society to an urban society +1.14
89. (Item 78) Urban patterns of mental illness +1.10
90. (Item 79) Characteristics of urban and rural societies +1.33
91. (Item 80) Ecological patterns of urban growth +1.10
92. (Item 81) Urban ecological processes +1.05

93. (Item 89) Social change +1.50
94. (Item 90) The process of social change +1.40
95. (Item 91) Basic factors in the rate of social change +1.30
96. (Item 92) Social movements and social change +1.30
97. (Item 93) Family and kinship systems +1.45
98. (Item 94) Families under stress +1.40
99. (Item 95) Identify the adjustments and changes in married life +1.35
100. (Item 96) Identify marital breakup, deterioration, divorce, and remarriage +1.35
101. (Item 97) Special group behaviors and their implications for practice: institutions and agencies +1.35
102. (Item 98) Professions +1.35
103. (Item 99) Communities +1.35
104. (Item 100) Minority groups +1.35
105. (Item 101) Public officials +1.35
106. (Item 102) List, compare, and contrast data gathering techniques and evaluation procedures in mental health; identify what is done, by whom, indications, rational implications at a basic level +1.10
107. (Item 103) Social history and vocational evaluation +1.14
108. (Item 107) Questionnaires and community surveys +1.00

109. (Item 109) Identify laws, issues, and actions related to mental health +1.05

110. (Item 110) List educational and professional issues relevant to mental health +1.24

111. (Item 111) Identify the social, fiscal, legal, and psychological issues: families, children, adults +1.38

112. (Item 112) The disengaged (the aged, the divorced, widowed and single) +1.38

113. (Item 113) The poor, the rich, the rural, and the urban +1.33

114. (Item 114) Minority groups +1.38

115. (Item 115) Education of the various target populations +1.38

116. (Item 116) Knowledge of physiology of human development and function +1.05

117. (Item 119) Identify normal sexual development and behavior +1.15

118. (Item 140) Have skill in recording subjective impressions of the individual +1.65

119. (Item 141) Have skill in establishing interpersonal relationships with clients, such as demonstrating the three characteristics described by Truax and Corkuff +1.67

120. (Item 142) Genuineness--the ability to be real +1.67

121. (Item 143) Accurate empathy--the ability to correctly "hear" the other person +1.67
122. (Item 146) Have skill in supervising other workers (aides) in a consulting relationship +1.35
123. (Item 147) Have skill in organizing and developing groups as a group process facilitator or consultant rather than as a task leader +1.40
124. (Item 148) Have skill in leading groups as a task leader +1.45
125. (Item 149) Have skill in group counseling +1.45
126. (Item 150) Have skill in group teaching +1.10
127. (Item 151) Have skill in group therapy including family therapy +1.00
128. (Item 152) Skills in coaching for new behavior patterns +1.00
129. (Item 153) Skills in counseling for new behavior and adjustment in client patterns +1.55
130. (Item 154) Skills in behavior modification +1.15
131. (Item 155) Have skills in teaching ordinary skills and knowledge to individuals +1.10
132. (Item 156) Have skill in teaching small groups +1.24
133. (Item 157) Have skill in consulting with other workers about individuals and their problems +1.48
134. (Item 158) Have skill in consulting with small local agencies about their mental health problems +1.19

135. (Item 159) Competence in neighborhood planning +1.19

136. (Item 160) Competence in activating local community resources on behalf of a client or program +1.24

137. (Item 161) Have skill in working with community agencies, professionals, etc., to mobilize their services and competence quickly on behalf of clients +1.67

138. (Item 162) Have skill in mobilizing community resources to serve classes of clients +1.57

139. (Item 163) Have skill in gathering clinical case data and in analyzing, abstracting, and using such data in decision making with due regard for confidentiality +1.00

140. (Item 165) Have skill in organizing information into logical and clear reports; written +1.62

141. (Item 166) Same as above but for oral presentations +1.67

142. (Item 167) Skill in reporting of clinical information about patients or information about programs, problems, or proposals +1.52

143. (Item 168) Skill in presenting reports appropriately for professionals and peers, or lay persons +1.52

144. (Item 169) Competence in ordinary social adaptive skills +1.30

145. (Item 170) Competence in being a role model to patients/clients--to assist them with emotional and behavior adjustments +1.50

146. (Item 171) Level of skill in first aid that would be expected of a rather sophisticated parent +1.25

147. (Item 172) Have skill in recognizing the therapeutic, toxic, allergic, and side effects of the most commonly used psychotropic drugs +1.25

148. (Item 185) Considerable conviction that the mental health of clients, families, and communities can be improved +1.62

149. (Item 186) Considerable conviction that the mental health of clients, families, and communities can be improved +1.62

150. (Item 189) Considerable conviction that knowledge, skills, and attitudes are in continuous change and that a commitment to continuing self-development and education is necessary +1.62

151. (Item 191) Thorough avoidance of labeling people with stereotyped derogatory terminology +1.62

152. (Item 192) Considerable conviction of the importance of being dependable and reliable in work with clients and communities +1.57

153. (Item 193) Considerable conviction of the importance of exercising personal initiative in carrying out work with clients and communities +1.48

154. (Item 194) Thorough conviction of need to respond and make oneself available whenever and wherever needed by the client +1.14

155. (Item 195) Thorough conviction of need to continue to serve the client in some appropriate way +1.57

156. (Item 197) Considerable concern regarding contemporary events, issues, and problems relevant to mental health +1.38

157. (Item 198) Conviction that all the human service professionals are working toward the same basic objectives though each from a different base (respect for differences) +1.48

158. (Item 199) Conviction of the responsibility to promote working with other professionals (rather than waiting for an invitation) +1.45

159. (Item 200) Basic awareness of various value positions and own value system regarding the Protestant work ethic +1.44

160. (Item 201) Awareness of the various attitudes held regarding the Protestant work ethic +1.33

161. (Item 202) Considerable awareness of own value system about work and the implications for worker's expectations of clients +1.62

162. (Item 205) Awareness of how issues of various value systems are manifested in issues of birth control, abortion, prolonging life by technological means, sterilizations, and euthanasia +1.43

163. (Item 207) Awareness of one's and society's attitudes and values regarding poverty, dependency, and income maintenance +1.38

164. (Item 208) Awareness of one's and society's attitudes and values regarding physical and mental disability and the persons afflicted with them +1.45

The Low Favorable Category

165. (Item 3) Identify the terminology and basic concepts of the more common theories of psychological functioning +0.68

166. (Item 4) Identify mental functions and their implications and applications +0.79

167. (Item 34) Identify major chemotherapeutic classes and agents: anticonvulsants +0.86

168. (Item 35) Same for tranquilizers +0.76

169. (Item 36) Same for sedatives +0.86

170. (Item 37) Same for narcotics +0.86

171. (Item 38) Same for energizers +0.76

172. (Item 39) Toxic, allergic, and side effects, as well as therapeutic effects of most commonly used agents +0.90

173. (Item 44) Identify and differentiate between the mental health, and retardation movements: list definitions, terminology, and history including value systems +0.95

174. (Item 47) Identify concepts in the social welfare field: identify the scope of the field and theories underlying various programs +0.90

175. (Item 82) Urbanization: know data about the central city +0.75

176. (Item 83) Same for metropolitan and suburban regions +0.85

177. (Item 84) Same for the concept of the megalopolis +0.71

178. (Item 85) Same for population +0.81

179. (Item 86) Growth of population in the United States +0.62

180. (Item 87) Current characteristics and trends +0.85

181. (Item 88) Population problems of the United States +0.90

182. (Item 104) Identify what is done in physical and neurological examinations +0.57

183. (Item 105) Identify what is done in mental status examinations and psychological tests +0.57

184. (Item 108) List the state, local, and federal laws and actions specific to mental health +0.81

185. (Item 117) Have a basic understanding of human genetics +0.65

186. (Item 118) Identify what is normal physiology, endocrinology, and neurophysiology +0.90

187. (Item 120) Identify pathological areas +0.79

188. (Item 164) Have skill in gathering clinical case data and in analyzing, abstracting, and using such data in decision making with due regard for confidentiality +0.90 (Due to typing error on original this response should be omitted.)

189. (Item 173) Have skill in recognizing and evaluating the signs and symptoms of common illnesses +0.65

190. (Item 174) Have skill in first aid for common medical problems +0.50

191. (Item 175) Have skills in a variety of recreational activities +0.70

192. (Item 176) Have skills in a variety of crafts activities +0.57

193. (Item 178) Have skills in dramatic arts +0.55

194. (Item 179) A mental health worker should have some competence in activity skills with considerable skill in at least one +0.85

195. (Item 180) Skills in remotivation and teaching of remotivation for aides +0.55

The Unfavorable Category

An item was rejected specifically if it had a score from +0.49 to -3.00. The score tended to indicate that the respondents felt this knowledge or level of performance was not necessary for a mental health worker.

196. (Item 2) To identify the most common concepts of normal personality growth and development from infancy to maturity and old age. Include orality and anality and their implications for personality functions +0.37

197. (Item 15) Identify and compose the methods of intervention with individuals: Electroconvulsive treatment +0.00

198. (Item 16) Same for: chemotherapies (not prescribe, but to participate) +0.20

199. (Item 17) Same for: hydrotherapy -0.40

200. (Item 18) Same for: physical therapy +0.05

201. (Item 46) Recite major contemporary legislation and commitments (for mental health and retardation movements) +0.48

202. (Item 106) List, compare, and contrast data gathering techniques and evaluation procedures: special studies--EEG, laboratory +0.45

203. (Item 177) Have skills in dramatic activities (singing, playing an instrument in a band or orchestra, etc.) +0.48

204. (Item 181) Skills in special therapies +0.29

205. (Item 182) Attitude therapy -0.10

206. (Item 183) Play therapy +0.43

207. (Item 184) Bibliotherapy +0.33

208. (Item 209) Other program objectives specifically for use in the mental hospital setting: to work as a team member in the process of evaluation and co-ordination of treatment +0.33

209. (Item 210) To recognize the interrelationships between physical and mental illnesses and the need for total emotional, environmental, and health services +0.33

210. (Item 211) To integrate classroom knowledge of social, medical, and psychological pathology into psychosocial diagnostic skills needed by the helping person +0.14

211. (Item 212) To relate theories of behavior to situations encountered in field experience +0.29

212. (Item 213) To protect the patient from self destructive acts +0.19

213. (Item 214) To distinguish the functions and roles of various professions found in helping agencies -0.33

214. (Item 215) To possess the necessary abilities, interest, personality, and maturity, to benefit from such experiences -0.60

215. (Item 216) To work with patients individually and in groups and to conduct group discussions and activities with assigned patients -0.45

216. (Item 217) To maintain activities, psychodrama, dental care, meals, movies, and other recreational activities -0.40

The evaluation of the twenty-one schools was made by a jury of five experts from the Southern Regional Education Board and the Center for Human Services Research of Johns Hopkins University. Table II indicates the tabulation results prepared by the same IBM method (2).

