THE UNIVERSITY OF OKLAHOMA

GRADUATE COLLEGE

CHANGING PATTERNS OF SERVICE AS THEY AFFECT THE SOCIAL WORK ROLE IN A COMMUNITY MENTAL HEALTH CENTER

A DISSERTATION

SUBMITTED TO THE GRADUATE FACULTY

in partial fulfillment of the requirements for the

degree of

DOCTOR OF PHILOSOPHY

BY

ROBERT W. KETNER

Oklahoma City, Oklahoma

1967

CHANGING PATTERNS OF SERVICE AS THEY AFFECT THE SOCIAL WORK ROLE IN A COMMUNITY MENTAL HEALTH CENTER

APPROVED BY

John D. Bruhn

Wilson A. Steen

M. H. Drey

A. W. Schottstaedt

C. Stanley Clifton

DISSERTATION COMMITTEE

ACKNOWLEDGMENTS

This dissertation is the culmination of many years of interest in community mental health. First, as a social worker in a mental health clinic and, later, as an instructor in social work, the need for examination of social work in a community mental health center became apparent.

This study represents the thoughts, interest, and work of so many people - professors, colleagues, and relatives - that it is not feasible to acknowledge all of them.

Certain persons, because of the strategic roles they played, are due a special measure of thanks.

To Dr. John Bruhn, I owe a sizeable debt. From the beginning, he provided intellectual stimulation, guidance and encouragement and gave freely and warmly of his time. Likewise, I am indebted to Dr. C. Stanley Clifton, who, as a member of my committee, offered many helpful suggestions and much support. As Director of the School of Social Work, he constantly sought ways to arrange my faculty responsibilities in order that I might devote more time to my program. To Dr. William Schottstaedt, Dr. Wilson David Steen, and Dr. Edwin Fair, I am deeply grateful for their constant interest, encouragement, and assistance. I am grateful to Dr. Michael H. Ivey for his help. I feel a deep sense of gratitude to Dr. Fair and the Staff of the

Kay Guidance Clinic whose warm interest, acceptance and help made my field assignment and the time spent in Ponca City both profitable and pleasant.

My colleagues in the School of Social Work were generous with their time, suggestions and reference materials. They, like Dr. Clifton, not only tolerated my preoccupation but helped with on-going responsibilities.

My deep gratitude and appreciation goes to my wife. Without her patience, encouragement, tolerance and help, the task could not have been completed. To my parents, who found many ways to translate their interest and support into helpful acts, we are both indebted.

TABLE OF CONTENTS

LIST OF TABLES

CHANGING PATTERNS OF SERVICE AS THEY AFFECT THE SOCIAL WORK ROLE IN A COMMUNITY MENTAL HEALTH CENTER

CHAPTER I

INTRODUCTION

The objective of this study is to develop a model of social work practice in a mental health center, specifically the Kay Guidance Clinic.

In recent years social work literature has emphasized the need for the new practitioner or the social worker of tomorrow. Rosen (1965) has suggested that the demands for community mental health programs make it mandatory that social work education and practice assess the role of the social worker in relationship to the demands of a new type of mental health center. Mark Tarail (1965), in describing the social worker of tomorrow, lists among his chief criteria the ability to assume a social work role as a member of an expanding community mental health team. The definition of this role is a crucial problem for social work education and practice in Oklahoma. The Director of the Oklahoma University School of Social Work, Dr. C. Stanley Clifton, has stated on several occasions that, in planning school expansion and curriculum revision, the school must be cognizant of the demand for practitioners who can effectively work in Oklahoma mental

health centers. This observation was further emphasized in the recent Long Range Plan for Mental Health in Oklahoma (1964), published by the Oklahoma Mental Health Planning Committee. The changes in social work must represent unified changes within the field of practice as well as in social work education. The question of social work role in the mental health centers is, by no means, a settled one. On one hand, Kendall (1967) has arrived at the conclusion that the generic curriculum in its current form certainly does not answer our present perplexities with sufficient clarity, nor does it meet our future needs with any sufficiency of power. She believes that the clinical social work controversy, for example, can no longer be hidden or truly resolved within the framework of the current curriculum policy. She suggests that the "action" must be placed back into a vital position in the social work role. On the other hand, Perlman (1967) pleads that we not assume that the development of new programs and new roles will diminish the need for the "clinical social worker" and suggests that, while social action, changes in social policy and the development of new treatment facilities may demand some modification of role, the "one-to-one" relationship, casework treatment, must not be abandoned.

It is assumed that, as a mental health center matures, the nature of the referrals will change and new demands will be made upon social work, which, in turn, will lead to the evolution of a new role for the social worker. At this moment, there is no adequate social work model. The development of these roles within the community mental health center is dependent upon the nature of the community, the special ecology and needs of the community, and the philosophy of the medical

director. This implies some variation in function and role. Yet, perhaps, in view of the federal regulations and objectives, there are some social work tasks which will be common to all centers.

The majority of the mental health centers proposed for development within the State of Oklahoma will operate in geographical areas somewhat comparable to that in which the Kay Guidance Clinic operates. In view of the criteria established for comprehensive mental health centers, it appears that the Kay Guidance Clinic operates from a mature, progressive orientation and is an excellent center for studying the developing social work role. The rural centers will be without the presence of Family Service Agencies and other social and psychiatric agencies and, thus, perhaps, the model will be somewhat different from that which might be evolved in a mental health center in a metropolitan area. It is hoped that, from this study of the Kay Guidance Clinic, a beginning social work model will be developed which will be helpful to social workers and administrators in the mental health field, to social work educators, and will serve as a base for the examination of the most expeditious use of social work time in other fields of social work practice.

Method

Material for this study was gathered from three primary sources.

First, some of the data were obtained from personal interviews with persons directly involved in the development and operation of the Kay Guidance Clinic. Considerable time was spent with the Director of the Clinic and with the current staff of the clinic. In addition to

interviews with the staff, contact was made with selected referral sources and community leaders who were involved in the establishment, maintenance, and the future plans of the Kay Guidance Clinic. A three-week field placement in the Clinic, as a part of the doctoral program, enabled the author to observe the operation of the Clinic, to participate in many of the functions carried out by the Director and social work staff of the agency.

Second, a descriptive study was made of referral sources, selected client characteristics, and disposition of a random sample of cases that were seen at the Clinic between January 1, 1958 and December 31, 1965. Cases in the Clinic are filed in numerical order and, every third case was selected for analysis. A total of 685 cases were selected for study. These data are presented and discussed in appropriate chapters.

Third, materials for this were gathered from various written primary and secondary sources designated in the bibliography. Although few books are available on the subject of the social worker's role in the expanding community mental health program, there are numerous articles, manuscripts, speeches and reports prepared by the State Board of Health and various federal agencies.

CHAPTER II

THE SOCIAL WORK ROLE IN COMMUNITY MENTAL HEALTH, PAST AND PRESENT

Introduction

Careful examination of the recent developments in the field of mental health, while applauded by social work actionists and clinicians, raises many provocative and urgent questions regarding the traditional role of social work. President Kennedy's call for "a bold new approach" to the problems of mental health and mental retardation highlighted only one dimension of the problem for social work. President Kennedy emphasized the fact that we must seek out the causes of mental illness and retardation in an effort to eradicate them, strengthen the underlying resources and knowledge which we have gained through social science, and recruit skilled manpower necessary to sustain the work on behalf of the mentally ill and retarded. Furthermore, in his Congressional Message, he suggested that we should strengthen and improve the programs and the facilities serving this group of people. In some respects the bold new approach seems to be related to the design of facilities which would enable social work to carry out its traditional role more effectively.

Another part of the problem posed for social work is perhaps best exemplified by the statement of the Surgeon General's Ad Hoc

Committee on Planning for Mental Health Facilities (1962) which suggested, in addition to President Kennedy's recommendations, that the mental health practitioner must promote mental health and make an effort to prevent mental illness. This report emphasized the importance of increased public understanding of the variety of factors which affect the well-being of individuals regardless of age. It further highlighted the need to remove the conditions which produce excessive stress, frustration, or deprivation and to strengthen those forces, perhaps within schools, which contribute to strengthening the emotional well-being of children.

Those two dimensions of the problem, prevention of mental illness and provision of more adequate service facilities, coupled with their implementation in the Mental Health Act of 1963, make the examination of the social work practice in mental health programs mandatory. The breadth of this challenge can hardly be overestimated. The commitment is to the total community mental health program and the concern is not only with the traditional care for those who are labeled as mentally ill, but also, for the vast majority of the population who are in need of some practical mental health information and assistance. Furthermore, the mandate for the mental health professional is to protect and strengthen those who are healthy as well as to help those who, because of a variety of life crises, may find their internal and external resources inadequate to meet their problems.

The expanse of this challenge to the mental health worker in general, and to the social worker in particular, is summarized in a publication of the Hogg Foundation (1962) which lists among its examples

of problems to be dealt with by the mental health professional: the unmarried mother who lacks resources to care for herself and her unborn child; the school age child who does well academically, but is socially handicapped; the older person who has retired and is, thereby, lost, lonely and confused; the adolescent who is acting out his rebellion against his parents in anti-social ways; the expectant mother who, because of ignorance, superstition or unhealthy attitudes, is not emotionally or physically prepared to bear her child; the family wage earner who is out of work and unable to maintain his family; the patient returning from a mental hospital who, with his family, is afraid; the infant deprived of maternal love and care; the man, alone, driven toward self-destruction; and the emotionally crippled.

This partial list of tasks designated as appropriate activity of the mental health center indicates that social work must continue its traditional role, perhaps with some modification, and at the same time be more involved in prevention, education and consultation. The problems presented by such a program are numerous. The solutions encompass a wide range of services, prevention, professional and lay education, and the translation of programs into practice. The scope of these problems raises a number of crucial questions for the social work educator and for the social work practitioner.

Wittman (1962) points out that there is a strong feeling "among those who have some awareness of where we now stand, that current efforts (of social workers) in mental health fall far short of meeting the vast needs". In viewing the breadth of services and the nature of the new demands, it becomes readily visible that the simple expansion

of existing services is not sufficient.

Wittman further suggests that the core of social work practice in mental health is related, and has been for many years, to the mentally ill. The educational programs for social work in the field primarily focus interest on understanding and reversing or, at least, controlling pathological processes as they impair social functioning. While this is a valid objective of social work, it is limited in that it focuses attention on etiology and treatment rather than promotion of mental health and prevention of mental illness and emotional disorders.

The federal and state legislative programs came at a moment in social work history when the profession was struggling to define its role in a variety of areas of practice. Social work education and practice has been attempting to digest and implement the findings of The Curriculum Study of 1958, and schools have been trying to find ways to implement and incorporate the new dimensions of The Curriculum Policy Statement of 1962. At the same time, social work has been attempting to incorporate new fields of practice and to redesign functions or roles in many areas.

For the social worker engaged in comprehensive community mental health centers, there is no model available. The lack of such a model is not a problem unique to social work alone. Social scientists of today who are interested in community mental health continue to point out the ambiguities in the definition of the term itself. George Albee (1964), in his review of The Community Mental Health Center, concludes that "There is no magic here - - - There is nothing on the inside except

the same old performers going through the same old routines". On the other hand, a careful reading of the federal regulations regarding the comprehensive mental health centers leads to some conclusions which specify how various services are to be available to the patients.

Neither social work practice nor social work education has actually yet come to grips with the basic problem facing those students who ultimately will become practitioners in the mental health field. That is, will the traditional social work methods and the usual concentration in one method of social work practice equip practitioners to work effectively in the new type agencies? Will the comprehensive mental health centers require social workers who are generalists or will they require greater use of social work specialists? The field of social work is in a state of flux and many changes in methodology and philosophy will be required of social work if it is to meet the demands placed upon it by the development of community mental health centers. Clifton (1967) has pointed out that this must be a partnership transition from "the old to the new" involving both education and agencies. He points out that the new social worker in an old, tradition bound agency will find his efforts leading to frustration and will, therefore, find himself blocked in an effort to carry out the role of the "new practitioner".

According to the current standard definition of mental health, as enunciated by recent legislation, social work has been involved in the promotion of mental health and the provision of mental health services since the earliest beginnings of the profession. The social work role has varied from decade to decade as new ideas, definitions

and concepts have been incorporated into social work education and social work practice. Historically, the nature of the social work role in mental health has been largely dependent upon, and influenced by, two major interrelated and interdependent forces - social, economic and political developments and the changing concept of mental health. Social work has not operated in a vacuum. It has been influenced by developments within the fields of psychiatry, developments within its own field, and developments in public health. Since no one mental health profession can operate in isolation, each borrowing knowledge and theory from the other, perhaps a brief review of the trends in the fields of psychiatry, social work and public health will enable social work to build an effective bridge from the old traditional roles to the demands of tomorrow.

Social Change

Massive changes which have been brought about by industrialization in the western world now are spreading at a rapid pace to isolated parts of this country. As Wilensky and Lebeaux (1965) have pointed out, the machine and the factory are the symbols of both progress and problems in human living. The Industrial Revolution has been followed by a succession of scientific, medical and technical discoveries. These, along with inventions, have led to automation and wide use of computers. These factors, coupled with cultural borrowings, have brought about sweeping social changes.

Social work in the United States is part and product of the larger socio-cultural-economic setting in which it operates. While

social work at times helps to shape the larger society, it also reflects, more than it determines, the nature of the whole. Social work cannot be understood apart from social change or social context. Wilensky and Lebeaux further point out that the more we understand its link to society and culture, the better we will see opportunities to influence the development of welfare services and professional activities of social work. Major shifts and changes in the larger institutional units (societies, communities and government) deeply affect what goes on in the smaller units of society such as the family, friendship clubs, groups or social agencies. Goode (1961) suggests that the larger institutions of society are rapidly changing. As the larger institutions change, smaller units such as the family also must change. Those social agencies and institutions which support the family, or which fill the gaps created by technical change, are affected by the change. Social and personal disorganization are frequent results. Wilensky and Lebeaux point out that there are many links between industrialization of American society on one hand, and the nature and function of social welfare services and practice on the other hand. They suggest that industrialization has created many problems related to unemployment and has made visible other social problems such as family breakdown, delinquency, mobility, and poverty. Furthermore, industrialization has made possible the financial resources necessary for the provision of services. Along with the expanded service has come governmental participation, creating a bureaucratic structure which depersonalizes the helping process and resulting in a large expenditure of professional time in paper work.

Ackerman (1958) has suggested that vast changes beginning with the industrial revolution have brought about a "peculiar disharmony" between the individual and society. He further states: A variety of hypotheses come to mind: Durkheim's concept of anomie; Fromm's emphasis on the trend toward alienation; Reismann's theory of the other-directed man. Whatever the term, we all agree on the trend toward a sense of aloneness, confusion of personal identity, and a search for acceptance through conformity. One effect of this trend toward disorientation is to throw each person back upon his family group for the restoration of a sense of security, belongingness, dignity and worth. The family is called upon to make up to its individual members in affection and closeness for the anxiety and distress which is the result of failure to find a place in the wider world. This pressure to compensate individual members with special security and affection imposes upon the family an extra heavy psychic load."

At the same time, Goode (1961), Frankl (1963) and others have pointed out that the traditional family which has, in the past, given the closeness and support of which Ackerman speaks, is now in a process of rapid transition and change. Sociologists have noted the implications of social mobility, expanded technology, changes within medical science and changing cultural values. In particular, changes within the form and function of the family are forcing social welfare, as an institution, to fill the gap.

Pollock (1959) observed that the American culture is a rapidly changing culture, and that social science is now beginning to be able to identify the changes which are occurring. Thus, social science is

able to develop a pertinent body of knowledge. One major task facing the professions is to translate that knowledge into methods of service. Parad and Lindemann (1964) have suggested that rapid social change is leading to a new kind of service based upon a beginning body of theory, the primary purpose of which is to deal with crises in the life of the individual.

Perlman (1956) described the social agency as an organization "fashioned to express the will of a society or some group in that society as to social welfare". She suggests further that a social agency carries out society's decisions to take care of its members and to protect them from social breakdown, and it should attempt to prevent their maladjustment as well as attempting to lift the level of human functioning.

A social agency develops a type of service program to meet the particular needs of the community in which the social agency operates. Those forces which bring about the development of problems or potential problem areas within the society may be social, economic, technological, political, or a combination of these. According to Perlman, the social agency can be described as "a living, adaptable organism, susceptible to being understood and changed, much as any other organism . . . Like any other living organism, it has a past history, and its present means and ends are fashioned by this. The circumstances of its inception, the persons who nurture it, and the social situations it encounters will have affected an agency's present behavior. The society of which it is a product constantly acts upon it to shape and reform its operations in many ways and, by the agency's responsive reaction to the community, will be influenced."

If a social agency, because of vested interests, entrenched policies, and/or a tradition-bound board, becomes static, it will invariably operate inappropriately and not meet the demands of a constantly changing society. The social agency must "live" in direct and reciprocal relationship to the other social organizations and institutions within its area of influence. Change in one agency, without concomitant changes in the others, will lead to an imbalance in service programs.

Reissman, Cohen, and Pearl (1965) suggest that, in the past ten years, the behavioral and social sciences have accumulated a great deal of research data which reveals:

> " . . . one of the serious paradoxes of our generation. While we are becoming increasingly aware of mental health problems of the lower socio-economic segment of our society, we have also recognized and documented the inadequacies of the mental health services available to them. The lack of knowledge and skill necessary to engage the poor in treatment further adds to their continually increasing dilemma. The low income person is bombarded with pleas and advice from the mass media, the schools, and the professional community to seek help with family and individual emotional problems. But he finds, after making a difficult decision to use such services, long waiting lists or costs for private care beyond his means."

Along with others, such as Hollingshead and Redlich (1958), they point out that there must be some alteration in the traditional methods of promoting and enhancing mental health. The traditional methods, with their emphasis on verbal communication as the chief vehicle of change, have often proven ineffective.

From Freud, who recognized that traditional psychoanalytic therapy would eventually have to be altered if it were to reach the

multitudes of people who were in need of help, to the recent studies by Hollingshead and Redlich, psychiatry has slowly moved in the direction of acknowledging its limitations and now seems to be attempting to implement new forms of treatment. Freud (1950) stated:

> "One may reasonably expect that at some time or other the conscience of the community will awaken and admonish it that the poor man has just as much right to help for his mind as he now has for the surgeon's means of saving his life . . . . The task will then arise for us to adapt our techniques to the new conditions. I have no doubt that the validity of our psychological assumptions will impress the uneducated, too, but we shall need to find the simplest and most natural expressions for our theoretical doctrines. We shall probably discover that the poor are even less ready to part with their neuroses than the rich, because the hard life that awaits them when they recover has no attraction, and illness in them gives them more claim to help of others. Possibly, we may often be able to achieve something if we combine aid to the mind with material support."

Throughout its history, social work has been attuned, in part at least, to the changes within the culture. This is particularly true of the public welfare agencies. The government has given public welfare the responsibility for meeting individual and family needs created by such factors as depression, unemployment, illness, accidents, technology, old age and changing cultural patterns.

Cloward (1966) has pointed out that the private agencies (because of status needs of the professional as well as demands from the middle class) have become disengaged with the poor. He suggests that, prior to the 1930's, private as well as public agencies were oriented to cash relief and concrete service designed to deal with environmental problems. This was a period in which mental hygiene services began to get a small foot-hold. However, the caseloads of the agencies during

the '30's did not really fully reflect this change, because the majority of the clients were still asking for (and receiving) concrete services.

The history of the private agencies (particularly family agencies) in the period of the '40's is marked by a temporary re-emphasis on concrete services. Cloward suggests that the outbreak of the War brought drastic changes in the economic and environmental conditions which diverted agencies away from their preoccupation with psychological services and back into the realm of concrete, environmental assistance. By 1940, however, the trend away from economically dependent clients had become quite marked. Most agencies, according to Cloward, had "abandoned the practice of making direct cash payments to clients for any purpose; indeed, many agencies began to charge fees for their services. The payment of fees, in turn, became defined as an important indicator of the client's motivation to seek and ability to use psychological help." Cloward points out that by the 1950's "the dimensions of the historic disengagement from the poor became unmistakably clear."

The social and political forces of the '60's are, perhaps, best exemplified by the programs of the Office of Economic Opportunity and the War on Poverty. Poverty and mental health frequently are closely related. The War on Poverty, the wide variety of social programs, have once again called attention of the social work profession to the needs of the poor. The recognition of the problems of motivation, discouragement, second and third generation relief recipients, and the unquestioned relationship between poverty and health, has given major impetus to the profession as it seeks to incorporate again "environment"

as a vital link in the treatment and prevention of illness. It has, in one sense of the word, forced the professional to re-examine, re-evaluate, and (in some instances) redefine his role. This has been particularly true in those mental health centers which have attempted to meet the standards set forth in the Mental Health Act of 1963.

Changing Concepts of Mental Health

Dunham (1964), speaking of community mental health, points out that, in spite of the widespread support which is being given now to community mental health programs, the concept of mental health still represents many different things to different people and suggests that, until the concept of mental health is clearly defined, the professions will continue to find the task of delineating their specific roles difficult. Felix (1958) goes a step further, pointing out that the problem for the professions also includes a definition of the term "community".

Schofield (1966) has suggested that the effective use of mental health personnel is a problem primarily because of "the unsatisfactory, abstract, contradictory and non-operational definitions with which we presently have to work". He points out that, historically, the past one hundred years has witnessed a movement away from a severely restricted, crude definition of insanity to our present situation "in which we struggle with unduly comprehensive and inadequately differential definitions. There is current philosophical controversy that is direct witness to this problem. On one hand, we have the application of the concept of mental illness as a blanket rubric to cover the

complete range of all behavioral, psychological, and emotional disorders. On the other hand, we have a position that mental illness is, in fact, a myth that we violate reality when we seek to work within the framework of such a concept". Farnsworth (1965) believes that the fields of psychology and psychiatry have, somewhat defensively, pointed out the inadequacies of current definitions rather than having identified their component parts. He further believes that any definition of mental health must include value judgments. He suggests, "Mental health entails freedom with responsibility, flexibility, self-reliance, and a genuine concern for the common welfare. It is not freedom from anxiety and tension, not freedom from dissatisfaction, not conformity or constant happiness or a lessening of accomplishment and creativity, nor is it the absence of person idiosyncrasies." On the other hand, Menninger (1948) takes a rather Utopian view that mental health is "harmony between the individual and his environment". The World Health Organization defines health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Caplan (1961) believes that the professions are problem-focused, and we need to clearly define the components of mental health.

Knee and Lampton (1965) point out that the earliest mental health activities in this country were those which attempted to remove patients with mental diseases from work houses and jails and place them in hospitals. From the establishment of the first mental hospital in Williamsburg, Virginia, in 1773, until the mid-1800's, fifteen states had established such hospitals or asylums. The crusading efforts of Dorothea Dix in the 1840's and the 1850's called public attention to

the plight of the mentally ill which resulted in the establishment of additional mental hospitals and improved hospital care. In the early 1900's, Clifford Beers focused attention on the inadequacies of the existing hospitals and, as a result of his organizational efforts, a State Society for Mental Hygiene was established in Connecticut in 1908 and, a year later, the National Committee for Mental Hygiene was formed. The 1920's saw the organization and development of child guidance clinics. World War I served to stimulate interest in the field of psychiatry, and the period of World War II brought even greater and more significant developments in the field of mental health. Since the end of World War II, there have continued to be many advances in the understanding of mental health and mental illness, and the last fifteen years have seen a broadening of the concept of mental health to include sociological as well as psychological factors.

As suggested earlier, mental health is a concept. It is a dynamic and fluid concept which, through the years, has undergone successive alterations. The dynamic nature of the concept makes it imperative that social work, along with other disciplines, define its role in relationship to the current concept. Brown and Cain (1964) have suggested that the team responsibilities assigned by any comprehensive mental health center program must take into consideration the competencies of the professions involved and the accepted definition of the priorities and needs expressed by the lay and professional citizens of each given community.

Arbuckle (1966) implies that public education regarding the acceptability of acknowledging mental illness or emotional disorder has,

in a way, backfired. Today, we find ourselves in a situation wherein millions of people who previously might have considered that they were having normal day-to-day problems, now have been convinced that they are ill and need to go for treatment. He suggests that our current definition of mental health was evolved from the concept of illness. This fact further complicates the process of selection or delineation of the treatment roles of the disciplines involved in mental health work.

Community Psychiatry

For the last four or five decades, social work has looked to psychiatry for leadership in the treatment process. The social worker involved in the child guidance clinic movements or psychiatric outpatient programs has traditionally accepted the psychiatrist as "the leader of the team". As new demands are being made upon psychiatry, and as psychiatry redefines its role and refocuses treatment plans, concomitant changes will evolve in social work.

In response to these social changes, psychiatry also has undergone rather marked changes. Glasscote (1964) and others have pointed out that, ten years ago, the community mental health center had scarcely been heard of and the movement supporting community psychiatry and mental health was only making a beginning. Today, the support of virtually every agency and organization concerned with mental health attests that there is, indeed, such "a movement and that it is widespread". While the idea of community mental health is not new in the philosophical sense, it is a realtively new idea in terms of concrete developments.

One of the first psychiatrists to discuss the basic concept was Adolph Meyer. Speaking to the delegates of the International Congress of Medicine in 1913, Meyer stated:

> "The characteristic traits of a clinic for mental diseases should be, first, service to the patient rather than to the administrating system; second, elaboration of the study of the diseases rather than of means of wholesale handling of patients; third, possibilities of following up the studies of nature's experiments beyond the hospital period, and preventive work through extramural efforts outside of the hospital."

Meyer continued by pointing out that the clinic should be responsible for "a fairly well-circumscribed unit of population, so as to make possible studies of the social situation and of the dynamic factors which led to the occurrence of mental derangement, which must be attacked for the purposes of prevention".

Nemiah (1965) has pointed out that the roots of community mental health, particularly the idea of treating the patient in his home community, date back to the time of Philippe Pinel, who, in 1809, insisted that before patients were accepted in his mental hospital they were to be treated in the general hospital. Pinel insisted that the patient be transferred to the mental hospital only if he proved refractory to the treatment administered in the general hospital or if they needed a longer period of convalescent care to complete their recovery than that which was possible in the general hospital. Bellak (1964) speaks of Pinel's efforts to "strike off the chains" of inmates as the most popular symbol of the first phase of psychiatry. He believes that, toward the end of the 18th century, a new, sympathetic attitude

toward the mentally ill evolved. Bellak further states that the second phase "in the evolution of psychiatry was initiated approximately 100 years later as a result of the development of psychoanalysis by Freud". Bellak speaks of community psychiatry as the third phase in the evolution of psychiatry. He suggests that community psychiatry did not spring to life full-grown in a single place or on a specific date. He believes that this, like all new concepts, has many and varied roots. Community psychiatry, he feels, may be considered a truly evolutionary phenomenon in that it is largely a synthesis of the two phases in the development of psychiatry which preceded it. It reflects a concern for the welfare of the patient which was previously characteristic of the age of reason. This concern gathered further momentum, primarily as the result of the increased insight into the nature and treatment of mental illness afforded by psychoanalytic theory. He believes that community psychiatry is intrinsically bound to psychoanalysis on one hand - and, on the other hand, represents a marriage of social and behavioral sciences which ultimately are the cornerstones of community psychiatry.

Bellak defines community psychiatry as "the resolve to view the individual's psychiatric problems within the frame of reference of the community and vice versa". He is quick, however, to point out that psychiatry as of this moment has not achieved a clear-cut, universally accepted definition of community psychiatry, and that literature reflects divergent points of view regarding the similarity, or dissimilarity, of community psychiatry and social psychiatry. Some psychiatrists raise the question as to whether community psychiatry is

a "new form of treatment" or whether it is a sub-speciality of psychiatry.

Redlich and Freedman (1966) point out that scientific advances, particularly in the area of psychotropic drugs, have changed our definition of the psychiatric patient and his treatment plan. Today, "psychiatric illness" is not equated with "psychiatric hospitalization". Chemotherapy, they believe, has a major place in the treatment of psychoses and an important (but, perhaps, less clear) role in the treatment of neurotic and less severe emotional distrubances. In the more recent trend of psychiatric practice, drugs have played an increasingly significant role. There is considerable evidence that drug therapy may often obviate the necessity for hospitalization.

Bellak points out that the use of drugs has helped to "make community psychiatry a reality". While he does not minimize the importance of chemotherapy, he does suggest that there is sufficient indication that drugs, when used as the only treatment modality, cannot effect a cure or bring about significant permanent improvement in the patient. He further believes that psychiatric disturbances can be effectively managed in the out-patient setting by the judicious use of tranquillizers and energizers.

Action for Mental Health (1961), on one hand, suggests that in the comprehensive mental health programs, one-to-one individual psychotherapy is held at a minimum. On the other hand, Glasscote (1964) notes that many administrators of community mental health centers still see individual psychotherapy as "the backbone of the treatment process".

Zwerling and Rosenbaum (1965) have pointed out, almost invariably, the responses of an individually-oriented and traditionally-trained psychiatrist to a definition of community psychiatry or to an encounter with a community mental health practice are either, "I have done this - what's new about it?" or "What's this got to do with psychiatry?" They believe that community psychiatry places essentially five new demands upon the psychiatrist which are of equal importance to the other mental health personnel including social workers. First, the basic concepts are new - in addition to relevant specialists at the biological and psychological levels of behavioral determinants, community psychiatry demands expertise at the social level as well, and the traditional clinic team of psychiatrist, psycholgist and social worker must be augmented by the epidemiologist, social psychologist, sociologist, group process specialist, community organizer, and social anthropologist. Second, the formulations concerning illness processes in individuals as well as in population groups are new. In addition to biological and psychodynamic formulations, mechanisms at various social levels - family, community, social class, national group, cultural value orientation - are provided. They suggest that these determinants or mechanisms regarding the individual's illness are in addition to, not in place of, psychological mechanisms. The great conceptual challenge to psychiatry, currently, is neither "in refining the dynamics of intrapsychic nor of social processes, but in developing articulations between the social determinants and the intrapsychic determinants." Third, the concept of diagnosis is inevitably altered. The unit of illness and health must remain the individual patient so long as we are dealing with

mental functioning; but the diagnostic label no longer aims solely to describe the illness of an isolated individual. It may also include the pathogenic qualities of the family, the community, the work, the classroom, or school and it may include the ward of a mental hospital. Fourth, techniques of treatment are altered. Family therapy, milieu therapy, are sufficiently close to the model of individual treatment so as to evoke frequently from the psychiatrist, "We've always done that." The family, the ward, or the shop may be the focus of the interventional efforts. Zwerling and Rosenbaum point out that the treatment of a neighborhood is a valid therapeutic effort as well as a measure of prevention in regard to the individual inhabitants. Finally, they suggest that the site of professional operation may be new. While the hospital and the clinic remain, in the majority of instances, the home base, the community psychiatrist and his team are likely to be found where the community is - in the churches, in the settlement houses, the community centers, the courts, the schools, and the executive offices of government where decisions concerning housing or welfare or community planning are made.

Kahn (1966) has pointed out that community psychiatry, as opposed to "case psychiatry", throws the psychiatrist and the other members of his team into a new and complex role. Only as psychiatry, in collaboration with its other team members, is able to redefine reciprocal roles, can the knowledge from psychology and sociology be blended into effective community treatment programs.

Developments in Social Work

Using the World Health Organization's or Dr. Karl Menninger's

definition of mental health as a screen upon which to project the history of social casework, it becomes apparent that social casework has been involved, along with other social work practices, in mental health activity since its inception. From decade to decade, the social worker's involvement in mental health has been called many things - social reform, friendly visiting, casework, community organization and psychiatric social work. Year by year, changes have modified the role of the social work practitioner and the role of social work education. As mentioned above, changes in the fields of psychiatry and the changing concept of mental health have influenced social work practice and social work education. In spite of the myriad of changes that have occurred since the beginning of the century, the thread of concern for the total well-being of the individual has never been completely obliterated, although at times it has appeared swamped by various innovations.

Bisno (1956) suggests that, as a response to a dynamic society, social work in the United States has continued to evolve, adding new functions, surrendering certain old perogatives, accumulating knowledge, developing new skills, and modifying certain of its underlying assumptions. In this process of gradual transformation, there has been a basic continuity. Two basic, interrelated aspects of the transition seem to be of particular importance in this day and age. Bisno recognized that the first significant milestone was the emergence of the National Conference of Charities and Corrections in 1879 as a distinct and separate entity from the American Social Science Association. He further states that, "in one sense of the word, this declaration of

emancipation helped to formalize a trend that was already in existence: that is, the shift in emphasis on the part of the social worker from broad scientific inquiry to a concentration on method and technique." The second well-known indicator of change was Porter Lee's statement in 1929 on the shift in social work from "cause to function". From that point on, social work was seen as moving from a period characterized by a fight against entrenched social problems to a stage characterized by a professional worker offering a service in a systematic and skillful manner.

The period between 1890 and 1920 was characterized in this country by great enthusiasm for social reform. It was during this period that a great body of reform legislation was sought to curb the most obvious abuses. Social work was responsive to the spirit of this period. Although it was vaguely recognized that every problem was psychosocial in nature, the emphasis was placed on treatment of the social component of the problem situation. Social work, like the society of that time, looked to the establishment of a more favorable, benign environment as the means of helping people to achieve happiness.