With the exception of item number seven all other items were accepted. In course content area six the judges' average was +1.2, and for item 163, the average was +1.0. This seems to indicate agreement. With regard to legal information, in course content area 17, the judges' response was +1.2, while the corresponding item, 108, shows +0.81; the agreement is a little farther apart in this area. In course content area 14 the judges' average was +1.2, and for item 112, which corresponds, the score was +1.38, which is in close agreement. In course content area 12 the judges'

TABLE II

TABULATION OF OPINIONNAIRE

Course Content Areas	Frequency of Response					
	+2 Strongly Approve	+1 Approve	0 Unde-cided	-1 Dis-approve	-2 Disapprove Strongly	Item Average
1. Orientation to human services or allied health careers, orientation to mental health technology.	5	0	0	0	0	+2.0
2. Introduction to mental health or mental health technology I.	3	2	0	0	0	+1.6
3. General or Introduction to Psychology.	4	1	0	0	0	+1.8
4. Mental health techniques (psychology), psychology for mental health workers.	5	0	0	0	0	+2.0
5. Psychology of interpersonal relations, technique(s) of working with individuals, group processes.	4	1	0	0	0	+1.8

TABLE II--Continued

Course Content Areas	Frequency of Response					
	+2 Strongly Approve	+1 Approve	0 Unde-cided	-1 Dis-approve	-2 Disapprove Strongly	Item Average
6. Introduction to tests and measurements, psychological testing.	2	2	1	0	0	+1.2
7. Hospital administration, ward supervision for nursing services and medical staff.	0	0	3	1	1	-0.6
8. Learning theory and behavior change.	4	1	0	0	0	+1.8
9. Psychopathology and Psycho-social problems.	5	0	0	0	0	+2.0
10. Small group lab, class-room lab for group processes, and group dynamics.	5	0	0	0	0	+2.0
11. Social agency case inter-view, social casework interview, and case study.	3	2	0	0	0	+1.6

TABLE II--Continued

Course Content Areas	Frequency of Response					
	+2 Strongly Approve	+1 Approve	0 Unde-cided	-1 Dis-approve	-2 Disapprove Strongly	Item Average
12. Introduction to occupational and recreational therapy, mental health recreational activities.	2	1	2	0	0	+1.0
13. Introduction to technique(s) of working in mental hospitals.	1	4	0	0	0	+1.2
14. Introduction to long term care with aged (gerontology) and chronically ill mental patients.	2	2	1	0	0	+1.2
15. Advanced study in physical and mental illness.	3	1	1	0	0	+1.4
16. Rehabilitation of the mentally retarded and mentally ill.	3	2	0	0	0	+1.6

TABLE II--Continued

Course Content Areas	Frequency of Response					
	+2 Strongly Approve	+1 Approve	0 Unde-cided	-1 Dis-approve	-2 Disapprove Strongly	Item Average
17. Introduction to legal information for mental health workers.	2	2	1	0	0	+1.2
18. Mental health practicum, field placement, internship, coordinated practice.	4	1	0	0	0	+1.8
19. Sociology area: Introduction or principles of sociology, sociology of mental health, social aspects of mental health and mental retardation.	4	1	0	0	0	+1.8

averaged +1.0; the corresponding item, 179, is +0.85, thus showing further agreement.

There was also agreement regarding the generalist model concept. Items tending to indicate specialization, such as items 18, 177, 181, 182, 183, 184, and 17 were all specifically rejected. This seems to show acceptance of this model by department heads and directors.

The mean rate of acceptance by the judges was 100 percent for course content items 1, 4, 7, and 10, which tends to be indicative of strong group consensus. The one item which was rejected (number 7) did not agree with the generalist model and seemed to be more in the aide culture.

Summary and Discussion

A tentative inventory of program objectives for a community college mental health technology program was adapted from SREB data as a questionnaire and was submitted to department heads and directors of mental health technology programs for their validation as to whether or not each of the items was a necessary element of knowledge or performance levels.

A panel of five experts was then asked to evaluate course content areas by use of an opinionnaire. The opinionnaire listed core course samples taken from the twenty-one respondent schools participating in seeking acceptance

for the inventory of program objectives. These core course samples were listed in the catalogs of the respondent schools. It was arbitrarily determined that any item to be retained as valid must have received a positive score of no less than +0.50 out of a possible +2.00.

The panel of five experts, in the ipinion of the researcher, did not hold the undecided category as negative. This category was given a score factor of zero. However, in a pre-test of department heads or directors, the undecided category was found to be not neutral but negative. Therefore, the questionnaire submitted to department heads or directors held the undecided category as a -1.00 score.

The questionnaire was passed out to department heads or directors at the 1972 conference. Each respondent had thirty minutes at the start of the convention to fill out the inventory questionnaire. As the questionnaires were returned, they were numbered so that they were in order. From the sample of forty-two, a jury of twenty-one was selected by use of a table of random numbers. The data was then subjected to an IBM data card method of analysis.

The opinionnaire was mailed out to a jury of five experts:

1. Dr. Harold L. McPheeters, M.D.
   Director for Mental Health Training and Research
   Southern Regional Education Board

2. Mr. James B. King, M.A.
   Director
   Community College Mental Health Workers Project
   Southern Regional Education Board

3. Dr. E. Jo Baker, Ph.D.
   Consultant for Research
   Southern Regional Education Board

4. Dr. John E. True, Ph.D.
   Director
   Center for Human Services Research

5. Dr. Carl E. Young, Ph.D.
   Assistant Professor
   Center for Human Services Research
   Johns Hopkins University

At the end of a four-week period of time all of the responses had been returned. The data from Table II contains the findings from these experts.

Of the nineteen items the jury tended to be in strong agreement on eighteen areas of course content. The opinionnaire did list one area not covered in the inventory. This category was listed as number seven, or "hospital administration, ward supervision for nursing services and medical staff." This question was designed to act as a check and balance to test the jury. The logic was to ascertain if there was agreement on the proper professional roles that mental health technicians should be taught in such an educational program. The result was that the jury did in fact reject number seven with a score of -0.6.

The data tends to show consensus among the department heads and directors regarding what knowledge or performance

levels should be taught. The five experts also showed consensus regarding the group of academic course requirements basic to mental health technology that they accepted.

CHAPTER BIBLIOGRAPHY

1. Sax, Gilbert, Empirical Foundations of Educational Research, Englewood Cliffs, N. J., Prentice-Hall, Inc., 1968, citing George W. Wnedecor, Statistical Methods, Ames, Iowa, The Iowa State University Press, 1962, pp. 10-13.

2. Staudt, E., 1401 Generalized Tabulate with or without Control Fields--1.4,226, Contributed Program Library, Program Information Department, International Business Machines Corporation, Poughkeepsie, N. Y., no date.

CHAPTER V

SUMMARY, FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This study was the result of experience and interest in the recent creation of the Mental Health Technology paraprofessional training program in community colleges in the United States. From the start of the Purdue University program in 1966, there has been an increase to about 150 programs nationwide.

The Federal Government has recognized the need for additional mental health services and staff. Various programs, such as The Allied Health Professions Personnel Training Act, The Experimental and Special Training Programs of the National Institute of Mental Health, and various other programs have noted the need for paraprofessionals to fill the manpower gap. However, such programs have grown rapidly without much analysis. This divergence from normal practice created a need for studies of various types, among them to seek acceptance of an inventory of program objectives which had been adopted for community college mental health technology programs by the Southern Regional Education Board. The SREB was aware of the need

for more information about the purposes and goals of such programs and cooperated fully in the research.

The purposes of this study were to

1. Seek acceptance for an inventory of program objectives for mental health technology graduates.

2. Review the literature from the field of mental health technology.

3. Secure a jury of department heads or directors to seek acceptance for an inventory of program objectives.

4. Use a panel of five or more experts to evaluate core course samples taken from the respondent schools participating in the consensus and to secure from this evaluation data regarding which courses professionals (both professional educators and mental health workers) prefer.

5. Answer the following pedagogical questions:

    a. What is the meaning of the directors' responses to the objectives?

    b. What is the meaning of the SREB's response to the courses?

    c. What elements of likeness(s) emerged?

6. The last purpose of the study was to formulate the findings of the study into a unified, valid inventory of program objectives for mental health technology education. Such an inventory could be used to define the role of

community colleges in meeting the common requirements of paraprofessional mental health workers.

The first phase of the study involved a review of the rather scant literature on training paraprofessional level mental health workers. This was done in order to identify some of the specific roles mental health workers would play in staffing patterns. After these "generalist" roles were determined, they were examined from the view of obtaining broad roles which covered the mental health staffing patterns.

After ascertaining the roles, the second phase adopted an inventory of program objectives from the Southern Regional Education Board's study of knowledge and performance levels required of paraprofessional mental health workers. The common roles of paraprofessional mental health workers were thus approached through the perspective of the professional-occupational offerings in the social and behavioral sciences. Those knowledge and performance levels which were accepted by the SREB as being fundamental in nature were listed as a Tentative Inventory of Program Objectives for a Community College Mental Health Technology Program.

The third phase of the study involved the acceptance of the Tentative Inventory of Program Objectives for a Community College Mental Health Technology Program. The

procedure used to accomplish this consisted of submitting the inventory to those department heads or directors present at the 1972 National Convention of Mental Health Technology Educators held in Louisville, Kentucky. Each department head or director had thirty minutes at the start of the convention to fill out the inventory. From the total sample of forty-two, a jury of twenty-one was selected by use of a table of random numbers. The sample thus selected was tabulated by use of a 1401 IBM computer.

The jury used a Likert-type scale, having these choices: (1) strongly approve, (2) approve, (3) undecided, (4) disapprove, or (5) strongly disapprove. In the inventory each respondent indicated his response by checking the area indicated. Scoring was accomplished by giving +2 to the "strongly approve" category, +1 to the "approve" category, a score of -1 to the "undecided" column, -2 to the "disapprove" category, and -3 to the "strongly disapprove" category. A pretest indicated that a score in the "undecided" column was a negative response. Therefore, on the basis of this pretest an arbitrary score of -1 was given to this category.

A final list of program objectives was retained on the basis of the evaluation dimension holding a plus rating at the +0.50 mean score level. Therefore, any item with a +0.50 rating was considered favorable and retained on the

basis of this score. A mean score of between +2.00 and +1.70 was ranked highly favorable. A score of +1.69 to +1.00 was ranked favorable, while a score of +0.99 to +0.50 was considered low favorable. Items with scores from +0.49 to -2.00 were not retained as they were considered unfavorable. The program objectives in question suggested the needed knowledge and types of performance levels required for a mental health worker at the paraprofessional level.

Phase four took the final list of program objectives and matched them to the existing curriculum of half of the schools from which the department heads or directors of phase three came. This resulted in the development of an opinionnaire, which was mailed out to a panel of five experts. The evaluation of the opinionnaire was carried out in the same manner as for the Tentative Inventory of Program Objectives. Scoring was similar except that the "undecided" column carried a score of zero because in a pre-test a response to this category was considered to be neutral, not negative.

Phase five had as its focus the answers to some pedagogical questions, utilizing the data as a practical guide for program operation. This area will be treated further under the section on findings.

Findings

Within the "generalist" concept of mental health technology there were ten roles found through which role functions could be performed. These were

1. (Social) Advocate.
2. Administrator.
3. Behavior Changer (a houseparent, for example).
4. Broker (a worker who arranges for treatment, etc.).
5. Community Planner (a worker who assists in the development of a community mental health volunteer program, for example).
6. Consultant.
7. Data Manager.
8. Evaluator.
9. Mobilizer (a worker who assists in the promotion of community mental health services, for example).
10. Outreach Worker (a worker who assists a rural population to obtain needed mental health services, for example). (1, pp. 13-14).

The above roles match those suggested by King and McPheeters.

Directors of mental health technology programs ranked thirty-six social and behavioral science concepts as highly favorable; that is, these concepts were perceived as providing some amount of sufficient knowledge or performance levels for the ten role functions of mental health workers. These thirty-six items are shown on Table III. In the favorable category 130 items were retained. As a check on consistency, item 185 was repeated, and both items received the same score. The last area in which any items were retained was the low favorable category, in which 31 items were selected as important enough to retain. An acceptable set of program objectives could be devised either by using

TABLE III

ITEM GROUPING FROM THE TENTATIVE INVENTORY OF PROGRAM OBJECTIVES

I. Highly Favorable Category

Item	Item	Item	Item	Item
19	21	23	30	31
32	33	121	122	123
124	125	126	127	128
129	130	131	132	133
134	136	137	138	139
144	145	187	188	190
196	203	204	206	

II. Favorable Category

Item	Item	Item	Item	Item
1	5	7	8	9
10	11	12	13	14
6	20	22	24	25
26	27	28	29	40
41	42	43	45	48
49	50	51	52	53
54	55	56	57	58
59	60	61	62	63
64	65	66	67	68
69	70	71	72	73
74	75	76	77	78
79	80	81	89	90
91	92	93	94	95
96	97	98	99	100
101	102	103	107	109
110	111	112	113	114
115	116	119	140	141
142	143	147	148	149
150	151	152	153	154
155	156	157	158	159
160	161	162	163	165
166	167	168	169	170
171	172	185-186	189	191
192	193	194	195	197
198	199	200	201	202
205	207	208		

only the highly favorable category or by integrating the highly favorable and favorable categories.

Three pedagogical questions may be asked:

1. What is the meaning of the directors' responses to the objectives?

Answer: The data indicates that the department heads and directors accept the "generalist" model advocated by the SREB. Items reflecting specialization, such as Items 17, 18, 182, 183, and 184, were all specifically rejected. This seems to indicate acceptance of which areas of specialization are perceived as necessary by department heads and directors.

2. What is the meaning of the SREB's response to the courses?

Answer: The item used to test agreement with an item not within the SREB's set of program objectives was rejected, as it should have been, with a score of -0.6. Course content area number six was rated +1.2 by the five judges, and corresponding Item 163 was rated +1.0 by the department heads and directors. With regard to legal information, course content area 17, the five judges' response was +1.2, while the equivalent Item 108 drew +0.81 from the faculty. Although in this area, the two groups were a little farther apart, general agreement is indicated. In course content area number 14 the five judges averaged +1.2; for Item 112, which corresponds for

the faculty, the score was +1.38, which is in close agreement. In course content area 12 the five judges averaged +1.0; that Item 179 was rated +0.85 by the directors shows further agreement. The data tends to indicate that the training and coordination efforts of the Southern Regional Education Board's Community College Mental Health Workers Project, funded by the National Institute of Mental Health, was a successful experiment in that it seems to have created faculty with clearly defined program objectives. As a result of Faculty Development Conferences, a unified teaching and role model for mental health technicians seems to have developed.

3. What elements of likeness emerged?

Answer: The data tends to indicate that among the twenty-one directors or department heads there is agreement regarding program objectives. The experts tend to agree with what the faculty are teaching with regard to knowledge and performance levels. Both groups accept the "generalist" role model for mental health technicians. Both groups tend to reject the specialization model used by many other paraprofessional groups.

Conclusions

The paraprofessional mental health worker movement started only recently, in 1966, and it is still developing.

Data tend to indicate that it is doing so in a unified and organized manner within those schools cooperating with SREB's team. Although additional research and improved evaluation methods are needed to improve the knowledge base, the following conclusions are offered

1. Although the ten role functions of the mental health worker are unique, they meet the criteria for the "generalist" model. The emphasis on these roles will tend to increase in the future as the manpower gap widens.

2. Comparison of the overall response by the faculty directors and department heads with that of the five experts suggests that both groups tend to agree on how mental health technicians should be trained. The exclusion of 21 "specialist" items indicates the acceptance of the "generalist" model. However, the shortcomings of the method provide data that is not validated but simply show a low level of acceptance by those faculty at the SREB Conference.

3. The inventory of program objectives for mental health technology which was accepted by this study suggests what the faculty at the SREB Conference agree should be a nucleus of concepts from which curricula for community colleges may be developed. It defines a major role to be played by community colleges, and by inference posits an orientation for program development in the field which

requires both acceptance of SREB guides and academic operation using time-tested methods. Such methods include the conscious use of program guidelines and the implementation of positive communication among authorities who share mutual interest in program development. Proper funding for lead-time academic and career organization would also seem essential. For example, if a state or federal agency plans to hire program graduates, sufficient appropriations should be made in time to hire the first group of graduates. There is a necessity for setting forth, for the benefit of students, a definite set of program objectives (see example in Appendix C) and similar standards for teaching and administrative personnel.

Implications

While data may not fully support the following suggestions, experience coupled with data from the field leads to the following observations:

1. The Mental Health Technology curriculum based upon the inventory of program objectives can be easily adopted for use in the community college setting as well as for other programs. (See Appendix C.) Workers who have graduated from several of these programs are able to furnish quality service which is required by patients/clients who are acutely in need of a responsible generalist to assist them in a variety of roles.

2. Community colleges will have an increasingly important effect on mental health technology training in the future. A. A. degree paraprofessionals have in many cases up-graded service and brought about positive changes in the mental health system. The "generalist" model may replace that of the old "aide." The new paraprofessional model should ameliorate the old "custody care" atmosphere found in many institutions. The positive acceptance of the enclosed program objectives, with their reliance upon the social and behavioral sciences, should go a long way in training effective, sensitive mental health paraprofessionals.

3. As of yet, very few paraprofessional mental health workers have the experience to become community college educators. Therefore, there may be a gap between theory and practice. How can a registered nurse, instructing mental health paraprofessionals, teach the students how to work in a role situation that she herself may never have encountered? There is no question that the field must develop more qualified academicians who have had actual work in a variety of mental health agencies. The end goal is to develop education and training courses which will provide the best patient treatment and care.

4. The tasks of the mental health technician under SREB guides will tend to demand an A. A. degree or some

other form of academic preparation. This will be required in order to have a viable understanding of role requirements.

5. In the case of the mental health technician, academic requirements seem to be almost synonymous with training needs as perceived by the trainers. The response of both groups of experts confirms the fact that certain levels of knowledge or types of performance found in the social and behavioral sciences could be required with a mix of field experience training. The SREB takes the stand that community colleges are capable of providing this mix of traditional and applied concepts.

Recommendations

In light of the findings, conclusions, and implications of this study, the following recommendations are made:

1. That additional research be conducted which would develop an interfacing between community college mental health worker programs and those of four-year institutions of higher education.

2. That additional research be conducted to determine the most desirable types or combinations of experience and education needed for faculty who will either administer or teach mental health technology programs in the community college.

3. That additional research be conducted to develop a community college specialist in administrative liaison with governmental staffing and financing agencies, in order to remove this function from the faculty work load.

4. That additional research be conducted to endeavor to ascertain the types of social forces that most often cause disruptions of program development in the field.

5. That additional research be conducted to develop adequate screening methods to prevent students with various psychopathological conditions from entering paraprofessional mental health programs and risking great disruptions in their stability or that of a client.

6. That continued emphasis be placed on the research efforts of the Southern Regional Education Board's Community College Mental Health Workers Project to assess the changing needs of faculty, paraprofessionals, community college programs, and the needs of the mental patients.

7. That additional research be conducted to develop a role model for the position of program or department head, in which a consensus would indicate specific role functions and authority, if such research should indicate a need for this.

CHAPTER BIBLIOGRAPHY

1. King, James B. and McPheeters, Harold L., Roles and Functions for Mental Health Workers, Atlanta, Georgia, Southern Regional Education Board, December, 1969.

APPENDIX A

PROGRAM OBJECTIVES FOR STUDENTS IN MENTAL HEALTH
FREQUENCY OF RESPONSE

Total Resp. (19-21)	Question Number (33-35)	Mean (in 46) 47-50	+2 1 -	P/C	+1 2 -	P/C	-1 3 -	P/C	-2 4 -	P/C	-3 5 -	P/C
20	1	1.00	6	30.0	12	60.0		.0	2	10.0		.0
19	2	0.37	5	26.3	7	36.8	5	26.3	1	5.3	1	5.3
19	3	0.68	7	36.8	6	31.6	5	26.3	1	5.3		.0
19	4	0.79	5	26.3	10	52.6	3	15.8	1	5.3		.0
20	5	1.55	15	75.0	3	15.0	2	10.0		.0		.0
21	6	1.24	11	52.4	7	33.3	3	14.3		.0		.0
21	7	1.14	9	42.9	9	42.9	3	14.3		.0		.0
21	8	1.29	10	47.6	9	42.9	2	9.5		.0		.0
19	9	1.37	9	47.4	9	47.4	1	5.3		.0		.0
19	10	1.58	11	57.9	8	42.1		.0		.0		.0
21	11	1.24	9	42.9	10	47.6	2	9.5		.0		.0
20	12	1.40	10	50.0	9	45.0	1	5.0		.0		.0
21	13	1.33	12	57.1	7	33.3	1	4.8	1	4.8		.0
21	14	1.10	8	38.1	10	47.6	3	14.3		.0		.0
20	15	0.00	3	15.0	8	40.0	4	20.0	5	25.0		.0
20	16	0.20	3	15.0	10	50.0	2	10.0	5	25.0		.0
20	17	0.40	3	15.0	5	25.0	5	25.0	7	35.0		.0
20	18	0.05	3	15.0	8	40.0	5	25.0	4	20.0		.0
21	19	1.71	15	71.4	6	28.6		.0		.0		.0
21	20	1.24	11	52.4	7	33.3	3	14.3		.0		.0
21	21	1.71	15	71.4	6	28.6		.0		.0		.0
21	22	1.62	13	61.9	8	38.1		.0		.0		.0
20	23	1.70	14	70.0	6	30.0		.0		.0		.0
21	24	1.52	13	61.9	7	33.3	1	4.8		.0		.0
20	25	1.60	12	60.0	8	40.0		.0		.0		.0
21	26	1.52	14	66.7	6	28.6		.0	1	4.8		.0
21	27	1.48	13	61.0	7	33.3		.0	1	4.8		.0