Wish (1945), the American historian, recapitulated the contrast of the period 1820 to 1890 with the 1920's. He suggests that the period of the 20's was a period characterized by relative indifference to social reform and apathy toward social problems. "Just as the dominant pre-war note was sociological, that is, committed to the idea of social reform by means of cooperative action, so the new era of individualism ushered in a preoccupation with self that was psychological in its emphasis."

Schroeder (1965) suggests that psychiatric social work had its beginning in 1905 when psychiatrists became convinced that emotional illness was influenced by social, economic, and moral conditions in the living experience of the patient. Unable to go beyond direct treatment of their patients because of time limitation and, yet, recognizing the importance of reaching into families and communities, psychiatrists at the Massachusetts General Hospital in Boston, at both Bellevue Hospital and Cornell Clinic in New York hired "agents". These agents were asked to get information from relatives about the patient's family background and life experiences. The agents, later called psychiatric social workers, were also expected to maintain channels of communication by acting as intermediaries between the patient and his family. Later, the worker also helped to prepare the family for the patient's return home.

After this inception, several events had a strong impact upon the development of psychiatric social work. The high number of neuropsychiatric casualties during the two wars, increased activity in the interest of veterans of these wars, and the child guidance movement - all dramatized the importance of professional social workers in the psychiatric field. They created a demand that accelerated recruitment and training of psychiatric social workers. In 1918, foreseeing the need to care for shell-shocked victims of World War I, Smith College initiated the first formal training course for psychiatric social workers. Subsequently, the American Red Cross organized social service departments in federal hospitals to which psychiatric social workers were assigned.

About 1926, the United States Veterans' Bureau organized social service departments in Veterans' Hospitals. The Veteran's Administration went on to develop a nation-wide program of hospitals, clinics, centers, and regional offices.

During World War II, psychiatric social workers served on draft boards and as medical field agents, helping the newly initiated screening processes through consultation and conduting interviews with draftees. The American Association of Psychiatric Social Workers provided consultation to the military regarding the expanded needs of the armed services. At the end of the war, psychiatric social work was given an officer's classification in the armed services.

The child guidance movement has been a third strong influence in the development of psychiatric social work. Initiated because of a concern for juvenile delinquents, the program was soon broadened to include children with many other emotional and mental problems. The Commonwealth Fund gave the movement a strong push forward when, in 1922, it financed the establishment of eight clinics in selected cities for experimental purposes. These experiments proved effective, local funds continued their support, and other child guidance clinics sprang up. From the beginning, psychiatric social work, psychology, and psychiatry have formed a close professional team relationship in the child guidance clinic. This structure has provided the model for many other types of psychiatric clinics subsequently developed in the mental health field.

Kahn (1959) has pointed out that, from the early 1920's, the key organizing concepts in social casework came first from psycho-

analytic theory. Freudian psychiatry has, from that time, provided the foundation for the development of social casework.

Garrett (1952) points out that "the attempt to modify the client's personality is not a recent and revolutionary undertaking of caseworkers, but an evolutionary development from its very beginning -- then, as now, there was general recognition of the need to stimulate clients to want to change and to influence them to participate actively in the solution of their problems."

In 1952, Perlman made the following statement:

> There has been a rather troubling trend in social casework in recent years. One hopes that it is symptomatic only of a temporary phase of our development - perhaps one of these excessive swings which may be found in the late adolescence of a maturing person and, also, of a maturing profession. It might be called an 'intra-psychic-mindedness', a kind of concentration or obsession with problems of emotional or personality malfunctioning, and with methods and schemes for casework treatment of these. That this is a proper and vital area of our concern, no one would deny, but the trouble has been that another proper and vital area of concern has, at least temporarily, been neglected or cast aside as unimportant. This is the area of concern with what is maladjusted or sick in the interpersonal, person to person, social living of our clients and with the enriched development of understanding and means by which the realities of the person's everyday living may be so modified or changed as to affect, benignly, his internal unhappiness."

During the period in which social work was "swamped by psychiatry", the social worker raised an arbitrary dictotomy between treatment and prevention and acted as if these two were inconsistent. Perlman further demonstrates that prevention can be individual or it can be mass. Garton and Otto (1964), in the same vein, point out that the 1940's was a period in which social casework skills were

quickened and sharpened with the emphasis of caseworkers swinging to individual treatment resulting in almost exclusive emphasis on the client's psychic problems. The result was a tendency to neglect the family and to overlook the social situation. They further suggest that, during the period from 1950 to 1960, social work once again began to turn to the social sciences and directed its efforts toward finding methods of combining the psychological and sociological factors involved in problems and solutions.

The Curriculum Study (1959) of the Council on Social Work Education called stringent attention to the social science material necessary for adequate social work performance. Furthermore, it brought respectability back to the treatment objectives geared toward the modification of the environment and identified a wide range of sociological concepts. The reflection of the return to social science concepts is further highlighted in the Curriculum Policy Statement of 1962. In a rather direct, dramatic and unequivocable way, the most recent Curriculum Policy Statement demands that the curriculum of social work education integrate a wide range of social content to be balanced with its previously, almost exclusive, psychological content.

Thus, the period of the '60's has seen a return to the emphasis on environmental forces and an effort on the part of social work to integrate the sociological and psychological frames of reference. Perlman (1967) has pointed out the recent emphasis (that is, the emphasis since the War on Poverty) has been in the direction of group work and community organization. She has taken sharp issue with

the inference that "casework is dead", and has pointed out that social forces and social conditions alone frequently are not adequate in the promotion of social functioning. She suggests that the profession must be as concerned with motivation and capacity as it is with opportunity.

Developments in Public Health

Social work has become increasingly interested in public health since the Princeton Seminar on Public Health for Schools of Social Work in 1962. Social work, since that time, has become increasingly engaged in revitalizing community dimensions in social work. Social workers are beginning to recognize anew the applicability of some public health concepts and methods to the daily practice of social work. Reichert (1963) has pointed out that social work has borrowed from public health strategies of prevention as well as of treatment. He feels, also, that social work has learned much from public health relative to positive health promotion, and has found the concept of "primary, secondary and tertiary prevention" useful. There are other models, such as those proposed by Leavell and Clark (1958) and by Ryder (1962) which have relevance to social work. The Leavell and Clark model, frequently mentioned in social work literature, includes the levels of prevention which many social workers have found useful.

Reichert further suggests that perhaps the biggest problem facing social work today, in the area of health and medical care, is the inability of the profession to provide services to the bulk of the population who really need the service. He suggests, "Much as

we try to spread ourselves, we cannot keep up with the social change which produces new problems or new variations of the old problems. We often rob one another for staff to demonstrate new methods of rendering service, or to apply known methods in a new setting." He believes that, by applying some concepts from public health (particularly in the area of planning, assessment, control and treatment) social work could make better use of its manpower and that, perhaps, this is a model which would be useful to social work. Kadushin (1962) points out that social work operates from a knowledge base, part of which is its own (that is, indigenous to social work, developed by social workers), and knowledge which has been borrowed from other disciplines. He suggests, "The interrelationship of borrowed and indigenous material is so compounded that it is often difficult to distinguish one from another. Borrowed material is translated, amended, reshaped for use often beyond recognition of the discipline which conceived it." He suggests that the classic example in social work literature is the extent to which the profession has depended upon, and borrowed knowledge from, the psychoanalytic field. Along with Stein and Cockrell (1958), he suggests that there is a considerable body of knowledge from the field of public health that would be useful to social work.

Wittman (1962) believes that it is imperative for social work to redefine and redevelop its interest and technique in the field of prevention. He suggests that the rationale and, perhaps, the best model for preventive social work comes from a translation of some of the basic concepts from the field of public health into

the social work practice. As far back as 1934, Reynolds spoke of the need for the social worker to assess a community, assess clientele, and implement strategies which would prevent further illness or further deterioration. Wittman suggests that preventive social work is an "organized and systematic effort by social workers to apply knowledge about social health and pathology in such a manner as to mitigate or eliminate social problems." He feels that social workers have always agreed that an ounce of prevention is worth a pound of cure, but have been fuzzy and unclear in their application of such a principle as prevention. Bartlett points out that we are just beginning to make use of public health ideas in a systematic way as we consider epidemiologic approaches, levels of prevention, and early case finding. Wittman suggests that social epidemiology is the basic science of preventive social work. He warns, however, that the development and the application of social epidemiology will have to be preceded by a very deep understanding of the interaction of human ecology and the individual. Only persons with such preparation will be capable of "carrying the fruits of clinical knowledge into the social system" which Leighton (1960) feels is one of the basic functions of social psychiatry.

It seems apparent that the social worker who is to be involved in preventive services will need to understand social epidemiology as a prerequisite to effective service. It might be added, parenthetically, that this content is not ordinarly available in the usual Master's Degree curriculum, and, thus, most people in the field are obtaining this study through the Schools of Public Health or, at times, through independent study.

Kahn (1962) offers a series of formulations relating to prevention and its use as a social work tool. He summarizes the history of social work thinking about prevention, and provides a summary of current literature on the subject. He proposes two levels of primary prevention. The first would deal with the broad institutional efforts concerned with providing a base within existing institutions for advancing the economic and social well-being of the population (ultimate prevention). The second level of prevention (intermediate) involves "the interposition of positive factors between negative social determinants and those who are generally affected". He concluded, " . . . the public health model has much to offer in the planning and coordination of social work services. The prevention concept has considerable application to many areas of social work concern. Indeed, we have hardly begun to work well at one end of the continuum, defining prevention in its quite specific and more delimited sense." After a review of the literature, Kahn arrives at five conclusions:

> Much of the public health model applies to social work services.
>
> Much should be done to strengthen specific prevention.
>
> Our image of social welfare and social work demands that we go beyond this.
>
> Social work has done too little by way of prevention in recent decades.
>
> The concept of provision or developmental provision, defined as independent of prevention, may serve to describe a broader role for social work, one not tied to the pathology continuum or to the residual limitations on the role of the profession.

Beck (1962) defines prevention in social work as those "activities

which have merit in averting or discouraging the development of specific social problems, or in delaying, or controlling the growth of such problems after they have presented beginning symptoms. It should be recognized that social work aimed at treatment and rehabilitation of severe problems can be considered as having preventive aspects, but for purposes of making a working definition and of sharpening the emphasis on prevention, this area of practice is excluded from the definition, except where it is incidental to a preventative aim. An example of such preventive aim would be service extended to parents with severe pathology or delaying the developments of problems in their children."

Witte (1962) suggests that public health and social work not only have much in common, but that each has knowledge and skills which, properly utilized, can enhance performance in the other field. He suggests, further, that we have in common the roots from which we have grown. They are found in the common interest of the early pioneers who may be considered "our common founders". Increased immigration and the development of slums became the concern of reformers who saw the effects of overcrowding on health and sanitation, on poverty and dependency, on family life, and organized in various ways to do something about them. Among those who contributed to some of these early developments in both public health and social work were such leaders as Dorothea Dix, Jane Addams, Florence Kelly, Benjamin Rush, Jacob Riis and Justice Louis Brandeis.

The early identification of public health and social work tended to disappear as the two fields developed their special interest and

their own unique training programs. As social work evolved, it placed increasing emphasis on direct services to individuals, whereas public health moved in the opposite direction. It is significant to note, however, that recent developments in both fields appear to be bringing both disciplines to a realization that many problems are shared. Mountin (1952) suggests, "In addition, a new approach to health, itself, is being fostered by professional groups as well as in the popular mind. Health is now being thought of, not in terms of disease or mortality figures, but in a positive way, in terms of physical fitness, mental and emotional adjustment, and social satisfactions and usefulness. In other words, health is no longer considered solely as an end, but also as a means. The responsibility of public health cannot be considered liquidated once we have reduced infant mortality to the vanishing point, or conquered malaria, syphilis, cancer, or heart disease. It must be geared to promoting even higher standards of human efficiency and satisfaction. As an important corrolary of this approach, public health workers are obliged to take a new look at the origins of social pathology. Health problems cannot be isolated from the environment, physical and social, in which they exist. Such factors as the individual's job, family life, housing, recreation, must all be evaluated for their impact upon health and disease. In other words, we must now not only put emphasis on the individual and his needs, but also consider him in relation to his whole, complex, socio-economic environment."

Hamovitch (1962) has pointed out that, if one examines the history of social work, a number of successive stages and phases can

be identified. During some of these stages, he suggests we approached problems in ways that were quite similar to those of the epidemiologist. Prior to the 20th century and even into the beginnings of the century, the spirt of social work was much in line with the prevailing epidemiological approach. Social workers paid a great deal of attention to ascertaining the cause of dependency and crime. Following World War I, social work turned to Freudian psychology and a clinical frame of reference. During this phase of social work history, the major concern was the individual case and the acqusition of skill in dealing with an individual client or patient. Even during the depression, when there was a considerable ferment in the realm of social policy, the trained social worker primarily sought his satisfactions in clinical practice. This persisted into the post World War II period. In the last ten years, there has been a resurgence of interest in research generally and, specifically, in research designed to investigate the etiology of social ills and emotional disturbances. Professionally, social work seems to be fumbling with inadequate tools, partly because it is not sure of the theories on which it operates. Hamovitch suggests that, instead of attempting to carve out all new theories, social work and social work educators should be more cognizant of the developments within the field of epidemiology.

CHAPTER III

MENTAL HEALTH IN OKLAHOMA

While professional social work services within the mental health institutions in the State of Oklahoma are a relatively recent innovation, social work activities in this field are inseparably related to the history of the development of mental health resources, facilities and services within the state. From the time of the employment of the first "social service worker" at Central State Griffin Memorial Hospital in the mid '30's, social work services in all institutions have grown at a rather steady pace. It was noted by the School of Social Work of the University of Oklahoma in 1956 that the mental health system in the State of Oklahoma had assumed leadership in the demand for and the provision of facilities for training professional social workers.

Almost a quarter of a century before statehood, the Cherokee Nation, which occupied the territory of Oklahoma, was the first governmental agency to establish facilities for the mentally ill. In the fall of 1872, a Committee for the Cherokee Nation established a "Home for the Insane, Deaf, Dumb, and Blind". This institution, known as Park Hill, came under the direct supervision of the United States Government in 1899, at which point the federal government, rather than the Cherokee Nation, provided the necessary funds for the mainte-

nance of the Home. In 1890, when the Territory of Oklahoma was formed, the territorial governor made a contract with the Oaklawn Retreat in Illinois for hospital care of Oklahoma Territory's mentally ill. In 1895, the Norman Sanitarium Company contracted for the care of those patients who previously had been transported to Illinois. One year after statehood, Western State Hospital at Fort Supply was established as the first state institution for the care of mentally ill in Oklahoma. One year later the first school for the mentally retarded was opened in Enid, Oklahoma. About 10 years after statehood, the Oklahoma State Legislature authorized the purchase of the private sanitarium in Norman. In 1913, Eastern Oklahoma State Hospital for Negroes was opened. Within 5 years after statehood, Oklahoma had made provision for custodial hospital care for approximately 2500 people. Within the last fifty years, rather remarkable changes in Oklahoma's attitudes toward, and care for, its mentally ill have occurred. However, it was not until the early 1950's that Oklahoma moved from its "snake pit" era and the enactment of the State Mental Health Law provided the foundation for the present mental hospital systems and services within the state.

A fairly recent development in the Oklahoma mental health system has been the provision of community mental health services. As traditional in this country, these services began with a concern for the needs of children. In an effort to meet these needs, the first community guidance clinic was established in Oklahoma City in 1947.

In spite of the progress which has been made, Oklahoma's Long

Range Mental Health Target (1963) points out that Oklahoma is losing ground in its war against mental disorders. The document suggests that gaps are growing wider between our needs and what can be offered in manpower, money and creative kinds of rehabilitive services. The report suggests that it is time for a long look at what we are and are not doing, and what is necessary in terms of services to meet the needs within the state.

Fair (1967) points out that the 30th Oklahoma State Legislature was one of the most productive sessions in the history of the state as far as mental health is concerned. He states: " . . . it's enactments combined with those of the United States Congress to provide a strengthened legal foundation from which to proceed toward a long range goal of community-based mental health and mental illness services in Oklahoma is a long step toward the need fulfillment". The state legislature passed twenty acts which have specific mental health implications. In 1963, Senate Bill 175 called for the establishment of regional guidance clinics under the designation, leadership, and directorship of the State Board of Health. The law stated that these regional clinics should be established on a regional rather than a specific community base, but that they must be located in a county having a County Department of Health or participating in cooperative district Health Department. This act gave the State Board of Health the authority to adopt rules, regulations, and standards for the operation of its guidance clinics across the state. Fourteen such clinics are now in operation.