Total Resp.	Question Number	Mean	+2 1 -	P/C	+1 2 -	P/C	-1 3 -	P/C	-2 4 -	P/C	-3 5 -	P/C
21	28	1.52	14	66.7	6	28.6		.0	1	4.8		.0
21	29	1.48	13	61.9	7	33.3		.0	1	4.8		.0
21	30	1.81	17	81.0	4	19.0		.0		.0		.0
21	31	1.76	16	76.2	5	23.8		.0		.0		.0
21	32	1.76	16	76.2	5	23.8		.0		.0		.0
21	33	1.71	15	71.4	6	28.6		.0		.0		.0
21	34	0.86	3	14.3	15	71.4	3	14.3		.0		.0
21	35	0.76	3	14.3	14	66.7	4	19.0		.0		.0
21	36	0.86	3	14.3	15	71.4	3	14.3		.0		.0
21	37	0.86	3	14.3	15	71.4	3	14.3		.0		.0
21	38	0.76	3	14.3	14	66.7	4	19.0		.0		.0
20	39	0.90	4	20.0	13	65.0	3	15.0		.0		.0
21	40	1.29	10	47.6	9	42.9	2	9.5		.0		.0
21	41	1.38	14	66.7	4	19.0	3	14.3		.0		.0
21	42	1.67	14	66.7	7	33.3		.0		.0		.0
21	43	1.57	14	66.7	6	28.6	1	4.8		.0		.0
21	44	0.95	6	28.6	12	57.1	2	9.5	1	4.8		.0
21	45	1.05	5	23.8	14	66.7	2	9.5		.0		.0
21	46	0.48	5	23.8	9	42.9	5	23.8	2	9.5		.0
20	47	0.90	7	35.0	10	50.0	1	5.0	1	5.0	1	5.0
21	48	1.57	12	57.1	9	42.9		.0		.0		.0
21	49	1.52	11	52.4	10	47.6		.0		.0		.0
21	50	1.52	11	52.4	10	47.6		.0		.0		.0
21	51	1.43	9	42.9	12	57.1		.0		.0		.0
21	52	1.43	9	42.9	12	57.1		.0		.0		.0
21	53	1.24	9	42.9	10	47.6	2	9.5		.0		.0
21	54	1.29	8	38.1	12	57.1	1	4.8		.0		.0
21	55	1.29	8	38.1	12	57.1	1	4.8		.0		.0
21	56	1.62	13	61.9	8	38.1		.0		.0		.0
21	57	1.62	13	61.9	8	38.1		.0		.0		.0
21	58	1.62	13	61.9	8	38.1		.0		.0		.0
20	59	1.20	6	30.0	13	65.0	1	5.0		.0		.0
21	60	1.24	7	33.3	13	61.9	1	4.8		.0		.0
21	61	1.24	7	33.3	13	61.9	1	4.8		.0		.0

Total Resp.	Question Number	Mean	+2 1 - P/C		+1 2 - P/C		-1 3 - P/C		-2 4 - P/C		-3 5 - P/C	
21	62	1.19	6	28.6	14	66.7	1	4.8		.0		.0
21	63	1.10	6	28.6	13	61.9	2	9.5		.0		.0
21	64	1.10	6	28.6	13	61.9	2	9.5		.0		.0
21	65	1.10	6	28.6	13	61.9	2	9.5		.0		.0
21	66	1.19	6	28.6	14	66.7	1	4.8		.0		.0
21	67	1.10	6	28.6	13	61.9	2	9.5		.0		.0
21	68	1.24	7	33.3	13	61.9	1	4.8		.0		.0
21	69	1.43	9	42.9	12	57.1		.0		.0		.0
21	70	1.24	9	42.9	10	47.6	2	9.5		.0		.0
21	71	1.19	8	38.1	11	52.4	2	9.5		.0		.0
19	72	1.05	5	26.3	12	63.2	2	10.5		.0		.0
20	73	1.25	9	45.0	9	45.0	2	10.0		.0		.0
20	74	1.25	9	45.0	9	45.0	2	10.0		.0		.0
19	75	1.11	7	36.8	10	52.6	1	5.3		.0		.0
20	76	1.10	6	30.0	12	60.0	2	10.0		.0		.0
21	77	1.14	7	33.3	12	57.1	2	9.5		.0		.0
21	78	1.10	7	33.3	12	57.1	1	4.8	1	4.8		.0
21	79	1.33	7	33.3	14	66.7		.0		.0		.0
21	80	1.10	6	28.6	13	61.9	2	9.5		.0		.0
19	81	1.05	5	26.3	12	63.2	2	10.5		.0		.0
20	82	0.75	4	20.0	12	60.0	3	15.0	1	5.0		.0
20	83	0.85	4	20.0	13	65.0	2	10.0	1	5.0		.0
21	84	0.71	4	19.0	12	57.1	5	23.8		.0		.0
21	85	0.81	4	19.0	13	61.9	4	19.0		.0		.0
21	86	0.62	4	19.0	11	52.4	6	28.6		.0		.0
21	87	0.85	5	23.8	12	57.1	4	19.0		.0		.0
20	88	0.90	4	20.0	13	65.0	3	15.0		.0		.0
20	89	1.50	10	50.0	10	50.0		.0		.0		.0
20	90	1.40	10	50.0	9	45.0	1	5.0		.0		.0
20	91	1.30	10	50.0	8	40.0	2	10.0		.0		.0
20	92	1.30	10	50.0	8	40.0	2	10.0		.0		.0
20	93	1.45	11	55.0	8	40.0	1	5.0		.0		.0
20	94	1.40	10	50.0	9	45.0	1	5.0		.0		.0

Total Resp.	Question Number	Mean	+2 1 -	P/C	+1 2 -	P/C	-1 3 -	P/C	-2 4 -	P/C	-3 5 -	P/C
20	95	1.35	9	45.0	10	50.0	1	5.0		.0		.0
20	96	1.35	9	45.0	10	50.0	1	5.0		.0		.0
20	97	1.35	9	45.0	10	50.0	1	5.0		.0		.0
20	98	1.35	9	45.0	10	50.0	1	5.0		.0		.0
20	99	1.35	9	45.0	10	50.0	1	5.0		.0		.0
20	100	1.35	9	45.0	10	50.0	1	5.0		.0		.0
20	101	1.35	9	45.0	10	50.0	1	5.0		.0		.0
20	102	1.10	4	20.0	15	75.0	1	5.0		.0		.0
21	103	1.14	7	33.3	12	57.1	2	9.5		.0		.0
21	104	0.57	4	19.0	11	52.4	5	23.8	1	4.8		.0
21	105	0.57	4	19.0	12	57.1	2	9.5	3	14.3		.0
20	106	0.45	3	15.0	11	55.0	4	20.0	2	10.0		.0
21	107	1.00	5	23.8	14	66.7	1	4.8	1	4.8		.0
21	108	0.81	8	38.1	8	38.1	3	14.3	2	9.5		.0
21	109	1.05	9	42.9	8	38.1	4	19.0		.0		.0
21	110	1.24	9	42.9	10	47.6	2	9.5		.0		.0
21	111	1.38	10	47.6	10	47.6	1	4.8		.0		.0
21	112	1.38	10	47.6	10	47.6	1	4.8		.0		.0
21	113	1.33	9	42.9	11	52.4	1	4.8		.0		.0
21	114	1.38	10	47.6	10	47.6	1	4.8		.0		.0
21	115	1.38	10	47.6	10	47.6	1	4.8		.0		.0
19	116	1.05	5	26.3	12	63.2	2	10.5		.0		.0
20	117	0.65	4	20.0	11	55.0	4	20.0	1	5.0		.0
20	118	0.90	5	25.0	12	60.0	2	10.0	1	5.0		.0
20	119	1.15	8	40.0	10	50.0	1	5.0	1	5.0		.0
19	120	0.79	5	26.3	10	52.6	3	15.8	1	5.3		.0
21	121	1.86	18	85.7	3	14.3		.0		.0		.0
21	122	1.81	17	81.0	4	19.0		.0		.0		.0
21	123	1.81	17	81.0	4	19.0		.0		.0		.0
21	124	1.76	18	85.7	2	9.5	1	4.8		.0		.0
21	125	1.71	17	81.0	3	14.3	1	4.8		.0		.0
21	126	1.81	17	81.0	4	19.0		.0		.0		.0
21	127	1.86	18	85.7	3	14.3		.0		.0		.0
21	128	1.86	18	85.7	3	14.3		.0		.0		.0
21	129	1.81	17	81.0	4	19.0		.0		.0		.0

Total Resp.	Question Number	Mean	+2 1	- P/C	+1 2	- P/C	-1 3	- P/C	-2 4	- P/C	-3 5	- P/C
21	130	1.86	18	85.7	3	14.3		.0		.0		.0
21	131	1.86	18	85.7	3	14.3		.0		.0		.0
21	132	1.76	18	85.7	2	9.5	1	4.8		.0		.0
21	133	1.76	16	76.2	5	23.8		.0		.0		.0
21	134	1.76	16	76.2	5	23.8		.0		.0		.0
21	135	1.67	16	76.2	4	19.0	1	4.8		.0		.0
21	136	1.76	16	76.2	5	23.8		.0		.0		.0
20	137	1.75	15	75.0	5	25.0		.0		.0		.0
20	138	1.70	14	70.0	6	30.0		.0		.0		.0
20	139	1.70	14	70.0	6	30.0		.0		.0		.0
20	140	1.65	13	65.0	7	35.0		.0		.0		.0
21	141	1.67	16	76.2	5	23.8		.0		.0		.0
21	142	1.67	16	76.2	5	23.8		.0		.0		.0
21	143	1.67	16	76.2	5	23.8		.0		.0		.0
21	144	1.81	17	81.0	4	19.0		.0		.0		.0
21	145	1.86	18	85.7	3	14.3		.0		.0		.0
20	146	1.35	11	55.0	7	35.0	2	10.0		.0		.0
20	147	1.40	8	40.0	12	60.0		.0		.0		.0
20	148	1.45	9	45.0	11	55.0		.0		.0		.0
20	149	1.45	9	45.0	11	55.0		.0		.0		.0
20	150	1.10	7	35.0	11	55.0	1	5.0	1	5.0		.0
20	151	1.00	8	40.0	9	45.0	1	5.0	2	10.0		.0
20	152	1.00	8	40.0	9	45.0	1	5.0	2	10.0		.0
20	153	1.55	11	55.0	9	45.0		.0		.0		.0
20	154	1.15	9	45.0	8	40.0	3	15.0		.0		.0
20	155	1.10	6	30.0	12	60.0	2	10.0		.0		.0
21	156	1.24	9	42.9	10	47.6	2	9.5		.0		.0
21	157	1.48	10	47.6	11	52.4		.0		.0		.0
21	158	1.19	8	38.1	11	52.4	2	9.5		.0		.0
21	159	1.19	7	33.3	13	61.9		.0	1	4.8		.0
21	160	1.24	8	38.1	12	57.1		.0	1	4.8		.0
21	161	1.67	14	66.7	7	33.3		.0		.0		.0
21	162	1.57	12	57.1	9	42.9		.0		.0		.0