Prior to the Regional Guidance Center Act of 1963, there were

a number of community mental hygiene clinics within the state. Some of these had been in operation for a number of years. The older and more established clinics served the metropolitan areas of Oklahoma City and Tulsa. While many such clinics operate primarily related to the health departments, no clinic (perhaps with the exception of the Kay Guidance Clinic) approaches the standards established by Senate Bill 175. None of these clinics has a program which enables it to qualify under the regulations of the Community Mental Health Centers Act of 1963 passed by the Federal Congress. It was this legislative act that, among other things, provided $50,000 per year for a 2-year period for our state to study and plan mental health services.

After the enactment of this law, the Oklahoma State Medical Association in its annual meeting suggested that funds for mental health planning be raised from private sources. However, since funds from private sources were not forthcoming, the State utilized Federal funds for planning. In 1963, the Governor of the State of Oklahoma established the Oklahoma Mental Health Planning Committee. The purpose of this committee was to "conduct a comprehensive mental health survey of all Oklahoma in an effort to identify the existing needs in the broad spectrum of mental health and illness programs." Particular emphasis was placed upon local community needs. One of the ultimate objectives of this study, through its findings, was to recommend the strengthening of community-based mental health centers. The Governor designated the State Health Department as the administrative agency for the study programs. Governor Bellman appointed a Mental Health Planning Committee, consisting of about 200 members, including

physicians, attorneys, politicans, educators, ministers, social workers and representatives of lay organizations.

Fair states that this large committee organization was designed so that it could function under the direction of an Executive Committee and 12 sub-committees. The responsibility of the Executive Committee was that of guiding the complete mental health study as well as serving as a liaison between the staff for the study and the Governor of the State. This Committee also had the power for some policy making decisions related to the focus of the study.

The range of Oklahoma's concern about mental health is reflected by the 12 sub-committee reports of the Mental Health Planning Committee. These 12 committees dealt with the broad spectrum of mental health problems including; aging, alcoholism, adult mentally ill, emotionally disturbed children, delinquency, financing, legal aspects, manpower, mental retardation, professional standards, regional task force, and research.

The sub-committees met regularly over a 2-year period of time. They did independent studies of their own areas, and utilized information provided by the regional task force sub-committee whose job it was to survey at the grass roots level the local communities and turn their findings over to the sub-committees directly concerned with the particular facets of the mental health and illness program. The sub-committees studied the data and presented their reports in a preliminary form to the Executive Committee on August 10, 1964.

After reviewing the 12 sub-committees' reports, the Executive Committee directed "that the staff of the Oklahoma State Department

of Health for Mental Health Planning should reduce the sub-committee reports into a single, composite document for submission to the entire membership of the Oklahoma Mental Health Planning Committee, and that the staff develop a separate section of over-all principles for the development of a system of community-based mental health services." Final instructions were given and comments made relative to preparing sub-committee reports for the Mental Health Planning Committee. The Committee was further instructed that it should make no recommendation which would change the responsibility of the existing state agencies; that it would make no recommendations which would imply the reduction of the budget of existing mental health services; that the document should be concerned with community services only and should present a set of principles "for implementing the community mental health services that are needed across the state". While it was recognized that the individual communities across the state would ultimately have the responsibility for implementation, the Committee recommended that a set of guidelines or principles should be drawn up to provide equal or comparable services in all areas of the state. In response to the instructions of the Executive Committee, the sub-committee reports were incorporated in a document, Oklahoma's Long Range Mental Health Target, and presented to the Executive Committee in October of 1965.

In summary form, the Department of Mental Health of the State of Oklahoma Health Department arrived at 10 conclusions (Appendix A) and 18 recommendations (Appendix B) which form the basic philosophy of Oklahoma's long range plan for mental health. These conclusions acknowledge that mental and emotional disorders are Oklahoma's

most extensive, varied, and generally unmet health problem, and suggest that the incidence or prevalence of these disorders will not diminish or abate in the future. The report concludes that Oklahoma's public mental health programs are inadequate and that, in order for the state institutions to achieve maximum efficiency, they must redefine their roles and coordinate their efforts with community-based programs.

Also, the summary includes the recognition that Oklahoma cannot expect to have adequate mental health care until more adequate funding, more organized research, and additional training facilities for professional personnel are incorporated. It suggests, furthermore, that the most effective financing must be of multiple source, with monies coming from state, federal, local and insurance sources.

Primary among the recommendations of the group was that the State should have a continuing State Mental Health Council, and that it should assume responsibility for directing Oklahoma's efforts toward the eventual establishment of comprehensive mental health facilities within the State. This Committee underlined and accepted the criteria established by the Community Mental Health Centers Act and suggested that, within each community (this may represent a rather wide geographical area), the following 10 services should be provided: 24-hour emergency service; partial hospitalization; consultation and education; rehabilitation; training; in-patient care; out-patient care; diagnosis; pre-and-after care; and research and evaluation.

Of marked interest to social work in Oklahoma was the emphasis placed upon the utilization of regional and state centers as training facilities for social work students. Of equal interest

but, perhaps, more concern were the ten tasks assigned to the community mental health centers. A careful examination of these tasks and an exploration of the social work role within them raise serious question as to the adequacy of manpower, education, training, and experience essential for the realization of a new social work role.

CHAPTER IV

STUDY OF THE KAY GUIDANCE CLINIC

History

The Kay Guidance Clinic, located in Ponca City, Oklahoma, in a semi-rural area of north central Oklahoma, was established in 1958 as a multi-purpose community mental health clinic. It was designed to offer services to children and adults. Incorporated as a county-wide, non-profit organization (Appendix C), it was established to serve all segments of the population. Since its establishment, the Clinic has steadily expanded its facilities, examined and redefined its role, engaged in periodic self-evaluation, and consistently sought ways to make the most effective use of its limited staff.

As the Clinic's role within Kay County has become more secure, its staff has participated actively in Oklahoma's state-wide efforts to develop regional mental health centers. More recently, the staff, the board, and the total community turned their attention toward the development of a comprehensive mental health center. A study of the Kay Guidance Clinic reveals that, even before the Mental Health Act of 1963, this Clinic was moving in the direction of a comprehensive center and had begun on a small scale many of the services recommended in that legislature.

In the early 1950's, a group of citizens, spearheaded by a

study group from the First Presbyterian Church in Ponca City, began to discuss the needs for some type of mental health service in the community. Their particular concern was stimulated by a number of emotional problems and learning difficulties noted in the school program. Many of these citizens were also aware of the need for psychiatric facilities to deal with the wide range of adult emotional, psychiatric, and social problems. The schools, through parents, teachers, and administrators gave a considerable amount of support which, coupled with that of the study group and other professionals in the community, led to the establishment of a Mental Health Association within the county. This group met regularly to discuss the problems within the community, to discuss the various dimensions of mental health, and to discuss with psychiatric personnel from outside of the county the problems involved in the establishment of a child guidance clinic. By 1956, the group was sufficiently organized to send a delegation of professional and lay leaders from the county to Topeka, Kansas, to discuss with Dr. Edwin Fair and members of the Menninger Foundation staff the possibilities of establishing such a clinic, the problems involved in staffing, the problems of funding and, particularly, sought help in securing a psychiatric director who would devote part time to the community mental health center and part time to private practice.

Their experience in Topkea confirmed their conviction that the needs of their county could be best met by a more comprehensive mental health center rather than by the traditional child guidance clinic or mental health center found in the metropolitan areas. They were told

that the type of facility which they sought required the leadership of a "community psychiatrist". They were further told that there was no real model for such a facility and that community psychiatry was a rather vague, unknown, and ill-defined speciality. With the help of Dr. Karl Menninger and other senior staff of the Menninger Foundation, Dr. Fair, having agreed to come to Ponca City and direct the clinic on a part-time basis, designed the latter portion of his residency program to include programs within the School of Psychiatry which would be useful in directing the work of the clinic.

In retrospect, community leaders point to this specialized training, Dr. Fair's previous experience and reputation as a thoracic surgeon, his many years of participation in a wide range of church and welfare organizations, and the sound planning and interpretation of the community power structure as factors which, in large measure, account for the ready acceptance and the minimum of resistance that has been experienced by the Kay Guidance Clinic and its staff.

"Community-mindedness", defined by the Director of the Clinic as a genuine concern for people from all segments of the community, respect for the knowledge and skill of all resources within the area, awareness and sensitivity to the needs and wishes expressed by the people to serve and be served, was, in addition to professional qualifications, the chief criterion for the selection of the original staff of the Clinic. These two criteria have continued to be paramount in the thinking of the Director and the Personnel Committee of the Board as the Clinic staff has expanded. This constant concern for the "community-minded professional" has, through the years, led to a

gradual sifting out of personnel who were unable to fulfill this role and to the bringing together of a staff with similar interest and concern. Currently, because of its solid position and its vision of expanded facilities, the staff and board have acknowledged the role of the expert clinician who is not particularly interested in working with the total community.

The Kay Guidance Clinic, according to the President of the Board, Mr. David Levy (1967), was built "on people". The original planners were committed to finding staff members who were professionally qualified and, of equal importance, could "open the doors of understanding" between the mental health clinic, the community agencies and organizations, and the public at large. The Clinic was envisioned as a "coordinator of a county-wide effort on behalf of the treatment and prevention of emotional disorders". Thus, a wide range of representation from professional and lay groups was included in the original planning and implementation of the plan for the establishment of a clinic.

Determined that the Kay Guidance Clinic not be identified as "a Ponca City clinic", the first Clinic was opened outside of the Ponca City city limits. Community leaders point with pride to the fact that they purchased a building with voluntary contributions from a varied group of citizens and received labor contributions from labor unions to recondition the facility. The community is equally proud of the fact t at a minister, two lawyers, two physicians and a banker borrowed money on a personal loan basis to meet a financial crisis during the second year of the Clinic's operation. While Ponca City

contains the largest share of the County population, Board representation includes persons from the total catchment area selected on a population basis.

In some respects, Kay Guidance Clinic was for many years "a one man clinic". Most of the key professional referral persons in the community referred their problems to the Director of the Clinic who, in turn, referred them to the appropriate Clinic staff members. Through conscious planning and interpretation, the Director has been able, in large measure, to transfer this confidence to his clinic staff members and, thus, currently, physicians, attorneys, court officials, and others call for consultation and make referrals to appropriate staff members without first screening through the Director. This transfer has been successful, according to the Director, primarily because of the competency of the clinic staff, their skill in relating to the needs of referral sources, and their willingness to extend themselves to referral sources almost on an around-the-clock emergency base.

In recent years, the Clinic has added to its function of direct or indirect services, the educational function, and provides summer educational programs and field instruction for graduate social work students.

In the course of the nine-year history, the Clinic has expanded from a staff of one social worker, one part-time clinical psychologist, and a part-time psychiatrist, to a staff of nineteen. Concomitant with that expansion has been an increase in the range of services provided by each discipline represented. The focus of this study is social work services of the Kay Guidance Clinic.

Characteristics of the Clientele

During the eight years encompassed in this study, 2055 cases have been seen at the Kay Guidance Clinic. Cases are filed numerically each year. For this study, each third case was selected. Thus, the sample consisted of 685 cases. Face sheets similar to those used by the Clinic were prepared and face sheet information was transferred from the original folder to the statistical face sheet (Appendix D). Names were omitted. Evaluation reports, referral reports, and case summaries were studied in an effort to determine such factors as diagnosis, type and length of treatment. This information was checked against the financial statement of each case. The intake book was used as a supplemental source when other information was needed. An effort was made to secure 26 items of information on each case. During the eight year history of the Clinic, statistical records, summaries, and narrative interviews have changed from time to time. As might be anticipated in any clinic, many records were incomplete. Thus, the standarization of the data year by year was not possible on many of the items.

Referrals

A study of the referral sources by years reveals a continuous, expanding use of the Clinic facilities by the total community. While there have been fluctuations from year to year, ranging from 21% in 1961 to 34% in 1962, it is apparent from Table 1 that approximately 25% of the clients have been referred to the Clinic by the school systems. Since the beginning of its operation, the Clinic and the

TABLE 1

REFERRAL SOURCES OF CLIENTS, KAY GUIDANCE CLINIC, 1958 - 1965
BY PERCENTAGES

Referral Source	1958 N=65	1959 N=66	1960 N=85	1961 N=92	1962 N=92	1963 N=84	1964 N=111	1965 N=93
Physician	24.6	33.3	24.4	21.7	34.8	32.1	29.8	25.8
School	26.1	24.3	31.7	23.9	21.7	19.1	28.8	32.3
Attorney	0	0	6.1	7.6	6.5	1.2	4.5	5.4
Court	6.1	3.0	1.2	10.9	6.5	13.1	7.2	4.3
Self	18.5	7.6	14.6	9.8	5.4	8.3	6.3	10.8
Friend	0	3.0	3.7	4.3	4.4	2.4	.9	1.1
Minister	0	3.0	1.2	2.2	2.2	5.9	2.7	4.3
Relative	7.7	3.0	2.5	1.1	3.3	3.6	.9	4.3
Parent	3.1	13.7	8.5	7.6	4.4	5.9	9.0	7.5
Public Welfare	0	0	1.2	2.2	6.5	3.6	1.8	2.1
Other & Unknown	13.9	9.1	4.9	8.7	4.3	4.8	8.1	2.1
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

schools within the County have had contractual arrangements whereby the overall school districts' contributions to the Clinic covered the cost of clinical services. A more detailed break-down of school referrals indicates that the four major towns within the County have received their proportionate share of Clinic time. This detailed break-down also indicates that the rural schools as well as the local Indian school, have turned to the Clinic for assistance. The basic services provided to the school referrals were evaluations of children with learning or behavior problems. In recent years, the Clinic has "gone to the school" on a more systematized basis. Social workers from the Clinic are assigned school areas and schedule weekly visits. Psychologists and psychiatrists also visit the school, tests are administered there, opportunitie for casework interviews with the family is provided, and consultation to the teachers is given. The consultation may assume either a formal or informal nature. The Clinic staff, having done a brief initial study at the school, make direct referrals to the Clinic for further evaluation and/or treatment when deemed appropriate.

Physicians from the catchment area have provided from 21.7% to 34.8% of the referrals. The majority of these referrals by physicians were adults. Generally speaking, these clients were referred for evaluation and treatment. Since the addition, in 1960, of EEG equipment, physicians have consistently made referrals for neurological and EEG examinations. In these instances, formal reports are returned to the physician. In other instances, formal reports are generally not sent to referring physicians. An analysis of

the referring physicians reveals that, while the percentage year by year has fluctuated, the number of physicians who refer to the Clinic continues to expand. Initially, the physicians attempted to refer their patients through the Director. However, in recent years, they have referred directly to the intake worker.

The courts, both adult and juvenile, have referred individuals to the Clinic for various types of service, most often for evaluations. Occasionally, especially with children, the court has requested and received recommendations regarding disposition of a case. While most of the court referrals have been made after charges have been filed, there has been a trend, particularly evidenced on the part of the juvenile judge, to use the evaluations of the Clinic as a basis for decision. It might be noted that the Juvenile Judge is one of the most active supporters of the Clinic and frequently attends the informal film and lecture series held regularly by the Clinic staff.

Attorneys in the area did not become active as referral sources until 1960. With one exception, 1963, the referrals from attorneys have averaged 5% to about 8% of the total clients seen at the Clinic. An analysis of the referrals by attorneys reveals that, while occasional referrals were made for sanity hearings or to assist in a decision regarding hospitalization for observation, most frequently the attorney referrals have been requests for marital counselling.

In 1960, the Kay County Department of Public Welfare began using the Kay Guidance Clinic facilities for assistance in their disability evaluations, and the Child Welfare Division started requesting assistance in foster home placements, adoptive studies, and other

Clinic services for their clients.

It is interesting to note that no referral was made by a minister in 1958. Since that time, percentage of referrals from ministers has fluctuated from about 1% to almost 6% in 1963. The referrals from the ministers represent a range of presenting problems but the largest percentage are for marital counseling.

The number of self referrals has decreased from about 18.5% in 1958 to 10.8% in 1965. It should be granted that the recorded "self referral" may not always be accurate. While the referral source listed on the fact sheet may be "self", it is not uncommon to discover upon reading the record, that prior suggestions for clinical help had been made by friends, ministers, or physicians.

The category "Unknown and Other" represents those clients for whom the referral source information was not available. This category also includes the occasional referral from employers, the Bureau of Indian Affairs, and social agencies outside of the County. Of particular interest in this category are those individuals referred to the Clinic for evaluation regarding their applications for employment with the Ponca City Police Department. Each new policeman or patrolman is placed on probationary status, referred to the Clinic for evaluation, and later given permanent employment or is dismissed on the basis of his performance and the evaluation. This is a service provided at no cost to the Police Department.

Type of Service

The Kay Guidance Clinic offers basically five types of services.

Social workers are involved in each type of service. Table 2 indicates the frequency of the type of service offered by the Clinic for each year from 1958 through 1965. As will be noted from the Table, many patients receive more than one type of service.

Each client is seen by a social worker for intake. The intake process may be one or several interviews. With few exceptions, notably marriage counseling cases and requests for EEG's, the intake is followed by a recommendation for an evaluation. As indicated in Table 2, a rather high percentage of the clientele do not return for service after the intake. Frequently, these cases are considered failures. They are not included statistically as treatment cases. Rapoport (1967) has pointed out the repeated failure of mental health centers to do adequate follow-up cases which terminate at the end of intake. It is possible that these people have come to the Clinic with false expectations. Perhaps these clients come under duress and are not ready to face or cope with their problems. It is equally feasible, however, that the process of intake, itself, as envisioned at the Kay Guidance Clinic as a treatment procedure, offering the client the opportunity to acknowledge a problem, to engage in clarification, to receive reassurance, and to relieve anxiety through verballization provides sufficient relief that the intake may be the treatment needed and, thus, the treatment of choice for the client at a crisis period in his life. Kay Guidance Clinic records contain many instances in which a client experienced relief and was mobilized to deal with his problem or to accept the normalcy of a child's behavior in one to three interviews. For example, a rather disturbed couple came to the Clinic expressing deep concern

TABLE 2

TYPE OF SERVICE PROVIDED CLIENTS, KAY GUIDANCE CLINIC, 1958 - 1965
BY PERCENTAGES

Type of Service	1958 N=65	1959 N=66	1960 N=82	1961 N=92	1962 N=92	1963 N=84	1964 N=111	1965 N=93
Intake	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Evaluation	58.4	53.0	73.1	73.9	78.2	58.3	61.2	46.2
Treatment	26.1	16.6	27.8	13.0	26.0	26.1	24.3	17.2
Referral	24.6	13.6	13.4	6.5	14.1	14.2	4.5	3.2
Consultation	20.0	15.1	20.7	36.9	34.7	25.0	48.6	43.9
Other	3.0	0	1.2	0	1.0	0	0	2.1

over the mastubatory activity of their 4-year-old child. After three hours of "intake", this case was terminated. A study of the record indicates that the intake process, a therapeutic experience, was a successful termination.

The social worker's role in evaluation varies from case to case. The Clinic operates flexibly in this area. Table 2 indicates that, from 1958 through 1962, there was a steady increase in the percentage of clients seen in evaluation. The decrease, from 1962 through 1965, is explained by the fact that, during these latter years, psychologists and psychiatrists did more evaluations at the schools.

It can be assumed that the yearly fluctuations in the type of service represents different expenditures of social work time related to the demands of the community and the program of the Clinic. The percentage of clients on whom consultations were held has increased from about 20% in 1958 to 44% in 1965. This implies, of course, that social caseworkers are spending an increasing amount of their time as consultants. Table 3 presents the range of consultation areas served by the Kay Guidance Clinic. It was not possible to determine the number of different schools, ministers and physicians involved in the consultation program. However, the areas served increased from 4 in 1958 to 12 in 1965. Case records reveal that consultation was used to secure information, to give information, and for mutual treatment planning.

A detailed break-down of the type of direct treatment offered by social work was not possible. One factor noted in Table 4, appears

TABLE 3

CONSULTATION AREAS SERVED, KAY GUIDANCE CLINIC, 1958 - 1965

Consultation area	1958	1959	1960	1961	1962	1963	1964	1965
School	*	*	*	*	*	*	*	*
Court	*	*	*	*	*	*	*	*
Physician	*	*	*	*	*	*	*	*
Police	*	*	*	*	*	*	*	*
Dept. of Public Welfare			*	*		*	*	*
Child Welfare					*	*	*	*
Vocational Rehabilitation							*	*
Minister							*	*
Bureau of Indian Affairs							*	*
County Health Department							*	*
Salvation Army								*
Big Brothers								*

Table 4

AVERAGE NUMBER OF INTERVIEWS PER ADULT CLIENT
KAY GUIDANCE CLINIC
1958 - 1965

Year	Average No. of Interviews per client
1958	20
1959	16
1960	18
1961	18
1962	15
1963	14
1964	13
1965	9

significant as far as trends in the use of social work time. The number of interviews per adult patient has decreased. This, coupled with the number of intakes, indicates that social workers are doing more short-term casework.

Social work treatment in a mental health center usually is equated with social casework. At the Kay Guidance Clinic, the social caseworkers are involved in group work with selected groups of clients. No data was available regarding the amount of social work time spent in group work, but discussions with the social work staff revealed a growing use of this treatment method.

While the study of the types of services offered from year to

year reveals no dramatic change, certain trends appear to be evolving. Social workers are spending more time in short-term treatment, consultation and group work.

Presenting Problems

According to Table 5, a high percentage of Clinic time is devoted to school learning and school behavior problems. While the number of cases referred to the Clinic as "learning problems" has risen, the percentage of "school behavior" problems has decreased. This may be related to the increased amount of clinical staff time spent directly in the schools. While it changes the location of the intake and evaluation procedure for the social worker and provides more opportunity for informal as well as formal consultation with school teachers, counsellors and administrators, it does not actually affect in any appreciable way the use of social work time, since, in either location, the social worker is a member of the evaluation team.

Among the adult clients, two presenting problems stand out. First, in each year, the percentage of marital problems was the highest of any category. Second, those persons referred because of "tension" or "nervousness" remained consistently high. The Table reveals that the social workers devote approximately 20% to 25% of their time with these two groups of clients. Consistently, the marital problems have a high drop-out rate. A more detailed analysis of the data reveals that social caseworkers have become progressively more successful in involving, in treatment beyond intake, the client who comes because of a marital problem. While a detailed follow-up study of these cases

TABLE 5

PRESENTING PROBLEMS OF CLIENTS, KAY GUIDANCE CLINIC 1958 - 1965
BY PERCENTAGES

Presenting Problem	1958 N=65	1959 N=66	1960 N=82	1961 N=92	1962 N=92	1963 N=84	1964 N=111	1965 N=93
School Learning	10.8	19.7	18.3	17.4	8.7	20.2	19.9	19.3
School Behavior	16.9	10.6	12.2	14.1	13.0	4.8	13.5	9.7
Childhood Behavior or Development	7.7	10.6	8.5	4.4	12.0	3.6	8.1	7.5
Adolescent Behavior Prob.	9.3	10.6	3.7	3.3	3.3	4.8	5.4	6.5
Tension Nervousness	4.6	7.6	15.8	9.8	14.1	15.5	9.0	8.6
Depression	9.3	10.6	6.1	0	5.4	5.9	2.7	3.2
Martial Prob.	16.9	12.1	17.1	19.6	16.3	17.8	16.2	16.1
Criminal Violation	4.6	3.0	2.4	9.8	5.4	11.9	6.3	4.3
Suicidal Attempt	0	1.5	1.2	0	1.1	3.5	2.7	2.2
Drinking	4.6	0	2.4	1.1	0	1.2	0	0
Somatic Complaints	0	3.0	1.2	2.2	3.3	0	2.7	2.2
Employment Problems	1.5	1.5	0	0	0	1.2	.9	2.2
Neurological	0	0	3.7	2.1	4.4	1.2	5.4	6.4
DPW Eval.	0	0	0	2.1	5.4	1.2	.9	2.1
Unknown	4.6	4.6	3.7	6.5	1.1	4.8	2.7	5.4
Other	9.2	4.6	3.7	7.6	6.5	2.4	3.6	4.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

would be essential to understanding the basic reason for their drop-out, it should be mentioned, as noted earlier, that the intake and/or evaluation process may be sufficient treatment in many of these cases.

The increase in the use of Clinic facilities by the Department of Public Welfare indicates an increase in the use of social work time in evaluation, consultation service and, perhaps, reflects more time being sent in collaborative effort with another social agency.

It should be noted that the requests for services regarding neurological problems are the only instances in which social work is not actually involved. This category represents those clients who are sent directly by their physicians to the psychiatrist at the Clinic for EEG's.

Racial Distribution

The population of Kay County is predominantly Caucasian. The total non-white population of the county is less than 5% (U. S. Census, 1960). Of those persons coming to the Kay Guidance Clinic for whom race was noted, from 1958 through 1965, there were 10 Negroes and 21 Indians. A further break-down reveals that 16 of the 21 Indian clients were children; 8 of the Negro cases were children. Table 6 indicates that the percentage of Negro clientele has remained essentially steady through the history of the Clinic. Over the 8 years of the study, the average percentage of the Negro clientele has been about 1.5% per year. Compared to the Negro population of the County, as revealed through the U. S. Census (1960), it appears that the Negro population of the County (which is 1.6%) are receiving their proportionate share of

TABLE 6

RACIAL DISTRIBUTION OF CLIENTS, KAY GUIDANCE CLINIC, 1958 - 1965
BY PERCENTAGES

Race	1958 N=65	1959 N=66	1960 N=82	1961 N=92	1962 N=92	1963 N=84	1964 N=111	1965 N=93
White	87.7	92.4	90.3	92.4	90.2	89.3	87.4	88.2
Negro	1.5	3.0	1.2	0	2.2	1.2	1.8	1.1
Indian	3.1	0	1.2	1.1	3.3	4.8	6.3	3.2
Unknown	7.7	4.6	7.3	6.5	4.3	4.7	4.5	7.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

services from the Clinic. A further breakdown indicates that this percentage is being upheld primarily because of the child population of the County. As was noted earlier, only two Negro adults have appeared at the Clinic, both having been referred by friends. One adult Negro client was referred because of nervousness, the other because of a marital problem. Neither of these cases returned after the initial interview. With the exception of one Negro child having been referred in 1964 by a physician, the other Negro children were referred by the schools and the court. According to the data, no Negro adults or children have been actively engaged in treatment.

The U. S. Census (1960), reveals that the Indian population of Kay County is 3.15%. Table 6 reveals that the overall average for the 8 years of the study shows 2.3% of the total clientele coming from the Indian population. Seventy-six percent of the Indians seen at the Clinic were children. They reflect referrals from the court and the parents, but the majority of them have been seen in the schools or referred to the Clinic by the Indian School in Pawnee or the school systems within the County. Primarily, they represent "learning problems". During the 8 years, only five Indian adults were seen in the Clinic. In two instances, they were seen at intake and for an evaluation but did not follow through in treatment. The majority of the Indian adults were referred by the Department of Public Welfare. Table 5 reveals an increase in the percentage over the span of the 8 years. The real increase began in 1962 when the services became known and were interpreted to representatives of the Bureau of Indian Affairs. Prior to that time, most of the Indian referrals had come from the

Court and Child Welfare.

Age

The Kay Guidance Clinic does not restrict itself to any age group. The age span of the clientele ranges from 2½ months to 73 years. In order to correlate the clinical services with referral sources and school referrals, the data were divided to include any individual 18 years of age and under as "child". Table 7, 8 and 9 present the age breakdown of the clientele by years. An analysis of these data indicates no marked change in the percentage of children versus adults seen in the Clinic. The percentage of children ranges from 46.1% in 1958 to a high of 59.4% in 1964. The U. S. Census Report (1960) reveals that 36.3% of the total population of Kay County is 18 years of age or under. It would appear that a disproportionate percentage of time is being spent in work with children. This is reflected not only in terms of the percentage of the clientele, but also in the fact that two clinical team members are involved in the majority of the childrens' cases. The exceptions to this are those instances in which the child is seen at the school. Yet, even in these instances, the caseworker may spend time with the parent, the child or teacher. The other exceptions are those few instances in which a child is brought to the Clinic for an EEG.

Children between the ages of 6 and 12 represent the majority of children's cases. This was notably true during the first two years of the Clinic operation. While the balance has not shifted, it is apparent that, during the past several years, more teen-age clients are being referred to the Clinic.

TABLE 7

AGE DISTRIBUTION OF CLIENTELE, KAY GUIDANCE CLINIC, 1958 - 1965
BY PERCENTAGES

Age	1958 N=65	1959 N=66	1960 N=82	1961 N=92	1962 N=92	1963 N=84	1964 N=111	1965 N=93
Adults	53.9	42.4	47.6	47.8	54.3	52.4	40.6	44.1
Children	46.1	57.6	52.4	52.2	45.7	47.6	59.4	55.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

TABLE 8

AGE OF ADULT CLIENTS, KAY GUIDANCE CLINIC, 1958 - 1965
BY PERCENTAGES

Age	1958 N=35	1959 N=28	1960 N=39	1961 N=44	1962 N=50	1963 N=44	1964 N=45	1965 N=41
19-24	17.1	14.3	23.1	25.0	24.0	22.7	22.2	17.1
25-30	20.0	28.6	23.1	25.0	20.0	18.2	26.7	29.3
31-36	25.7	14.3	15.4	22.7	22.0	22.7	17.8	14.6
37-42	8.6	17.8	17.9	4.5	12.0	6.8	13.3	14.6
43-48	5.7	10.7	12.8	4.6	4.0	11.4	13.3	4.9
49-54	5.7	0	2.6	6.8	4.0	4.5	4.5	9.8
55-60	0	0	0	2.3	0	9.1	2.2	2.4
61-66	0	0	0	0	2.0	0	0	0
67+	2.9	0	0	0	2.0	2.3	0	2.4
Unknown	14.3	14.3	5.1	9.1	10.0	2.3	0	4.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

TABLE 9

AGE DISTRIBUTION OF CLIENTS 18 YEARS AND UNDER, KAY GUIDANCE CLINIC, 1958 - 1965
BY PERCENTAGES

Age	1958 N=30	1959 N=38	1960 N=43	1961 N=48	1962 N=42	1963 N=40	1964 N=66	1965 N=52
5 years and Under	6.7	5.3	4.7	2.1	7.2	2.5	7.6	7.7
6 - 12	53.3	55.3	74.4	56.2	59.5	62.5	53.0	57.7
13 - 18	40.0	39.4	20.9	41.7	33.3	35.0	39.4	34.6
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Twelve point two percent (12.2%) of the total population of Kay County is under 6 years of age. Yet an analysis of the data reveals that the percentage of clients under 6 years of age fluctuates from 1.09% to a high of 4.50%. A more detailed break-down of the clients 5 years and under reveals that the majority of these children are referred by physicians. The nature of the presenting problems, compared to the type of service offered, indicate relationship disturbance between parent and child. In about 25% of these instances, the case was considered successfully terminated after relatively short-term counseling with the parent. Approximately, 20% of these children were referred by the physicians for neurological examinations, and no casework service was involved. Two children were referred to Central State Hospital; in one instance, the Clinic participated in an adoptive study at the request of the Child Welfare Division. In the remainder of cases, the parent did not return after the initial intake.

In spite of the current concerns of social work for the problems of the older segment of the population, that is, those individuals 65 years of age and older, as a group, they are making minimal use of the Kay Guidance Clinic. According to the 1960 Census this age group constitutes 9.9% of the population of Kay County. During the eight years encompassed in this study, only 4 clients in this age group were referred to the Clinic. Percentages by year range from 0 to 1.5%. Of the 3 female and 1 male clients in this age group, none entered treatment. One half of them were referred by physicians, one did not follow through past the 1-hour intake, the other participated in an evaluation and was referred back to the physician. The other two

clients were referred by relatives. After an evaluation, one was referred to the family physician, the other was referred to Central State Hospital.

It is apparent that the very young and the old are not taking advantage of Clinic facilities. While the Clinic has extended itself, as will be noted later, to the development of preventive programs, it would appear that this segment of the population is being neglected.

Fees of Adult Patients

Fees paid by clients for the services of the Clinic constitute a minimal portion of the Clinic's income. The social workers who do the initial interview with each client are convinced of the therapeutic values of the fee and, with few exceptions, the cost of service is discussed with each adult client. The only exceptions noted in the data were situations wherein, through contractual agreement, no fee was charged for the school referral and, in a few instances with adults, the referring agency was charged directly. The latter seems to be a customary procedure with Department of Public Welfare referrals. No one is refused the services of the Clinic. The fees range from no fee to a maximum of $10.00 per hour. The exception to the fee scale is the standard $30.00 fee charged for EEG examinations. The social worker establishes the fee with the client on a sliding scale, taking into account family income, the number of persons in the family, and other factors affecting the client's ability to pay. Those persons who are financially able are referred to private psychiatric facilities.