Total Resp.	Question Number	Mean	+2 1 -	P/C	+1 2 -	P/C	-1 3 -	P/C	-2 4 -	P/C	-3 5 -	P/C
21	163	1.00	9	42.9	8	38.1	3	14.3	1	4.8		.0
21	164	0.90	6	28.6	11	52.4	4	19.0		.0		.0
21	165	1.62	13	61.9	8	38.1		.0		.0		.0
21	166	1.67	14	66.7	7	33.3		.0		.0		.0
21	167	1.52	11	52.4	10	47.6		.0		.0		.0
21	168	1.52	11	52.4	10	47.6		.0		.0		.0
20	169	1.30	10	50.0	8	40.0	2	10.0		.0		.0
20	170	1.50	12	60.0	7	35.0	1	5.0		.0		.0
20	171	1.25	7	35.0	12	60.0	1	5.0		.0		.0
20	172	1.25	5	25.0	15	75.0		.0		.0		.0
20	173	0.65	3	15.0	13	65.0	2	10.0	2	10.0		.0
20	174	0.50	5	25.0	9	45.0	3	15.0	3	15.0		.0
20	175	0.70	7	35.0	7	35.0	5	25.0	1	5.0		.0
21	176	0.57	6	28.6	8	38.1	6	28.6	1	4.8		.0
21	177	0.48	6	28.6	7	33.3	7	33.3	1	4.8		.0
20	178	0.55	6	30.0	7	35.0	6	30.0	1	5.0		.0
21	179	0.85	9	42.9	7	33.3	3	14.3	2	9.5		.0
20	180	0.55	6	30.0	7	35.0	6	30.0	1	5.0		.0
17	181	0.29	4	23.5	6	35.3	5	29.4	2	11.8		.0
21	182	(0.10-)	4	19.0	6	28.6	6	28.6	5	23.8		.0
21	183	0.43	4	19.0	10	47.6	5	23.8	2	9.5		.0
21	184	0.33	5	23.8	8	38.1	5	23.8	3	14.3		.0
21	185	1.62	15	71.4	5	23.8	1	4.8		.0		.0
21	186	1.62	15	71.4	5	23.8	1	4.8		.0		.0
21	187	1.71	15	71.4	6	28.6		.0		.0		.0
20	188	1.75	15	75.0	5	25.0		.0		.0		.0
21	189	1.62	15	71.4	5	23.8	1	4.8		.0		.0
21	190	1.71	17	81.0	3	14.3	1	4.8		.0		.0
21	191	1.62	17	81.0	2	9.5		.0		.0		.0
21	192	1.57	16	76.2	3	14.3	2	9.5		.0		.0
21	193	1.48	14	66.7	5	23.8	2	9.5		.0		.0
21	194	1.14	11	52.4	6	28.6	4	19.0		.0		.0

Total Resp.	Question Number	Mean	+2 1 -	P/C	+1 2 -	P/C	-1 3 -	P/C	-2 4 -	P/C	-3 5 -	P/C
21	195	1.57	14	66.7	6	28.6	1	4.8		.0		.0
21	196	1.76	18	85.7	2	9.5	1	4.8		.0		.0
21	197	1.38	14	66.7	4	19.0	3	14.3		.0		.0
21	198	1.48	15	71.4	4	19.0	1	4.8	1	4.8		.0
20	199	1.45	13	65.0	5	25.0	2	10.0		.0		.0
18	200	1.44	10	55.6	7	38.9	1	5.6		.0		.0
21	201	1.33	11	52.4	8	38.1	2	9.5		.0		.0
21	202	1.62	15	71.4	5	23.8	1	4.8		.0		.0
21	203	1.71	17	81.0	3	14.3	1	4.8		.0		.0
20	204	1.70	16	80.0	3	15.0	1	5.0		.0		.0
21	205	1.43	13	61.9	6	28.6	2	9.5		.0		.0
21	206	1.71	17	81.0	3	14.3	1	4.8		.0		.0
21	207	1.38	15	71.4	4	19.0		.0	1	4.8	1	4.8
21	208	1.43	16	76.2	3	14.3		.0	1	4.8	1	4.8
21	209	0.33	8	38.1	5	23.8	3	14.3	4	19.0	1	4.8
21	210	0.33	9	42.9	4	19.0	3	14.3	3	14.3	2	9.5
21	211	0.14	7	33.3	5	23.8	4	19.0	3	14.3	2	9.5
21	212	0.29	7	33.3	6	28.6	4	19.0	2	9.5	2	9.5
21	213	0.19	9	42.9	3	14.3	5	23.8		.0	4	19.0
20	214	(0.30-)	5	25.0	4	20.0	5	25.0	3	15.0	3	15.0
20	215	(0.60-)	3	15.0	4	20.0	7	35.0	3	15.0	3	15.0
20	216	(0.45-)	4	20.0	4	20.0	6	30.0	3	15.0	3	15.0

APPENDIX B

OPINIONNAIRE

Listed below are a number of academic courses. Please indicate which of these courses you feel would be an important contribution to a mental health workers educational program. Assume that content and curriculum meet the objectives of the Southern Regional Education Board.

	Strongly Approve	Approve	Undecided	Disapprove	Disapprove Strongly
1. Orientation to human services or allied health careers, orientation to mental health technology.	( )	( )	( )	( )	( )
2. Introduction to mental health or mental health technology I.	( )	( )	( )	( )	( )
3. General or Introduction to Psychology.	( )	( )	( )	( )	( )
4. Mental health techniques (psy.) Psychology for mental health workers.	( )	( )	( )	( )	( )
5. Psychology of interpersonal relations, technique(s) of working with individuals, group processes.	( )	( )	( )	( )	( )
6. Introduction to tests and measurements, psychological testing.	( )	( )	( )	( )	( )
7. Hospital administration, ward supervision for nursing services and medical staff.	( )	( )	( )	( )	( )

		Strongly Approve	Approve	Unde- cided	Dis- approve	Disapprove Strongly
8.	Learning theory and behavior change.	( )	( )	( )	( )	( )
9.	Psychopathology and Psycho-social problems.	( )	( )	( )	( )	( )
10.	Small group lab, classroom lab for group processes and group dynamics.	( )	( )	( )	( )	( )
11.	Social agency case interview, social casework interviews and case study.	( )	( )	( )	( )	( )
12.	Introduction to occupational and recreational therapy, mental health recreation activities.	( )	( )	( )	( )	( )
13.	Introduction to technique(s) of working within mental hospitals.	( )	( )	( )	( )	( )
14.	Introduction to long term care with aged (Gerontology) and chronically ill mental patients.	( )	( )	( )	( )	( )
15.	Advanced study in physical and mental illness.	( )	( )	( )	( )	( )
16.	Rehabilitation of the mentally retarded and mentally ill.	( )	( )	( )	( )	( )
17.	Introduction to legal information for mental health workers.	( )	( )	( )	( )	( )

	Strongly Approve	Approve	Unde-cided	Dis-approve	Disapprove Strongly
18. Mental health practicum, field placement, internship, coordinated practice.	( )	( )	( )	( )	( )
19. Sociology area: Introduction or principles of sociology, sociology of mental health, social aspects of mental health and mental retardation.	( )	( )	( )	( )	( )

_____

(Signature-Optional)

_____

(Address-Optional)

_____

(Title-Optional)

_____

(Highest Degree-M.A. Sociology, etc.)

APPENDIX C

Health 100
Orientation to Allied Health Careers
Mental Health Tech. Sec.
Lecture--one hour per week (1 cr.)

	Educational Objective	Experience	Faculty Criteria
1.	Orientation to the interrelated roles and functions of various members of the health team. a. Health Services b. Social Services c. School Services d. Rehabilitation Services e. Mental Hospital Services f. Activity Therapy g. Mental Health Clinics h. Coordination of Services	Classroom Lecture(s) Textbook Readings Guest Lecture(s) From all related fields. Field trips and Field observations. Development of a word terminology list.	Passing Average on quizzes, final tests. Passing Average on resource binder. Passing Average on word list. Attendance at required field trips.

Ment 104
Introduction to Mental Health I
Program Objectives

	Educational Objective	Experience	Faculty Criteria
1.	To identify the most common concepts of normal personality growth and development from infancy to maturity and old age. Include orality and anality and their implications for personality functions.	Classroom Lecture(s) Western State Hosp. (Lab Sessions) Textbook Readings	Passing Average on quizzes, final test.
2.	Identify the terminology and basic concepts of the more common theories of psychological functioning, and especially knowledge of the kinds of situations for which the various theories seem especially useful.	Classroom Lecture(s) Western State Hosp. (Lab Sessions) Textbook Readings Library Readings	Passing Average on quizzes, final test.
3.	Identify common personality patterns and behaviors (i.e. passivity, aggressiveness, dependence, independence, authoritarianism, compulsiveness, mood swings).	Classroom Lecture(s) Audio-visual films WSH--Lab sessions Textbook Readings	Passing Average on quizzes, final test.
4.	List basic information about the mental health professionals and their profession's power and influence (medicine, psychiatry, psychology, social work and nursing).	Classroom Lecture(s) Guest Lecture(s) from other professionals in field. Textbook Readings	Passing Average on quizzes, final test.

Ment 104--continued

	Educational Objective	Experience	Faculty Criteria
5.	List basic information about the related mental health professions. (rehabilitation counseling, occupational therapy, chaplaincy, recreation therapy, music therapy, physical therapy, sociology).	Classroom Lecture(s) Guest Lecture(s) from other professionals in field.	Passing Average on quizzes, final test.
6.	List basic information about the middle-level mental health workers (psychiatric aides and attendants, mental health workers, etc.).	Classroom Lecture(s) Guest Lecture(s) and visits to wards at WSH.	Passing Average on quizzes, final test.
7.	Identify community resources that provide human services.	Student will prepare workbook with agency information.	Passing Average on quizzes, final test.
8.	Identify resources available for the mentally disabled in each program, and how to mobilize them on behalf of clients and the mentally disabled in general: a. Public agencies--local and statewide b. Voluntary agencies c. Private resources	Workbook Classroom Lecture(s) Field trips: a. Entire class b. Individual student visits c. Guest lecture(s)	Discusses with inst. satisfactorily at least.

Ment 104--continued

	Educational Objective	Experience	Faculty Criteria
9.	Develop competence in being a role model to patients/clients--to assist them with emotional and behavior adjustments.	Classroom Lecture(s) Lab sessions (WSH) Role play in class	Case study in lab.
10.	Conviction that the mental health of clients, families and communities can be improved.	Classroom Lecture(s) Observations of other professionals during lab sessions.	Discusses with inst. in class or office--results satisfactorily at least.
11.	Conviction that the mental health worker can help bring about improvements.	Lab sessions observations Classroom discussions	Discusses with inst. in class or office--results satisfactorily at least.
12.	Conviction that knowledge, skills, and attitudes are in continuous change and that a commitment to continuing self-development and education is necessary.	Lab sessions observations Classroom discussions	Discusses with inst. in class or office--results satisfactorily at least.
13.	Through respect for the dignity of the individual.	Lab sessions observations Classroom discussions	Discusses with inst. in class or office--results satisfactorily at least.

Ment 104--continued

	Educational Objective	Experience	Faculty Criteria
14.	Conviction of the importance of being dependable and reliable in work with clients and communities.	Observation of student in class and lab situations.	Discusses with inst. in class or office--results satisfactorily at least.
15.	Conviction of the importance of exercising personal initiative in carrying out work with clients and communities.	Observation of student in class and lab situations.	Discusses with inst. in class or office--results satisfactorily at least.

Ment 105
Introduction to Mental Health II
Program Objectives

	Educational Objective	Experience	Faculty Criteria
1.	Identify mental functions and their implications and applications (from the text: Adjustments and Mental Health by A. Arkoff).	Classroom Lecture(s)	Passing Average on quizzes, final test.
2.	Identify common personality patterns and behaviors.	Classroom Lecture(s)	Passing Average on quizzes, final test.
3.	Identify the terminology and basic concepts of the more common theories of psychological functioning and especially knowledge of the kinds of situations for which the various theories seem especially useful (from the text: Abnormal Psychology and Modern Life by James C. Coleman).	Classroom Lecture(s)	Passing Average on quizzes, final test.
4.	List, compare and contrast uses, effects and abuses of chemotherapeutic agents. Be able to recite what to do in the event of abuse of untoward effects.	Classroom Lecture(s)	Passing Average on quizzes, final test.
5.	Be able to interview normal and disabled persons (from the text: Interviewing--Its Principles and Methods by Annette Garrett).	Classroom Lecture(s) Lab sessions (WSH) Role play in class	Case study in lab Inst. and WSH Staff observe performance.

Ment 105--continued

	Educational Objective	Experience	Faculty Criteria
6.	Have skill in talking with people comfortably and productively.	Classroom Lecture(s) TV tape of role play in class, etc. Lab sessions (WSH)	Review of TV tape by Inst. and WSH staff. Observance of performance.
7.	Have skill in observing behaviors, emotions, and physical characteristics of people and settings.	Classroom Lecture(s) TV tape of class, etc. Lab sessions (WSH)	Review of TV tape by Inst. and WSH staff. Observance of performance.
8.	Have skill in establishing interpersonal relationships with clients, such as demonstrating the three characteristics described by Truax and Carkuff. a. Genuiness b. Accurate empathy c. Nonpossessive warmth	Classroom Lecture(s) TV tape of class, etc. Lab sessions (WSH)	Review of TV tape by Inst. and WSH staff. Observance of performance.
9.	Have skill in gathering clinical case data and in analyzing, abstracting and using such data in decision making with due regard in confidentiality.	Classroom Lecture(s) Sample TV tape on gathering data. Students will practice reporting what they hear. Inst. will give them sample case record with all data they should have taken.	Grade on sample case.

Ment 105--continued

	Educational Objective	Experience	Faculty Criteria
10.	Competence in ordinary social adaptive skills (grooming, appropriate manners, sense of time, sense of responsibility, etc.).	Classroom Lecture(s) Lab sessions (WSH)	Passing Average on quizzes, final test. Staff observance of performance.
11.	Skill in first aid.	Be able to pass Health 104 First Aid I.	Passing Average on quizzes, final test.
12.	Have some skills in a variety of recreational activities (table games, sports, exercises, dancing, etc.).	Classroom Lecture(s) Lab sessions with recreation therapy unit (WSH), student will spend at least four lab sessions in this unit.	Passing Average on quizzes, final test. Staff observance of performance. (Student will practice leadership in some form of recreation under supervision for evaluation.)

Ment 190-290
Coordinated Practice for Mental Health Technology

	Educational Objective	Experience	Faculty Criteria
1.	Skill in interviewing normal and disabled persons. Have skill in obtaining information, "reading" the feeling tones of what people say, and observing and reporting behaviors people exhibit in interviews.	Clinic Experience Observations Identifies behavioral changes	Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.
2.	Have skill in relating to a wide range of the disabled--aged, mentally ill, retarded, children, alcoholics, etc.	Clinic Experience Observations Identifies behavioral changes	Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.
3.	Have skill in sensing the impact of self on the person being interviewed, and responding appropriately.	Clinic Experience Observations Identifies behavioral changes Use of TV tape to "play-back" self for evaluation.	Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.

Ment 190-290--continued

	Educational Objective	Experience	Faculty Criteria
4.	Skills in observing and recording. Be able to use ordinary check forms to record observations.	Clinic Experience Observations Trial under supervision. Skill improvement from 190 to 290.	Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.
5.	Skill in recording observations and interview data in simple descriptive fashion (graphic descriptions of exactly what the person is saying and doing).	Clinic Experience Observations Trial under supervision. Skill improvement from 190 to 290.	Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.
6.	Skill in recording subjective impressions of the individual.	Clinic Experience Observations Trial under supervision. Skill improvement from 190 to 290.	Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.

Ment 190-290--continued

	Educational Objective	Experience	Faculty Criteria
7.	Skill in dealing with other mental health worker(s) in various role relationships.	Clinic Experience Observations Trial under supervision. Skill improvement from 190 to 290.	Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.
8.	Skill in supervising other workers.	Clinic Experience Observations Trial under supervision. Skill improvement from 190 to 290.	Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.
9.	Skill in group counseling (i.e. giving information, exploring alternatives, effecting minor behavior change).	Clinic Experience Observations Trial under supervision. Skill improvement from 190 to 290.	Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.

Ment 190-290--continued

	Educational Objective	Experience	Faculty Criteria
10.	Skill in group teaching	Clinic Experience Observations Trial under supervision. Skill improvement from 190 to 290.	Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open ended coordinated practice evaluation guide.
11.	Skill in group therapy as an aid to professionals.	Clinic Experience Observations Trial under supervision. Skill improvement from 190 to 290.	Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.
12.	Skills in changing the behavior and enhancing the emotional growth of individuals, skills in coaching for new behavior patterns (giving directions, persuading, practicing).	Clinic Experience (290 level under direction of M.D. or Ph.D. level supervisor).	Clinical performance indicates understanding and supervisory experience of this role. Must satisfy field instructor and faculty.

Ment 190-290--continued

	Educational Objective	Experience	Faculty Criteria
13.	Skills in counseling for new behaviors and adjustment in client patterns (helping explore alternatives, asking questions to lead the person to new insights).	Clinic Experience (290 level under direction of M.D. or Ph.D. level supervisor).	Clinical performance indicates understanding and supervisory experience of this role. Must satisfy field instructor and faculty.
14.	Skills in behavior modification.	Clinic Experience (290 level under direction of M.D. or Ph.D. level supervisor).	Clinical performance indicates understanding and supervisory experience of this role. Must satisfy field instructor and faculty.
15.	Competence in instructional skills. Have skills in teaching ordinary skills and knowledge to individuals (i.e. grooming and knitting).	Classroom Lecture(s) 190 level lab sessions (WSH)	Clinical performance indicates understanding and supervisory experience of this role. Must satisfy field instructor and faculty.
16.	Skill in teaching small groups (i.e. a high school class about drug abuses. This will include use of visual aides group discussions and other simple educational skills based on sound learning principles).	Clinic Experience (290 level under direction of field instructor) Observations use of TV tape methods.	Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.

Ment 190-290--continued

	Educational Objective	Experience	Faculty Criteria
17.	Skills in consulting. Have skill in consulting with other workers about individuals and their problems.	Clinic Experience in 290. Student expected to know this for all patients.	Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.
18.	Have skill in consulting with small local agencies about their mental health problems.	Clinic Experience in 290. Student expected to know this for all patients.	Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.
19.	Competence in community process skills. Competence in neighborhood planning. Also competence in activating local community resources on behalf of a client or program.	Clinic Experience in 190. Student in community agency is expected to know this.	Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.

Ment 190-290-- continued

	Educational Objective	Experience	Faculty Criteria
20.	Skill in mobilizing community resources. Skill in working with community agencies, professionals. Mobilize their services and competence quickly on behalf of clients. This may involve techniques for short-cutting standard "procedures" in the case of clients in crisis. Also skill in mobilizing community resources to serve classes of clients.	Clinic Experience in 190 with improvement in the 290 course.	Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.
21.	Skill in gathering and using mental health data. Ability to gather clinical case data and in analyzing abstracting and using such data in decision making with due regard for confidentiality. Skill in gathering statistical data (i.e. number of cases) organizing it into systematic records, or tables, analyzing and abstracting it as needed and using it for program planning and evaluation.	Clinic Experience Observations students will write daily log in process recording form and turn into instructor. Skill improvement from 190 to 290.	Daily log will be satisfactorily done. Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.

Ment 190-290--continued

	Educational Objective	Experience	Faculty Criteria
22.	Competence in reporting skills. Have skill in organizing information into logical and clear reports. a. Written b. Oral presentations This includes reports of clinical information about patients or information about program, problems, or proposals. Skill in presenting reports appropriately for professionals and peers, or lay persons.	Clinic Experience Observations student will write daily log in process recording form and turn into instructor. Skill improvement from 190 to 290.	Daily log will be satisfactorily done. Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.
23.	Competence in daily living skills. Competence in ordinary social adaptive skills (grooming, appropriate manners, sense of time, sense of responsibility). Competence in being a role model to patients/clients--to assist them with emotional and behavior adjustments.	Clinic Experience Observations role play skill improvement from 190 to 290.	Daily log will be satisfactorily done. Daily work sheet notes if experience has been provided. Field supervisor and instructor note progress on student rating sheet and the open-ended coordinated practice evaluation guide.

Ment 190-290--continued

	Educational Objective	Experience	Faculty Criteria
24.	Skills in remotivation and teaching of remotivation for aides (Text: The Remotivators' Guide Book by Allen Gibson).	Clinic Experience with remotivation coordinator (WSH) Regional center for remotivation training centers 190-290.	Passing Average on quizzes, final test oral or written evaluation of effectiveness by remotivation coordinator and instructor.
25.	Skills in special therapies a. Play therapy b. Behavior M.D.	Clinic Experience 190-290.	Passing Average on quizzes, final test oral or written evaluation of effectiveness by remotivation coordinator and staff and instructor.
26.	Considerable conviction that the mental health of clients, families and communities can be improved. Conviction that the mental health workers can help bring about improvements. Considerable intention to work to bring about improvements.	Demonstrates this conviction during clinic experience 190-290.	Verified by instructor or staff.
27.	Considerable conviction that knowledge, skills, and attitudes are in continuous change and that a commitment to continuing self-development and education is necessary.	Demonstrates this conviction during clinic experience 190-290.	Verified by instructor or staff.

Ment 190-290--continued

	Educational Objective	Experience	Faculty Criteria
28.	Through respect for the dignity of the individual and a respect for the individual's person, privacy, decisions, and opinions. Through conviction that no person shall be treated in demeaning, patronizing, condescending, or arbitrary ways. Avoidance of labeling people with stereotyped or derogatory terminology.	Demonstrates this conviction during clinic experience 190-290.	Verified by instructor or staff.
29.	Considerable conviction of the importance of exercising personal responsibility and initiative in carrying out work. Conviction of the importance of being dependable and reliable in work with clients and communities. Conviction of the importance of exercising personal initiative in carrying out work with clients and communities.	Clinic Experience	Daily work sheet notes if student has dependable work habits. Daily log notes if student is exercising personal responsibility and initiative etc. Instructor notes progress. Other factor reviewed with conference with field supervisor.