Table 10 is based on data concerning adult cases only. Children's

TABLE 10

FEES PAID BY ADULT CLIENTS, KAY GUIDANCE CLINIC, 1958 - 1965
BY PERCENTAGES

Fee	1958 N=35	1959 N=28	1960 N=39	1961 N=44	1962 N=50	1963 N=44	1964 N=45	1965 N=41
Unknown	25.7	17.9	15.4	2.3	14.0	25.0	6.7	7.3
No Fee	25.7	3.6	0	13.6	8.0	4.6	6.7	9.8
$.25-.99	0	14.3	12.8	13.6	12.0	11.4	0	0
1.00	8.5	25.0	38.5	34.1	28.0	13.6	35.5	26.8
2.00	14.3	17.9	12.8	6.8	18.0	11.4	6.7	2.4
3.00	11.4	7.1	2.6	6.8	4.0	15.9	15.6	19.5
4.00	8.6	0	7.7	0	0	0	4.4	4.9
5.00	2.9	7.1	5.1	11.4	6.0	13.6	6.7	17.1
6.00	2.9	0	0	0	0	0	4.4	4.9
7.00	0	0	0	0	0	0	2.2	4.9
8.00	0	0	0	2.3	0	0	0	0
9.00	0	0	0	0	0	0	2.2	0
10.00	0	7.1	0	4.6	4.0	0	0	0
10.00+	0	0	5.1	4.5	6.0	4.5	8.9	2.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

cases were excluded from this analysis because of the preponderance of school referrals for which no fee is charged. The Table reveals that, consistently, the highest percentage of the clients paid $1.00 per interview for their service. Because of the variables mentioned above, it was not possible to correlate fees with family income. It is interesting to note that the number of clients for whom no fee was charged dropped markedly after the first year of the Clinic's operation. The number of clients whose fee was set less than $1.00 has steadily declined since 1959, when 14% of the clients fell into this category, to 0% in 1964 and 1965. The years 1964 and 1965 show a marked increase in the number of clients whose fees were $6.00 and $7.00. While the fluctuations are obvious and no steady trend is discernible, it should be noted that, in 1958, 2.9% of the clientele paid $5.00 per hour whereas, in 1965, this percentage had risen to 17.%. It should be noted that, in 1960, the Clinic started providing the EEG examinations and these referrals, which do not involve social work time, account for the clients who were charged more than $10.00.

According to the U. S. Census Report, 1960, the average income per family in Kay County was $5,500. The average family income of Kay Guidance Clinic clients by year ranges from $3,165 in 1958 to $4,686 in 1963. Table 11 indicates that, with minor fluctuation, the average family income of the clientele has steadily increased. The family income of clients in 1965 was approximately 36% above the 1958 level. This is about double the income increase as estimated by the U. S. Department of Agriculture.

TABLE 11

AVERAGE ANNUAL INCOME OF CLIENTS*
KAY GUIDANCE CLINIC
1958 - 1965

Year	Average Annual Income
1958	$3,165
1959	4,003
1960	4,222
1961	4,315
1962	4,369
1963	4,686
1964	4,061
1965	4,304

*Based on cases in which data were listed

City of Residence

As noted earlier, the Board and Staff of the Clinic have consciously attempted to negate a specific identification of the Clinic as a Ponca City clinic. Table 12 reveals that, in spite of yearly fluctuations, the over-all trend has seen a decrease in the number of clients from Ponca City and an increase in the number of clients from Newkirk and Tonkawa. Also noted is the fact that the percentage of clients coming to the Clinic from communities other than the four major towns (Ponca City, Blackwell, Tonkawa and Newkirk) has increased.

TABLE 12

CITY OF RESIDENCE OF CLIENTS, KAY GUIDANCE CLINIC, 1958 - 1965
BY PERCENTAGES

City	1958 N=65	1959 N=66	1960 N=82	1961 N=92	1962 N=92	1963 N=84	1964 N=111	1965 N=93
Ponca City	70.8	66.7	68.3	71.8	77.2	72.6	67.6	67.7
Blackwell	10.8	12.1	18.3	14.1	13.0	13.1	16.2	9.7
Newkirk	4.6	4.6	6.1	4.3	4.3	6.0	4.5	6.4
Tonkawa	3.1	3.0	3.7	6.5	2.2	8.3	6.3	10.7
Kaw City	0	1.5	0	0	0	0	.9	0
Braman	0	0	1.2	0	2.2	0	1.8	1.1
Pawnee	0	0	0	0	0	0	1.8	0
Billings	0	0	0	1.1	0	0	0	0
Other	1.5	1.5	0	0	0	0	.9	2.2
Unknown	9.2	10.6	2.4	2.2	1.1	0	0	2.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

While Ponca City contains 47.8% of the County population, the percentage of the clientele from Ponca City ranges from a low of 66% to a high of 77%. It would appear, then, that the residents of Ponca City more frequently take advantage of Clinic facilities. This, according to Glasscote (1964), is a typical experience of any community mental health center. Throughout the history of the Clinic, from 9.7% to 18.2% of the Clinic intakes have come from Blackwell. Blackwell contains 18.8% of the County population. Newkirk, which contains 4.1% of the County population, appears to make good use of the Clinic facilities. With minor fluctuations, the over-all trend has seen an increase from 4.6% to a high of 6.4%. Tonkawa contains 6.1% of the County population. There has been a rather consistent trend toward the increase of the use of Clinic facilities by the population of Tonkawa.

A more detailed analysis of the data reveals, however, that the majority of clients who list Blackwell, Newkirk, Tonkawa, and others as the city of residence are children. The majority of adult clients are residents of Ponca City.

Educational Level of Adult Patients Related to Type of Service

The data reflect no appreciable change in the educational level of clients who seek help at the Kay Guidance Clinic. An analysis by year reveals that those persons with high school education constitute the highest percentage of the clientele. This is followed by clients whose educational level ranges from 13 through 16 years. There appeared to be no correlation between the educational level and

the type of service offered and accepted by the client with one exception. Detailed analysis of the disposition of those who were referred from the Clinic elsewhere reveals that those persons whose educational level was 13 through 16 years were more frequently referred to other out-patient psychiatric facilities, primarily to private practice, whereas those clients whose educational level was 11 years or below were more frequently referred to social agencies for concrete services or to hospitals.

CHAPTER V

DATA AND OBSERVATIONS RELATED TO SOCIAL WORK PRACTICE

The data reveals no dramatic changes with respect to the characteristics of the clientele of the Kay Guidance Clinic. However, the data, observations, and discussions with the social work staff reflect the development of certain trends regarding the use of social work time.

Less time is being spent in the Clinic; more time in the community. In 1958, the clinical staff included one full-time social worker. By 1965, the clinical staff included two full-time and one one-half time social workers. During this period of time, the number of applicants coming to the Clinic for direct service has increased 42%. Table 4 indicates that the amount of social work time spent with each client or family has steadily decreased. This study indicates that, in addition to an increase in direct services to clients and families, there has been a marked increase in the use of social work time in the areas of consultation, community education, and participation in professional educational activities.

Direct work within the schools provides the opportunity not only for service to clients but also for formal and informal consultations. Each social worker is assigned as a consultant to schools

within the catchment area. A yearly schedule is worked out with the school principals, and the social worker is available at the specified times for work with families, consultation with teachers, counsellors, administrators, and directors of special education programs. A site visit to the Blackwell School System during the author's field placement at the Clinic revealed that in one-half day consultation visit, the social worker talked with the Superintendent of the Blackwell Schools, reviewed records, did an evaluation interview with a parent, attended a special program presented by members of the Special Education and Remedial Speech classes, talked informally with parents, and held an informal consultation with the Director of the Special Education Class.

In addition to the services provided to the schools, this study also indicates that more consultation time is being spent with other referral sources than formerly. This consultation time may take the form of collaborative work with such agencies as the Juvenile Court and the Child Welfare Division of the Department of Public Welfare in planning services for clients, or it may involve working with a care-taking agency such as the American Legion Home located just outside of Ponca City. In recent years, the Clinic has established a hospital based office. The social workers spend specified periods of time in the office at the hospital. Thus, the social worker is available to patients who have been hospitalized, to their families, and is frequently actively engaged by the physician in planning with and for the patient.

Table 4 indicates a definite shift toward shorter-term case-

work treatment. It should not be inferred that the social caseworkers do not carry long-term cases. The case load of each worker contains clients and families for whom long-term intensive casework is the method of choice as well as clients and families who are carried on a long-term, supportive basis essential for the maintenance of functioning.

The Clinic has evolved some specialized programs and services which represent a different use of casework time. In addition to the hospital-based service mentioned above, the social workers have opened an Evening Clinic. One evening each week, the Clinic remains open for regularly-scheduled and intake appointments. The Evening Clinic was initiated in response to the request of clients and referral sources for those people who could not arrange daytime appointments. Compensatory time is provided for the social workers.

The social workers and other Clinic staff conduct Parent Counselling Groups. While these groups are essentially composed of parents who have participated in evaluations at the Clinic, it is interesting to note that, occasionally, parents and referral sources who have not brought problems to the Clinic participate in these sessions. Parent Counselling Groups are used frequently in conjunction with other treatment methods.

The Director of Social Work Services, in consultation with other team members, plans an informal monthly meeting, to which representatives from the Court, the schools, the Department of Public Welfare and other agencies and organizations are invited. These sessions are generally educational in nature and rely on the use of

audio-visual aids. They also provide an opportunity for the interpretation of changes within the Clinic program and the discussion of mutual interests, concerns and problems.

In 1966, the Kay Guidance Clinic entered into an agreement with the University of Oklahoma School of Social Work whereby the Clinic provides field instruction placements for two graduate social work students. One third of the time of one social work staff member is released for field instruction. The Clinic also provides housing, office space, and library facilities for the students. In addition to the social work program, the Clinic provides a summer placement for medical students from the University of Oklahoma Medical School. The social workers, through formal and informal arrangements, spend time with the medical students explaining the role of social work in community mental health.

CHAPTER VI

IMPLICATIONS FOR SOCIAL WORK

This study of the Kay Guidance Clinic, coupled with the projected plans for comprehensive mental health centers throughout the state, leads to certain suggestions for social work practice. The trends which have been noted earlier indicate a need for continued assessment of social work roles. Contrary to the opinions expressed by some social work educators, this study indicates the need, not for a new social worker, but for a shift of emphasis and re-examination of some of the traditional roles of the profession. To this writer, the most striking implication for social work practice and education is the need for deepened skill in short-term casework, consultation with care-taking agencies, community education directed toward the prevention of emotional problems, and the ability to work more effectively with groups of clients.

Short-term Casework

Short-term, or brief, casework treatment is not a new innovation and certainly not a new area of interest in the field of social work. A review of the social casework literature reveals many references to brief treatment, short-term casework, and more recently, crisis intervention. As Rapoport (1967) has pointed out,

social work has not yet defined the term "brief" as related to social casework treatment. The term as used herein is directed toward treatment focus and the casework objective rather than solely to the time involved in the problem solving process.

Experiences at the Clinic during the summer of 1966 which included discussions with the social work staff, participation in the social work consultations with the psychiatrist, attendance at staff conferences, and review of case records lead to the conclusion that social workers at the Kay Guidance Clinic have made successful use of short-term casework treatment. While a careful follow-up would be needed to document the effectiveness of the short-term treatment, it is the experience and opinion of the social work staff that, used on the selective basis, brief treatment is frequently the treatment method of choice. It appears to the writer that the success of brief treatment at the Kay Guidance Clinic is based upon several factors. First, the social workers are experienced and have a good grasp of basic social casework. Second, they have an excellent understanding of the dynamics of human behavior. Third, they operate on the conviction that a quick pledge of help to the client and an immediate focus on the precipitating problem serve to quickly develop a good worker-client relationship. They are careful not to offer false expectations, but are equally careful to offer the facilities of the Clinic either for direct service or as a referral source to another agency. Fourth, the intake process focuses first on the internal and external forces which have created the situation which brings the client to the Clinic at this particular time in his life. While underlying

or overt pathology is noted, attention is given also to an assessment of the ego strengths of the individual. Fifth, special note is made of his past problem solving efforts, skill, and success. Intake also includes careful attention to the environmental resources such as family, social agencies, or friends who are potential resources of help in the problem-solving effort. Sixth, the staff is not hesitant to contact referral sources which may be helpful in providing background information or insight concerning the current situation and who may be helpful in planning with the client. Seventh, the staff members appear to make excellent use of the psychiatric consultation which is available to them.

The Clinic records contains many examples of such treatment. For example, a teen-age girl came to the Clinic shortly after having seen the Juvenile Judge, who insisted she should come to the Clinic. The girl felt that the living conditions in her home were intolerable and insisted that she was going to run away from home. After violent disagreements, her father had relented, suggesting that she could leave but that, if she did so, it would be for good and she would not be permitted to return to her home. Finding herself unable to tolerate the current situation but unable to give up her relationship with her family, the girl had accepted the Judge's referral to the Clinic. After a telephone conversation with the Judge, an immediate attempt was made by the social caseworker to contact the father. He was found to be non-cooperative. A telephone conversation with the mother revealed that she was physically and mentally ill and unable to be of any real assistance to her daughter. When this teen-ager revealed

that she had, on many occasions in the past, spent nights and weekends in the home of a girl friend, the caseworker (after consultation with the father) called the mother of the girl friend. Arrangements were made for her to stay with the friend until a more permanent arrangement could be made through the Child Welfare Division of the Department of Public Welfare. A consultation was held with the child welfare worker, who agreed to assume responsibility for the case. The father was contacted and informed of these developments. He endorsed the plan, permitted the girl to come home to pick up her clothes and leave her home in an amicable atmosphere.

On another occasion, a 26-year-old employee of a local business establishment came to the Clinic in panic. The initial interview with the caseworker revealed that this young man had a good employment record with a local firm. A week or so prior to his Clinic appointment, he had been transferred from one area of activity to another department which involved working high above the ground. This young man revealed a life-time fear of heights and was at the point of quitting his job. After a brief interview with him, a consultation was held with the psychiatrist, and the social worker spent three sessions clarifying the alternatives and eventually helping this young man to discuss the problem with his employer and request transfer to another department. A brief, informal follow-up indicated several months later that this young man had made a comfortable adjustment to a new job.

The use of short-term casework raises certain philosophical, theoretical, and practical questions for the social worker in the

mental health center. Perhaps a brief review of some of the current materials concerning short-term treatment will provide a conceptual framework and, thus, make possible a more systematic use of the method by social workers.

As Rapoport points out, if we are to effectively use short-term treatment, we must re-examine our concept of motivation and be able to capitalize on the individual's need or "motivation" to alleviate the painful situation or circumstances which brings him to the clinic. Perhaps because of psychiatric social work's deep alliance with psychoanalysis and psychoanalytic theory, we have over-emphasized the value of insight and self-understanding or awareness as far as the client is concerned. Too often, brief casework is equated with superficial, symptomatic change, and thus is given extremely low rating on the hierarchy of treatment modalities. This frequently leads the mental health social worker to the conclusion that if treatment is to be effective it must deal with deeper, underlying factors or causes rather than with the current, stressful situation and the alleviation of the stress. As Rapoport suggests, discussions about briefer forms of treatment in psychiatry and social work always elicit the questions concerning whether or not changes brought about over a short period of time, or in the limited goal way, actually are lasting. This raises the question as to whether or not changes of a long range nature can be brought about in short time. As Parad and Caplan (1965) repeatedly note, we do know that life circumstances bring about disequilibrium or crises with which the individual cannot cope. Thus, frequently, assistance in re-establishing the equilibrium enables the individual

to function in quite an adequate way.

As indicated in Chapter II, the trend within the field of social work education to understand and incorporate more social science content has led to a deeper understanding of the concepts of cause and cure. "Cure", like "diagnosis", has been borrowed from the medical field and these terms have frequently led to false assumptions regarding the selection of the treatment of choice for the client in the mental health center. The concept of specific etiology related to emotional or behavioral disorders is a limiting one. It suggests to the social worker that specific, unresolved conflicts must be dealt with. It has led to the conclusion that very careful attention must always be paid to historical or background material and that effective treatment can only follow a carefully done intake and diagnostic process. It is not intended to suggest that study and diagnosis are not preferable. It is suggested that these two concepts need to be re-evaluated in light of the demands made upon the social caseworker in a mental health center.