Ment 190-290--continued

	Educational Objective	Experience	Faculty Criteria
30.	Through conviction of maintaining a continuing affirmative relationship to clients and communities whenever and as long as it is needed.	Clinic Experience	Daily work sheet notes if student has dependable work habits. Daily log notes if student is exercising personal responsibility and initiative etc. Instructor notes progress. Other factor reviewed with conference with field supervisor.
31.	Considerable respect and tolerance for different individual and cultural life styles.	Clinic Experience	Daily work sheet notes if student has dependable work habits. Daily log notes if student is exercising personal responsibility and initiative etc. Instructor notes progress. Other factor reviewed with conference with field supervisor.
32.	Considerable concern regarding contemporary events, issues and problems relevant to mental health.	Seeks help from competent persons appropriately.	Involves self in professional organizations.

Ment 190-290--continued

	Educational Objective	Experience	Faculty Criteria
33.	Conviction of collaborative team effort that promotes working with other professionals in the fields of mental health, social welfare, education. To protect the patient from self destructive acts and/or to seek assistance in protecting the patient.	Clinic Experience	Instructor notes progress. Other factor reviewed with conference with field supervisor.

Ment 221-222-223
Mental Health I-II-III

	Educational Objective	Experience	Faculty Criteria
1.	Knowledge of abnormal psychology. Identify abnormal behaviors; descriptions, natural history and psychodynamic aspects of psychoses, neurosis, personality disorders and psychophysiologic disorders.	Classroom Lecture(s) Textbook readings and library readings. Role play in class.	Passing Average on quizzes, final test.
2.	Identify psychopathologic conditions related to children, adolescents, and the aged as well as young and middle-life adults.	Classroom Lecture(s) Textbook readings and library readings. Role play in class.	Passing Average on quizzes, final test.
3.	Identify behaviors, natural history, and psychodynamics of special problems, such as mental retardation, sex problems, and alcohol and drug addiction and abuse.	Classroom Lecture(s) Textbook readings and library readings. Role play in class.	Passing Average on quizzes, final test.
4.	Knowledge of the conceptual basis for various theories of intervention. Identify the various models for individual client intervention (i.e. medical model, social learning model).	Classroom Lecture(s) Textbook readings and library readings. Role play in class.	Passing Average on quizzes, final test.

Ment 221-222-223--continued

Educational Objective	Experience	Faculty Criteria
5. Identify the principles of treatment, supportive care, rehabilitation, partial disability.	Classroom Lecture(s) Textbook readings and library readings. Role play in class.	Passing Average on quizzes, final test.
6. Differentiate between the concepts of prevention, positive health promotion, social system in intervention, anticipatory guidance, etc.	Classroom Lecture(s) Textbook readings and library readings. Role play in class.	Passing Average on quizzes, final test.
7. Identify and compare the methods of intervention with individuals.	Classroom Lecture(s) Textbook readings and library readings. Role play in class. Guest lecture(s) from related fields.	Passing Average on quizzes, final test.
8. Identify the psychological methods (what is done, rational indications, limitations, what to expect): a. non-directive methods (client centered). b. Psychotherapy (identify psychoanalysis). c. Counseling. d. Short term eclectic methods (crisis intervention, hypnotherapy, supportive theory). e. Group methods.	Classroom Lecture(s) Textbook readings and library readings. Role play in class. Guest lecture(s) from related fields.	Passing Average on quizzes, final test.

Educational Objective	Experience	Faculty Criteria
9. Identify educational methods: a. Behavior therapy b. Rehabilitation	Classroom Lecture(s) Textbook readings and library readings. Role play in class. Guest lecture(s) from related fields.	Passing Average on quizzes, final test.
10. Differentiate between the social models: a. Therapeutic use of self b. Milieu therapy c. Activity therapy d. Therapeutic community	Classroom Lecture(s) Textbook readings and library readings. Role play in class. Guest lecture(s) from related fields.	Passing Average on quizzes, final test.
11. Identify community intervention methods: a. Consultation b. Community planning c. Public education d. Legislative and administrative process (especially at local community levels).	Classroom Lecture(s) Textbook readings and library readings. Role play in class.	Passing Average on quizzes, final test.

Ment 221-222-223--continued

	Educational Objective	Experience	Faculty Criteria
12.	List, compare and contrast uses, effects and abuses of chemo-therapeutic agents. a. Anticonvulsants b. Tranquilizers c. Sedatives d. Narcotics e. Energizers f. Toxic, allergic, and side effects, as well as therapeutic effects of most commonly used agents.	Classroom Lecture(s) Textbook readings and library readings. Role play in class.	Passing Average on quizzes, final test.
13.	Recite what to do in the event of abuse or untoward effects.	Classroom Lecture(s) Textbook readings and library readings. Role play in class.	Passing Average on quizzes, final test.
14.	Identify and differentiate between the mental health and retardation movements. List definitions, terminology and history including value systems. Identify organizational, legal and fiscal structure of agencies.	Classroom Lecture(s) Textbook readings and library readings. Role play in class.	Passing Average on quizzes, final test.

	Educational Objective	Experience	Faculty Criteria
15.	List, compare and contrast data gathering techniques and evaluation procedures in mental health; identify what is done, by whom, indications, rational implications at a basic level. a. Social history and vocational evaluation. b. Physical and neurological examinations. c. Mental status examinations and psychological tests. d. Special studies--EKG, lab e. Questionnaires and community surveys	Classroom Lecture(s) Textbook readings and library readings. Write sample social history from film interview. See film on the mental status exam. Guest lecture(s) for physical neurological examinations, psychological tests, survey research.	Passing Average on quizzes, final test.
16.	Knowledge of physiology of human development and function.	Be able to pass natural science nasc 100.	Passing Average on quizzes, final test.

Ment 221-222-223--continued

	Educational Objective	Experience	Faculty Criteria
17.	Construct and study one's self concept: a. one's abilities b. one's personality c. one's values d. one's philosophies e. one's competencies f. one's experiences g. one's interpersonal style h. one's disabilities i. one's limitations j. one's one's reaction patterns k. one's motivations for mental health work	Classroom work on a self study project.	Passing Average on project.
18.	Competence in group skills. Have skill in organizing and developing groups as a group process facilitator or consultant rather than as a task leader. Have skill in leading groups as a task leader. Have skill in group counseling, group teaching, group therapy and family therapy.	Classroom Lecture(s) Role play in class.	Passing Average on quizzes, final test. Performance in role play should be passing.
19.	Skills in changing the behavior and enhancing the emotional growth of individuals.	Be able to pass prin. of applied psychology Psy 110.	Passing Average on quizzes, final test.

Ment 221-222-223--continued

	Educational Objective	Experience	Faculty Criteria
20.	Competence in understanding of the characteristics of mental health.	Be able to pass the Psy. of personal adjustment.	Passing Average on quizzes, final test.
21.	Identify important concepts of sociology.	Be able to pass: a. Introductory sociology b. Social problems c. Marriage and the family	Passing Average on quizzes, final test.
22.	Considerable conviction of the importance of exercising personal responsibility and initiative in carrying out work.	Classroom Lecture(s) Theory in review by students in class or group experiences.	Conviction verified by instructor. Subjective assessment.
23.	Integrate classroom knowledge of social, medical and psychological pathology into psychosocial diagnostic skills needed by the helping person.	Classroom Lecture(s) Theory in review by students in class or group experiences.	Conviction verified by instructor. Subjective assessment.

BIBLIOGRAPHY

Books

Albee, George W., Mental Health Manpower Trends, New York, Basic Books, 1959.

Blocker, C. E., Robert Plummer, and Richard C. Richardson, The Two-Year College: A Social Synthesis, Englewood Cliffs, N. J., Prentice-Hall, Inc., 1965.

Carnegie Commission on Higher Education, The Open-Door Colleges: Policies For Community Colleges, New York, McGraw-Hill, 1970.

Clark, Burton R., Open Door College, New York, McGraw-Hill, 1960.

Greenfield, Harry I., Allied Health Manpower: Trends and Prospects, New York, Columbia University Press, 1969.

Kelley, Win, and Leslie Wilbur, Teaching in the Community Junior College, New York, Appleton-Century-Crofts, 1970.

Moore, William Jr., Blind Man on a Freeway, Jossey-Bass, Inc., Publishers, 1971.

Reynolds, James W., The Junior College, New York, Center for Applied Research in Education, 1965.

Sax, Gilbert, Empirical Foundations of Educational Research, Englewood Cliffs, N. J., Prentice-Hall, Inc., 1968, citing George W. Snedecor, Statistical Methods, Ames, IA, The Iowa State University Press, 1962.

Sobey, Francine, The Nonprofessional Revolution in Mental Health, New York, Columbia University Press, 1970.

Thornton, James W., The Community Junior College, New York, John Wiley and Sons, Inc., 1960.

Yolles, Stanley F., "The Community Mental Health Center in National Perspective," The Practice of Community Mental Health, edited by Henry Grunebaum, Boston, Little, Brown and Company, 1970.

Articles

Arnhoff, Franklyn N., and others, "The New Mental Health Workers," Manpower For Mental Health, edited by Franklyn N. Arnhoff, Chicago, Aldine Publishing Co., 1969.

Baker, E. Jo, "The Mental Health Associate: A New Approach in Mental Health," Community College Mental Health Journal, 8 (November 1972), 281-291.

Bertleson, Chad M., "Helping Personnel: The Use of Trained Volunteers in the Treatment of Mental Patients in a Community Psychiatric Clinic," American Journal of Orthopsychiatry, 34 (1964), 266-267.

Blau, Theodore H., "The Professional in the Community Views the Nonprofessional Helper," Professional Psychology, 1 (November 1969), 25-30.

Bouhoutsos, Jacqueline C., "The Nontraditionally Trained Mental Health Worker: Fad or Future?" Professional Psychology, 1 (Fall 1970), 455-459.

Christmas, Jung Jackson, "Group Methods in Training and Practice: Nonprofessional Mental Health Personnel in a Deprived Community," American Journal of Orthopsychiatry, 36 (April 1966), 410-419.

Cochran, M. A., and Kelley E. Steiner, "Evaluation of an Inservice Training Program Using the SREB Information Test," American Journal of Mental Deficiency, 70 (May 1966), 913-917.

Cowen, Emory L., Jack M. Chinsky, and Julian Rappaport, "An Undergraduate Practicum in Community Mental Health," Community Mental Health Journal, 6 (April 1970), 91-100.

Davidoff, Ida F., Agnes C. Lauga, and Robert S. Walzer, "The Mental Health Rehabilitation Worker: A New Member of the Psychiatric Team," Community Mental Health Journal, 5 (February 1969), 48.

Eisdorfer, Carl, and Stuart E. Golann, "Principles for the Training of New Professionals in Mental Health," Community Mental Health Journal, 5 (October 1969), 349-357.

Ellsworth, Robert, Authur Bryant, and Grace Butler, "Psychiatric Aide in Service Training: An Experimental Approach," Nursing Research, 9 (Winter 1960), 12-16.

Epstein, Laura, "Differential Use of Staff: A Method to Expand Social Services," Social Work, 7 (1962), 67-72.

Gordon, Jesse E., "Project Cause, the Federal Anti-Poverty Program and Some Implications of Subprofessional Training," American Psychologist, 20 (May 1965), 334-343.

Gottesfeld, Harry, Chongik Rhee, and Glenn Parker, "A Study of the Roles of Paraprofessionals in Community Mental Health," Community Mental Health Journal, 6 (August 1970), 285-291.

Hadley, John M., John E. True, and Sherwin Y. Kepes, "An Experiment in the Education of the Preprofessional Mental Health Worker: The Purdue Program," Community Mental Health Journal, 6 (February 1970), 40-50.

Haid, Doris M., "Teaching of Psychiatric Aides," Teaching and Implementation of Psychiatric Mental Health Nursing, edited by Mary N. Redmond and Margery E. Drake, Washington, D. C., The Catholic University of American Press, 1958, pp. 160-176.

Hallberg, Edmund C., Ben Karr, and Cathy Skrip, "Paraprofessionals as Counselors," Community and Junior College Journal, 43 (October 1972), 30-31.

Hallowitz, E., and Frank Riessman, "The Role of the Indigenous Nonprofessional in a Community Mental Health Neighborhood Service Center Program," American Journal of Orthopsychiatry, 37 (1967), 776-778.

LeFkowitz, Leon J., "Paraprofessionals: An Administration/School Board Conspiracy?" Phi Delta Kappan, 54 (April 1973), 546-547.

Levinson, P., and J. Schiller, "Role Analysis of the Indigenous Nonprofessional," Social Work, 11 (July 1966), 95-101.

Light, Israel, "Development and Growth of New Allied Health Fields," Journal of the American Medical Association, 210 (October 6, 1969), 114-120.

Michael, Elizabeth B., "No Conspiracy, But Let's Use Paraprofessionals Wisely," Phi Delta Kappan, 54 (April 1973), 548-549.

Mitchell, William E., "Amicatherapy: Theoretical Perspectives and an Example of Practice," Community Mental Health Journal, 2 (1966), 307-314.

Pryer, Margaret W., M. K. Distefano, and Mary B. Poe, "Effects of Training Programs on Psychiatric Attendants," Mental Hygiene, 50 (January 1966), 66-70.

Pyle, Robert R., and Fred A. Snyder, "Students as Paraprofessional Counselor at Community Colleges," The Journal of College Student Personnel, (July 1971).

Richan, W. A., "A Theoretical Scheme for Determining Roles of Professional and Nonprofessional Personnel," Social Work, 4 (October 1961), 22-28.

Riessman, Frank R., "Strategies and Suggestions for Training Nonprofessionals," Community Mental Health Journal, 3 (Summer 1967), 103.

Summers, David A., Ted Faucher, and Sue B. Chapmen, "A Note on Nonprofessional Judgements of Mental Health," Community Mental Health Journal, 9 (Summer 1973), 169-177.

Truax, Charles B., "The Training of Nonprofessional Personnel in Therapeutic Interpersonal Relationship," American Journal of Public Health, 57 (October 1967), 1778-1791.

Vaugn, Rufus, Stanley Teitlebaum, and Helen Kempman, "A Research Project in Psychiatric Aide Training," American Journal of Psychiatry, 119 (December 1962), 555-559.

Walker, C. Eugene, Milton Wolpin, and Lloyd Fellows, "The Use of High School and College Students as Therapists and Researchers in a State Mental Hospital," Psychotherapy: Theory, Research and Practice, 4 (November 1967), 186-187.

Young, Carl E., John E. True, and Mary E. Packard, "A National Survey of Associate Degree Mental Health Programs," (Accepted for publication by the Community Mental Health Journal, January 1974), a reprint.

Reports

Fort Hays Kansas State College, The Community Junior College, a report of an Institute for Faculty, Administrators, and Trustees of Community Colleges, held June 18-July 28, 1973, Hays, Kansas, 1973.

Publications of Learned Organizations

King, James B., and E. Jo Baker, 1970 Status Worker Programs in the South, Southern Regional Education Board, Atlanta, Georgia, 1971.

King, James B., "The Black and White Issues," a position paper from the project director, Community College Mental Health Workers Project, Southern Regional Education Board, Atlanta, Georgia, 1972.

King, James B., "The Tide and the Westerly Wind: Keynote Address for the Western Interstate Commission for Higher Education," unpublished paper read before the Western Interstate Commission for Higher Education, Denver, Colorado, April 2, 1971. (Multilithed)

King, James B., and Harold L. McPheeters, Plans for Teaching Mental Health Workers: Community College Curriculum Objectives, Southern Regional Education Board, Atlanta, Georgia, February 1971.

King, James, and Harold L. McPheeters, Roles and Functions for Mental Health Workers, Southern Regional Education Board, Atlanta, Georgia, December 1969.

Koltai, Leslie, and Alice S. Thurston, "The Community Colleges," American Junior Colleges, 8th Edition, edited by Edmund J. Gleazer, Jr., American Council on Education, Washington, D. C., 1971.

McPheeters, Harold L., "Faculty Relationships to Graduates," a position paper prepared for the 1972 National Faculty Development Conference, Community College Mental Health Workers Project, Southern Regional Education Board, Atlanta, Georgia, August 13-16, 1972.

McPheeters, Harold L., "Faculty Responsibilities Regarding the Introduction and Use of Mental Health Worker Graduates in Agencies," a position paper from the Commission on Mental Illness and Retardation, Southern Regional Education Board, Atlanta, Georgia, 1973.

McPheeters, Harold L., Manpower Utilization in Social Welfare: A Report Based on a Symposium on Manpower Utilization in Social Welfare Services, Southern Regional Education Board, Atlanta, Georgia, June 1970.

McPheeters, Harold L., "Recommendations for Mental Health Workers Upon Entering Employment in a Mental Health System," a position paper from the Commission on Mental Illness and Retardation, Southern Regional Education Board, Atlanta, Georgia, 1973.

McPheeters, Harold L., "Some Considerations in Introducing New Mental Health Workers," a position paper from the Commission on Mental Illness and Retardation, Southern Regional Education Board, Atlanta, Georgia, 1973.

North, Robert, "Micro-Lab Training of Mental Health Workers," a position paper prepared for the 1972 National Faculty Development Conference, Community College Mental Health Workers Project, Louisville, Kentucky, August 14-16, 1972.

Report of the American Association of Junior Colleges and the National Health Council Ad Hoc Committee: A Guide for Health Technology Program Planning, Washington, D. C., 1967.

Riendeau, Albert J., The Role of the Advisory Committee in Occupational Education in the Junior College, American Association of Junior Colleges, Washington, D. C., 1967.

Schulman, Eveline D., "The Four W's of the Mental Health Technologist's Field Work Placement," a position paper prepared for the 1972 National Faculty Development Conference, Community College Mental Health Workers Project, Louisville, Kentucky, August 13-16, 1972.

Southern Regional Education Board, "Roles and Functions for Mental Health Workers: A Report of a Symposium on Manpower Utilization for Mental Health," Community College Mental Health Worker Project of the Southern Regional Education Board, Atlanta, Georgia, December, 1969. (Multilithed)

Southern Regional Education Board, Summary Analyses of National Survey, Atlanta, Georgia, 1973.

Encyclopedia Articles

Medsker, Leland L., "Community College Education," The Encyclopedia of Educational Research, 4th Edition, edited by Robert L. Ebel, a project of the American Educational Research Association, London, Macmillan Co., 1969.

Unpublished Materials

Simon, Ralph, "The Paraprofessionals are Coming! The Paraprofessionals are Coming!" a paper presented at the 78th Annual Convention, American Psychological Association, Miami Beach, Florida, 1970.

Sinnett, E. Robert, and Linda K. Niedenthol, Research Report Number 1: The Use of Indigenous Volunteers in a Rehabilitation Living Unit for Disturbed College Students, Student Health Service, Kansas State University, September 1967.

Staudt, E., 1401 Generalized Tabulate with or without Control Fields - 1.4, 226, Contributed Program Library, Program Information Department, International Business Machines Corporation, Poughkeepsie, N. Y.

Public Documents

Blue Ridge Community College, Bulletin, 1971-1972 Blue Ridge Community College, Weyers Cave, Virginia, 1971.

Glaser, Daniel, and Vincent O'Leary, Parole Decision-Making Report, JD-5003, Office of Juvenile Delinquency and Youth Development, The Alcoholic Offender, Washington, D. C., U. S. Government Printing Office, 1966.

Hollander, Fred, "A Mental Health Training Program for Clergymen," Mental Health Program Reports--No. 2, February 1968, Department of Health, Education and Welfare, Public Health Service Publication No. 1743, Superintendent of Documents, Washington, D. C., U. S. Government Printing Office, February 1968.

National Institute of Mental Health, Training and Manpower Resources Branch, The Psychiatric Aide in State Mental Hospitals, Department of Health, Education and Welfare, Publication PHS1286, Superintendent of Documents, Washington, D. C., U. S. Government Printing Office, March 1965.

National Institute of Mental Health, Survey and Reports Section, Biometry Branch, Descriptive Data on Federally Funded Community Mental Health Centers 1971-1972, 2nd Edition, Rockville, Maryland, May 1973.

National Institute of Mental Health, Private Mental Hospitals, 1969-1970, Department of Health, Education and Welfare Publication No. HSM 72-9089, Superintendent of Documents, Washington, D. C., U. S. Government Printing Office, 1972.

National Institute of Mental Health, Survey and Reports Section, Biometry Branch, Staffing of State and County Mental Hospitals, Department of Health, Education and Welfare Publication No. HSM 72-9012 (Statistical Note 52), Superintendent of Documents, Washington, D. C., U. S. Government Printing Office, June 1971.

National Institute of Mental Health, Staffing Patterns in Mental Health Facilities, 1968, Public Health Service Publication No. 5034, Superintendent of Documents, Washington, D. C., U. S. Government Printing Office, 1970.

National Institute of Mental Health, Survey and Reports Section, Biometry Branch, Staff and Manhours in Mental Health Facilities in the United States, Department of Health, Education and Welfare Publication Statistical Note 51, Superintendent of Documents, Washington, D. C., U. S. Government Printing Office, May 1971.

National Institute of Mental Health, The Nation's Psychiatrists, Public Health Service Publication No. 1885, Superintendent of Documents, Washington, D. C., U. S. Government Printing Office, 1969.

National Institute of Mental Health, Memo: Estimates of Unmet Needs with Respect to Mental Health Services, August 28, 1970, Mimeo. Copy.

Sanders, Richard, "Training a New Breed of Mental Health Worker," Mental Health Program Reports--3 January 1969, Department of Health, Education and Welfare, Public Health Service Publication No. 1876, Superintendent of Documents, Washington, D. C., U. S. Government Printing Office, January 1969.

Senate Report of the Health Facilities, Manpower, and Community Mental Health Centers Act of 1972, 92nd Congress, 2nd Session, No. 1014, Washington, D. C., August 16, 1972.

Unpublished Materials

Chinsky, Jack M., "Nonprofessional in a Mental Hospital: A Study of the Student Volunteer," unpublished doctoral dissertation, Psychology Department, University of Rochester, Rochester, N. Y., 1968.

Rappaport, Julian, "Nonprofessionals in a Mental Hospital: College Students as Group Leaders with Chronic Patients," unpublished doctoral dissertation, Psychology Department, University of Rochester, Rochester, N. Y., 1968.