Caplan (1962) suggests that the outcome of the crisis is most often less dependent upon the person's personality structure or his specific pathology than upon the current strength of his ego and the immediacy of the help he can receive. Caplan and Parad (1965) believe that a crisis may be viewed as a threat either to the instinctual need of the individual or to his sense of integrity; a loss involving either a person or a feeling of acute deprivation; or a challenge. They further believe that each of these three states has a rather typical or characteristic accompanying effect. If the crisis is experienced primarily

as a threat or challenge, it is most often apt to be experienced as anxiety. If it is deprivation or loss, it is most apt to be accompanied by depression. While researchers generally agree that the crisis situation and the individual's reaction to it is generally linked with earlier life experiences and old conflicts which may be reactivated because of the stress, it is not necessary to focus casework attention on the old reactivated problems. It has also been noted that the state of stress, or upset, or disequilibrium is limited in time. This seems to have several implications for social work in mental health centers. First, in order to help people with current life crises, we must make ourselves available to them. The incorporation of 24-hour service or emergency facilities (Appendix B) seems to be one answer to this problem. This also questions routinely structured, traditional weekly interviews, and calls for flexibility of planning with the client. Rapoport has suggested that brief treatment should be highly focused and segmental. The focus should basically be on the present, precipitating stress and the resulting consequences for the individual and his family. Parad has pointed out that crisis intervention calls for quick assessment of the strengths within the individual and those strengths within the environment which may be called into play at the moment of crisis. Certain "old" casework techniques which, in the last thirty or forty years, seem to have come into disrepute, need to be re-examined in light of the current body of knowledge. For example, advice-giving, active, direct participation and engagement with the client and the use of authority must be examined. At the same time, such concepts as study and diagnosis will

need to be clarified and screened against the treatment objective. Rapoport (1967) again points out that social work must take a fresh look at the concept of relationship. Social work and the other therapies have relied heavily upon relationship as the instrument through which change occurs. Rapoport suggests that 'relationship' is a rather vague term. The two case illustrations mentioned above seem contrary to the idea that a meaningful relationship can be developed only over an extended period of time, and the caseworkers were able to take advantage of the regressive phenomenon within each instance without permitting the development of a regressive transference phenomenon. Furthermore, social caseworkers at the clinic were able to use the authority of their agency and the authority of their professional competency in effecting rather immediate change. Their focus was on the future rather than on the past.

Many aspects of traditional casework theory and practice are appropriate and relevant to brief casework treatment. Other concepts will need to be redefined and re-evaluated. The further implementation of such a treatment modality emphasizes the need not only for casework departments to assess and redefine casework in the new (as compared to the orthodox) mental health center, but also brief treatment must be understood and accepted by the other disciplines within the center. Only then can it be seen as a treatment of choice rather than a treatment based upon expediency.

Consultation

Gradual changes in Kay Guidance Clinic have led to an increased

use of social workers' time as consultants to care-taking agencies and individuals within the community. From statistical data and interviews, it appears that the quantity and quality of casework consultation has steadily increased. Consultation is viewed as an interaction between two individuals or between the consultant and the institution with the focus of helping the individual or institution to solve a mental health problem within the framework of the professional role of the consultee. Consultation is further viewed as having educational and preventive value. As Bellak (1964) has pointed out, an effective mental health consultant must have not only a breadth and depth of clinical knowledge and skills but also an understanding of the consultation method. While many assumptions have been made about consultation, the profession has a dearth of conceptualized formulations, models, or hypotheses which, in actuality, have been tested out. It has been assumed frequently that the expert clinician or the expert supervisor can move into an effective consultation role. While Caplan (1959) has pointed out the similarities between therapy and consultation, suggesting that the role of the consultant may frequently be to remove "emotional blocks" from the consultee, he suggests that a careful delineation of role is essential for consultation. Thus, some of the techniques of the consultant may be similar to those of the teacher or supervisor. The differences have been recognized by the Kay Guidance Clinic staff. They suggest, for example, that consultation is usually initiated by the care-taking agency or the individual in the community in response to a specific, current problem; the consultant is usually of a different professional background from the

consultee and is, thus, not just a more experienced member or a senior member of the same profession; the consultant's role is advisory, he has no responsibility for the implementation of a plan; and the consultant is not in a position of administrative authority over the consultee. While the helping aspects of consultation bring the process very close to the casework method and many of the technical difficulties present in the casework process are also present in the consultation process, the social work consultant maintains a clear stance and a firm position that the care-taking agency or the individual (consultee) is dealt with by the consultant as another professional.

The social work staff have adopted the position most clearly expressed by Rapoport (1963) in which she points out that there are certain "core conditions" of a situation which must be present if consultation is to be an appropriate activity of the social worker.

First, the social worker must be willing to accept consultation as an indirect method of service. This implies that he is dealing with a colleague or an associate, and this implies that the use of a professional relationship solely within the context of treatment-oriented clinical model or the authoritative administrative model will be a barrier to the success of consultation.

Second, when there is a voluntary relationship, a mutual respect and responsibility is implied. The consultant, thus, has the responsibility to bring his professional knowledge and experience to bear on a problem. The consultee has the responsibility to implement some solutions to the problem, hopefully making use of the contributions of the consultant. It further implies a relationship of equal order

with an absence of subordinate or superior roles.

Consultation is task-oriented and involves a circumscribed problem or situation within the limited time span. As Rapoport says, it is "not concerned with total personality or global type organizational goals that can develop indefinitely". The consultation from the Clinic is further enhanced by administrative agreement with care-taking agencies in the community.

The social work personnel at the Kay Guidance Clinic have primarily functioned as consultants in three categories of services. First, they have attempted to enable the consultee to find solutions to their particular problems by bringing to the consultation interview knowledge which will increase insight of the consultee. This is based upon the strong conviction that, usually if the consultee can be helped to understand the client, his situation, and his environment, the consultee can find his own method of helping the client or student which is appropriate to his professional skill. Second, the social work consultants have been able to utilize their skill in quick assessment of the person and the situation and, in crisis situations, have been willing to offer direct suggestions, direct advice, within the framework of the consultee's professional role and competency. This is most often demonstrated at the Kay Guidance Clinic when the consultant collaborates with the consultee in working out a plan of action which may involve not only insight and action but knowledge of resources available to deal with a problem outside the realm of competency of the care-taking person. While the consultation is primarily based upon the "client problem", the staff has been attentive to the response

and reaction of the consultee wherein concrete suggestions and advice are called for. Third, the consultants are constantly aware of the educational and preventive implications of the opportunity for consultation. While they, of course, stress the individuality of each student or client, at the same time they use the consultation sessions to deepen the consultee's understanding of the basic emotional needs of the individual. They have concluded that this type of knowledge-giving or problem-solving has a transferrability from case to case. They operate, also, on the assumption that when, for example, a teacher is helped to look at the relationship between the child's learning or behavior problem and the factors or forces within his environment or when a teacher is helped to explore the meaning of his own relationship with the students, these experiences enable the teacher to establish a climate which is conducive to healthy psychological growth and development.

Finally, social workers at the Kay Guidance Clinic have identified two other effective ingredients for effective consultation. They recognize the need to understand clearly and carefully, the role and function of the agency or individual requesting consultation. This is most clearly demonstrated in their work with the adult and juvenile courts. Not only have they been respectful of the limitations of the caretaker, but they also have been equally careful to define for themselves and for the community the appropriate role and function of the social worker. They have developed the kind of security in their professional role which enables them to refer a consultee to another member of the clinical team or to another agency.

Community Education

No portion of the social work role at the Kay Guidance Clinic has been given more conscientious consideration than that of community educator. To the social worker at the Clinic, this role is directed toward three goals which are accepted as vital to the Clinic and to the total community. These goals are interpretation of the clinic function, the provision of assistance to care-taking individuals and agencies, and prevention. In some instances, community education takes on the formal nature of participation in community activities, presentations to community groups, development of specialized programs in the agency, and participation in the development of specialized programs within the community. In other instances, community education is seen as an informal activity carried on by members of the clinic staff through their various social and professional activities.

Interpretation of the Kay Guidance Clinic through its community education program basically contains two elements. First, it provides an opportunity for mental health personnel to interpret the function of the clinic. Throughout the eight years of its existence, the clinic has added new services, expanded its facilities, and encountered many problems. The staff has made a concerted effort to alert the total community to the expanded program and has not been hesitant to discuss with the community the needs and the problems encountered by the staff in their efforts to meet the increasing demand for services. A study of the presenting problems stated by clients as they came for their initial interview reveals not one inappropriate referral. Many clinics are plagued by inappropriate requests and referrals. These have been

non-existent at the Kay Guidance Clinic primarily because of the effectiveness of their community educational program. Furthermore, interpretation to potential referral sources has offered the staff the opportunity to present the clinic in realistic terms, discussing its services and its limitations, and, thus, perhaps, preventing the range of unreal expectations and demands usually made upon clinics. A careful study of the referral sources over an eight year period indicates that the clinic has not "lost" a referral source. As Glasscote (1964) points out, most clinics are plagued with disenchanted referral sources because they are not aware of real and unreal expectations. The willingness, through the years, of the community to support the Clinic as it moved from a staff of three to the current staff of nineteen, and the community enthusiasm as the Clinic has moved in the direction of a comprehensive mental health center is further evidence of the validity of the community education program. The presentation of the Kay Guidance Clinic program is invariably seen by the staff as an opportunity to present and interpret mental illness, mental retardation, and mental health. Thus, in such interpretative sessions to both lay and professional citizens, the staff has the opportunity to dispel misconceptions and taboos about mental health. Furthermore, such interpretative education provides the staff with the opportunity to "spot pockets of opposition" and to deal with them effectively and appropriately.

Second, many community education programs, both within the agency and with other professional and lay groups, are designed to enable other agencies and care-takers in the community to do a better job.

In this connection, community education takes on a flavor of consultation focused on developing understanding about particular problems or particular groups within the community. Such projects as, for example, the regular monthly film discussion program held at the Clinic and participation in the Nursing Education Program at the local hospital are specifically designed to enhance understanding about mental illness and mental health. Such programs also provide the opportunity for clarification of Kay Guidance Clinic's role as a member of the total community effort toward the promotion of mental health and the prevention of mental disorders. In other words, during such sessions, the staff is alert to point out to the total community the other existing services such as Vocational Rehabilitation, the Public Welfare programs, Special Education programs at school, and new services within the community.

Community education is the heart of the Clinic's effort toward the prevention of mental illness and emotional disorders. Prevention in social work is generally defined as any activity which has merit or value in averting or discouraging the development of specific social problems, or in delaying or controlling the growth of such problems after they have presented beginning symptoms. This, of course, implies that prevention can be most effective when the preventive measures are applied to those who are still unaffected or when the problem is in its earliest stages. Thus, in a real sense, any community education carries with it a commitment or a component of prevention. The Clinic staff has, in spite of its manpower shortage, undertaken a number of programs designed to prevent rather than cure.

Most notable is the program of sex education conducted at the invitation of the Ponca City School System. The Clinic's attention to the "second level of prevention" was evidenced by its role in the establishment of a Big Brother organization and its support of Special Education programs within the school system.

Because of the experiences of the Kay Guidance Clinic social work staff as well as the guide lines for regional and comprehensive mental health centers, two questions should be raised. First, has social work education assumed that the communications skill considered necessary for effective social work practice is sufficient for the task of a broad, effective community education program? Second, are social work students being given sufficient encouragement, knowledge, and skill to be able to make effective use of the study of case records and statistics? For example, each year encompassed in this study reveals a high percentage of marital problems among the presenting problems brought to the Clinic. Routinely, this is a group of high incidence of drop-out immediately after brief intake. If the comprehensive mental health centers are to achieve their potential as agents of prevention, they will need to take a more aggressive position in analyzing their intakes, in giving consideration to those groups in the community which are generally affected by certain defined experiences, and know who our vulnerable populations are and how they can be sought out with educational and direct service at a point which is, for them, a critical or crucial time in their lives. Only by such methods of knowing how to reach persons who are most likely to be affected negatively by certain experiences can we hope to prevent

the serious results which are now the main focus of most mental health centers.

CHAPTER VII

CONCLUSIONS AND SUMMARY

This dissertation was the study of the changing characteristics of the clientele as they affect the role of the social work practitioner in the Kay Guidance Clinic and a review of social work literature relevant to those changes. The objective was to develop a model of social work practice in community mental health and to examine this model in relationship to current practice and education.

Social work practice at the Kay Guidance Clinic does provide a good beginning model for social work in community mental health. Certain role changes have occurred in response to the demands of the community. It is acknowledged that this is a beginning model which must change as new knowledge becomes available, as the team expands and as changes occur within the community. It is further acknowledged that, perhaps, this model will not, in its detailed form, be appropriate in every community. Relative emphasis on social work activities will vary from community to community, depending upon the local need, the presence or absence of other social agencies, and the size, skill, and experience of the staff.

The demands on social work in clinics such as the Kay Clinic require a re-evaluation and a re-emphasis of some social work methods. The social workers in the Kay Guidance Clinic have developed an ef-

fective method of short-term casework treatment. It is suggested that the evolving body of crisis theory would be an effective conceptual framework upon which to continue the development of short-term treatment methods.

The study reveals that social caseworkers at the Kay Guidance Clinic spend a considerable amount of their time in consultation and community education, which includes preventive social work. While consultation, community education, and preventive social work are not new to the profession, the magnitude of the demand for these kinds of services in community mental health seems to require a reassessment of the social work curriculum related to these areas of practice. It would appear, also, that more careful examination of knowledge from the fields of public health and epidemiology, coupled with more accurate and better use of records from the community mental health centers would add effective tools to the social work practitioner in community mental health. The request for group work activities and the recognition of group work as an effective, therapeutic tool raise the question of the need for a multi-method social worker or the use of social work specialists in the area of group work within the mental health centers.

The alternative to the development of multi-method social workers or the inclusion of group work specialists on the clinical team will be a poor quality of service and a social work program which does not meet the expectations and the needs of a community.

REFERENCES

Ackerman, N. The psychodynamics of family life. New York: Basic Books, 1958.

Albee, G. A declaration of independence for psychology. Bulletin of Psychology, 1964, 8, 141-144.

Arbuckle, D. S. Psychology, medicine and the human condition known as mental health. Community Mental Health Journal, 1966, 2, 129-134.

Bartlett, H. Social work practice in the health field. New York: N.A.S.W., 1961.

Beck, B. Prevention and treatment. New York: N.A.S.W., 1962.

Bellak, L. The third psychiatric revolution. In L. Bellak (Ed.) Handbook of Community psychiatry. New York: Grune & Stratton, 1964, 36-69.

Bisno, H. How social will social work be? Journal of Social Work, 1956, 1, 12-18.

Brown, B. S. & Cain, H. P. The many meanings of comprehensive: underlying issues in implementing community mental health center programs. The American Journal of Orthopsychiatry, 1964, 34, 834-849.

Caplan, G. An approach to community mental health. New York: Grune & Stratton, 1961.

Caplan, G. Concepts of mental health and consultation. Washington, D. C.: Department of Health, Education and Welfare, 1959.

Clifton, C. S. Personal Communication, 1966.

Cloward, R. A. The adjustment of social welfare to social change. Proceedings, Eighth Annual Social Work Day, State University of New York, Buffalo, 1965, 15-39.

Cockerill, E., et al., A conceptual framework for social casework. Pittsburg: University of Pittsburg Press, 1952, 27.

Dunham, H. W. Community psychiatry: the newest therapeutic bandwagon. Archives of General Psychiatry, 1965, 12, 303-313.

Fair, E., Personal Communications, 1966.

Farnsworth, D. L. Mental health implications for teachers. In Torrance, P. & Strom, R. (Eds.) Mental health and Achievement. New York: John Wiley & Sons, 1965, 184-196.

Felix, R. H., et al., Mental health and social welfare. New York: Columbia University Press, 1961.

Garrett, A. Historical survey of the evolution of casework. Journal of Social Casework, 1949, 30, 218-229.

Garton, N. R. & Otto, H. The development of theory and practice in social casework. Springfield, Illinois: Charles C. Thomas, 1964.

Glasscote, R., et al., The community mental health center: an analysis of existing models. Washington, D. C.: Joint Information Service of American Psychiatric Association and National Association for Mental Health, 1964.

Goode, W. J. The family. Englewood, N. J.: Prentice Hall, 1961, Chapters 1 & 10.

Hamovitch, M. B. Epidemiology - its application for social work. In Proceedings of Princeton Seminar, Public health concepts in social work education. New York: Council on Social Work Education, 1962, 97-107.

Hogg Foundation Report on Mental Health. In E. McDanald (Ed.) Challenge of mental health. Austin: University of Texas Press, 1965.

Hollingshead, A. & Redlich, F. Social class and mental illness. New York: John Wiley & Sons, 1958, Chapter 4.

Joint Commission on Mental Illness and Health. Action for mental health. New York: Basic Books, 1961.

Kadushin, A. The knowledge base of social work. In A. Kahn (Ed.) Issues in American social work. New York: Columbia University Press, 1962, 41-45.

Kahn, A. Function of social work in the modern world. In A. Kahn (Ed.) Issues in American social work. New York: Columbia University Press, 1962, 3-38.

Kahn, A. Planning and practice perspectives on the boundaries of community psychiatry. In L. Roberts, S. Halleck, & M. Loeb (Eds.) Community psychiatry. Madison: University of Wisconsin Press, 1966, 165-182.

Kahn, A. Therapy, prevention and developmental provision: a social work strategy. In Proceedings of Princeton Seminar, Public health concepts in social work education. New York: Council on Social Work Education, 1962, 132-148.

Kendall, K. To fathom the future. Paper read at Fifteenth Annual Program Meeting, Council on Social Work Education, Salt Lake City, January, 1967.

Knee, R. & Lampton, W. Mental health and mental illness. In H. L. Lurie (Ed.) Encyclopedia of social work. New York: N.A.S.W., 1965, 486-497.

Leavell, E. & Clark, G. Preventive medicine for the doctor in his community. New York: McGraw Hill, 1958, 651.

Leighton, A. H. An introduction to social psychology. Springfield, Illinois: Charles Thomas, 1960, 34-48.

Levy, D. Personal Communication, 1966.

Menninger, K. A. The human mind. New York: Alfred A. Knoff, 1948, p. 1.

Meyer, A. Cited by Glasscote, R., et al., The community mental health center: an analysis of existing models. Washington, D. C.: Joint Information Service of American Psychiatric Association and National Association for Mental Health, 1964, p. 1.

Mountin, J. W. The health department dilemma. Public Health Reports, 1952, 67.

Nemish, J. C. Recruitment in general [illegible] hospitals. Psychiatric Opinion, 1965, 1-9.

Oklahoma Mental Health Planning Committee Report. Long range plan for mental health in Oklahoma. Oklahoma City: Oklahoma State Department of Health, 1965.

Perlman, H. H. Casework is dead. Social Casework, 1967, 48, 22-25.

Perlman, H. H. Putting the social back in social work. Child Welfare, July, 1952, 49-62.

Perlman, H. H. Social casework: a problem solving process. Chicago: University of Chicago Press, 1957, 45-58.

Pollock, O. Integrating sociological and psychoanalytic concepts. New York: Russell Sage Foundation, 1956, 196-201.

Rapoport, L. Crisis-oriented short-term casework. Social Service Review, 1967, 41, 31-43.

Rapoport, L. Consultation: an overview. In L. Rapoport (Ed.) Consultation in social work practice. New York: N.A.S.W., 1963, 7-21.

Redlich, F. & Freedman, D. The theory and practice of psychiatry. New York: Basic Books, 1966, 37-42.

Reichart, K. In program planning, what can social work adopt from public health? Paper read at Institute for Social Workers in Public Health, University of California, Berkley, 1963.

Reichart, K. Application of public health concepts and methods to the field of social work. In Proceedings of Eleventh Annual Program Meeting, Council on Social Work Education. New York: Council on Social Work Education, 1963, 1-16.

Reynolds, B. Social casework, what is it? What is its place in the world today? The Family, 1935, 16, 9-14.

Riesman, F., Cohen, J. & Pearl, A. Mental health of the poor. New York: The Free Press, 1964, 3-5.

Rosen, A. A social work practitioner to meet new challenges. In The social welfare forum, New York: Columbia University Press, 1965, 224-237.

Ryder, C. The five faces of prevention. In Proceedings of Princeton Seminar, Public health concepts in social work education. New York: Council on Social Work Education, 1962, 107-115.

Satir, V. Conjoint family therapy. New York: Science & Behavior Books, 1964, p. 23.

Schofield, W. In sickness and in health. Community Mental Health Journal, 1966, 2, 244-251.

Schroeder, D. Mental health and psychiatric services. In H. L. Lurie (Ed.) Encyclopedia of social work. New York: N.A.S.W., 1965, 498-504.

Seligman, B. B. Man, work and the automated feast. In B. Rosenberg, I. Gerver, & F. W. Howton (Eds.) Mass society in crisis. New York: MacMillan, 1964, 463-479.

Stein, H. D. Social science in social work education. In H. J. Parad (Ed.) Ego psychology and dynamic casework. New York: Family Service Association of America, 1958, 226-229.

Surgeon General's Ad Hoc Committee on Planning for Mental Health Facilities. Cited by R. Glasscote, et al., The community mental health center: an analysis of existing models. Washington, D. C.: Joint Information Service of American Psychiatric Association and National Association for Mental Health, 1964.

Tarail, M. Cited by A. Rosen. A social work practitioner to meet new challenges. In The social welfare forum, New York: Columbia University Press, 1965, 224-237.

Wilensky, H. & Lebeaux, C. Industrial society and social welfare. New York: Free Press, 1965.

Wish, H. Contemporary America. New York: Harpers, 1945, p. 333.

Witte, E. Great expectations. In Proceedings of Princeton Seminar, Public health concepts in social work education. New York: Council on Social Work Education, 1962, 7-17.

Wittman, M. The role of social work in preventive services: between clinic and community. In The social welfare forum, New York: Columbia University Press, 1962, 1-14.

Wittman, M. Education for community mental health practice: problems and prospects. Journal of Social Work, 1958, 3, 64-70.

Zwerling, I. & Rosenbaum, M. The challenge of community psychiatry to medical education. Paper read at Southern Regional Educational Board Meeting, Atlanta, November, 1966.

APPENDIXES

APPENDIX A

CONCLUSIONS OF MENTAL HEALTH PLANNING COMMITTEE, 1965

Mental and emotional disorders are Oklahoma's most extensive, varied, and generally unmet health problem. Their impact on daily living in our society warrants continued public concern, planning and action.

There is no reason to predict that the incidence or prevalence of mental disorders will naturally diminish or that their accompanying problems will naturally abate in the future.

Oklahoma's public mental health programs are inadequate. The characteristics of patients entering state mental hospitals are changing, and these institutions must redefine their roles constantly. To make full use of institutions and professions which have long had primary community responsibility for health, law and order, and education, community based programs of care and support for the mentally ill are urgently needed.

Society will depend increasingly upon community mental health guidance for alternative solutions to problems for which there are no pat answers, or for which answers that once worked are either no longer widely practiced or are ineffective.

Oklahoma's long range mental health goal must be to control mental disorders in the general population. This is most likely to be accomplished through progressive medical leadership and the development of community based mental health services sufficient to meet most community mental health needs. Services needed must be dependably and understandably available to all people.

Until an adequately funded, organized research program is initiated, developed, and maintained, Oklahoma cannot expect to have the most prudently obtainable mental health and mental illness programs and services that the citizens and institutions of this changing state require.

Considerable additional financing is justified and will be required if a comprehensive system of mental health and mental illness programs and services is to be developed and maintained.

This financing must come from multiple sources, with major increases from federal, state, and insurance sources.

Although increased numbers of mental health professionals are being trained in Oklahoma, not enough are being retained full time or part time in public mental health programs to meet present or future needs. The numbers of appropriately trained and retained psychiatrists, psychologists, social workers, counselors, special education teachers, and physical therapists should be doubled during the next decade. In addition, provision must be made for the training and retention of psychiatric nurses, public health nurses, occupational and recreational therapists, administrators, and a variety of mental health and home care aides.

Oklahoma is changing rapidly in many ways. Mental health services must be located where the people are. Mental health and mental illness programs must be flexible enough to adjust to needs and solve problems as they are and where they are. The Community Mental Health Centers Act of 1963 and its subsequent amendments should accelerate the provision of much needed community mental health services in Oklahoma.

No single official or voluntary agency or association can be expected to develop and maintain on a statewide, regional, or community basis the full range of services a comprehensive mental health program requires. The cooperative and coordinated efforts of all official and voluntary agencies and associations at all levels of service and jurisdiction are required.

APPENDIX B

RECOMMENDATION OF OKLAHOMA MENTAL HEALTH COMMITTEE

Physicians, together with ministers, educators, attorneys, officials, and members of mental health and mental retardation associations, lead their communities to recognize the effects of mental disorders upon community living, and to organize and participate in area and community efforts to develop and strengthen programs and services which will contribute to mental health and which will enable each community to solve increasingly more of its own mental health problems.

Let statewide mental health planning be the continuing responsibility of a State Mental Health Council.

That the Mental Retardation Facilities and Mental Health Facilities Construction Act of 1963 do activate on a statewide basis by the preparation of state plans by the State Department of Public Welfare for Retardation and the State Department of Health for Mental Health, as provided by state law.

That the purpose of actions with respect to services for the mentally and emotionally ill be to provide as many as possible of the following elements of the inter-related services in every area and, ultimately, in each community in the state.

24-hr. Emergency Service	Inpatient Care
Partial Hospitalization	Outpatient Care
Consultation and Education	Diagnosis
Rehabilitation	Precare and Aftercare
Training	Research and Evaluation

That after interstate negotiation, appropriate state legislation be adopted which will permit the practical development of the foregoing elements of service by communities located in more than one state.

That the purpose of actions with respect to services for the mentally retarded be to provide an opportunity for each retarded individual to attain his or her highest potential through an overall program of accessibility.

That the State of Oklahoma construct and operate or take a beneficial interest in the construction and operation of comprehensive mental health centers to serve populations of 75,000 to 200,000.

That state mental hospitals be supported and encouraged in their efforts to continue to develop a therapeutic milieu correlated to community programs.

That in keeping with advances in psychological medicine, regional guidance centers be developed by state and local health departments as provided by state laws which permit several counties to combine their resources and efforts to provide community education and consultation, prevention and early detection, rehabilitation, training, diagnostic and outpatient services.

That the State of Oklahoma construct and operate or take a beneficial interest in the construction and operation of, regional health and health related service centers in communities which are medical, trade, and economic areas. That the function of these centers be to house the personnel and operations of official and, to such extent as possible, voluntary agencies providing health and health related services to people.

That financing for mental health and mental illness programs and services be derived from multiple sources, including fees paid by the patient: Third party payments, such as insurance and pre-payment plans: Local tax levies: State appropriations for the provision and purchase of direct services: And federal grants-in-aid.

That the allocation of funds to the appropriate departments within the colleges and universities of the Oklahoma system of higher education be increased substantially to permit the education and training of increased numbers of mental health and mental health related professionals in the next decade.

That five percent (5%) be added to the operating budgets of all mental health facilities and services and earmarked for inservice training grants for mental health and mental health related professionals.

That the postgraduate course in psychiatry for physicians in Oklahoma's communities be increasingly supported and continued by the Department of Psychiatry, University of Oklahoma School of Medicine.

That an intensive effort be made by the State Board of Education and local school boards to fund and staff adequate

numbers of special education classes in the Oklahoma public schools.

That the public and parochial schools in Oklahoma be encouraged to include, at appropriate levels in their curricula, alcohol education and consumer education.

That the State Department of Health develop, with appropriate official and voluntary agencies, a statewide community based program for the control of alcoholism.

That appropriate reporting systems and registers which do not invade individual rights to privacy be developed for delinquency, birth defects, and mental disorders by appropriate official agencies.

APPENDIX C

CONSTITUTION AND BY-LAWS
THE KAY COUNTY ASSOCIATION FOR CHILD GUIDANCE
(As Revised Feb. 13, 1964)

ARTICLE I - NAME

The name of this Association shall be the Kay County Association for Child Guidance. The headquarters shall be located at Ponca City, Oklahoma.

ARTICLE II - PURPOSE

To provide an Association for citizen action to work for the prevention of mental illness in children; to formulate an educational program for the benefit of the public; and to work toward the establishment and operation of a child guidance clinic.

ARTICLE III - MEMBERSHIP

Membership in this Association shall consist of those persons who, by any method devised by the Board of Directors, express their interest in the Association, their approval of it's purpose, and their desire to be sympathetically associated with it. Such membership may be subject to reaffirmation of such interest, approval and desire, annually.

This Association, by action of the Board of Directors and approval of the membership, may effect affiliation with other mental health associations.

The Board of Directors may elect as many Honorary members as they deem advisable and beneficial to the work of the Association.

ARTICLE IV - CORPORATE POWERS

All powers allowed by statute to charitable and benevolent associations shall be vested in and exercised by the Board of Directors. Actions and proceedings of the Directors shall be carried into effect by officers elected by the Board of Directors and by Committees appointed in accordance with these By-Laws.

The Board of Directors shall have the power to fill all vacancies in the elective offices.

ARTICLE V - BOARD OF DIRECTORS

The Board of Directors shall consist of not less than 18 persons nor more than 21 including the officers.

Lay and professional members of the Board of Directors shall be chosen with due regard to geographical distribution and variety of professions and fields of interest in mental health.

The Board of Directors to be chosen each year shall be elected by the members of the Association at the annual meeting. The Board of Directors may replace any Director who has failed to attend three successive meetings of the Board, if such absences are declared by the Board to create a vacancy.

At the first meeting of the Association, one-third of the Directors shall be elected to serve a term of three years, one-third to serve a term of two years, and one-third to serve a term of one year. Thereafter, one-third of the Directors shall be elected annually to serve a term of three years. During the period between annual meet-

ings of the Association, such vacancies as may occur in the Board may be filled by the Board of Directors.

Any person who has served for three consecutive years shall be ineligible for election for one fiscal year.

The President of the Association shall serve as chairman of the Board of Directors.

Seven Directors shall constitute a quorum.

ARTICLE VI - OFFICERS

The Executive Officers of this Association shall consist of the following: President, Vice-President, and a Secretary-Treasurer, elected annually by the Board of Directors at the first Board of Directors meeting following the Association's annual meeting. The terms of the officers shall commence immediately following their election and they shall serve until their successors are elected and qualified.

The officers of the Association shall also serve as officers of the Board of Directors.

All officers shall perform the duties commonly incident to their respective offices, and shall perform such other duties and have such other powers as are prescribed by the Board of Directors.

The treasurer shall be the custodian of all funds and securities of the Association. He shall report in writing the state of the treasury at the annual meeting of the Association and at each meeting of the Board of Directors. He shall be responsible for keeping of regular accounts which shall at all times be open to the inspection of the officers and directors of the Association.

In addition to the elected executive officers, additional executive officers may be added by the President, by and with the approval of the Directors, such presidential appointees to serve until the next annual election.

Special groups, working on mental health projects, or organizations of kindred interests, may be represented on the Board of Directors by one (1) member.

ARTICLE VII - MONEYS

All funds received by the Association shall be deposited to the credit of the Association in depositories approved by the Board of Directors. All checks drawn by the Association shall be signed in the name of the Association by the Treasurer, and in the absence of the Treasurer, by the President.

The Board of Directors shall authorize the bonding of officers having access to the funds of the Association.

ARTICLE VIII - COMMITTEES

Committees shall consist of two classes, elective and appointive. The Board of Directors shall determine the various committees needed to carry out the purpose of the Association.

ARTICLE IX - NOMINATING COMMITTEE

The Nominating Committee shall be composed of three (3) members, to be appointed by the President, and shall propose nominees for officers and directors in the Association.

ARTICLE X - MEETINGS

There shall be one annual meeting of the Association, to be held at a time and place to be determined by the Board of Directors.

Special meetings of the Association shall be called by the President or the Board of Directors upon the written request of 10% of the membership or a majority of the Board of Directors. Notice of the time and place of the annual meeting shall be mailed to members by the Secretary at least five (5) days before the meeting. All notice of special meetings shall be mailed to members by the secretary at least five (5) days before the meeting, stating the time and place and purpose for which the meeting is called.

There shall be at least three regular meetings of the Board of Directors held each year. One of these meetings, which shall be the regular meeting, shall be held on the same day in the same place as the annual meeting of the Association. Special meetings of the Board of Directors may be held at the discretion of the President or upon the written request of nine (9) members of the Board.

ARTICLE XI - AMENDMENT

The Constitution and By-Laws may be amended as follows: Any proposed amendment shall be presented to the Board of Directors by the President upon written request of two members of the Board of Directors or any six (6) members of the Association who are not members of the Board of Directors. The amendment, with recommendation of the Board of Directors, shall be presented to the membership of the Association. An affirmative vote of two-thirds of the membership present shall be required for the adoption of an amendment to the Constitution and By-Laws.

Revised and re-adopted by the Kay County Association for Child Guidance this 13th day of February, 1964.

APPENDIX D

FACE SHEET INFORMATION

FILE NO: _____

DATE OF ADM: _____

FEE: _____

AGE _____ SEX _____ MARITAL STATUS _____

STUDENT: _____ OCCUPATION: _____

(MOTHER/WIFE) _____

OCCUPATION: _____

(FATHER/HUSBAND) _____

OCCUPATION: _____

GRADE: _____

RELIGION: _____

RACE: _____

REFERRED: _____ CITY _____

REASON: _____

_____

DIAGNOSIS

RECOMMENDATION

DISPOSITION

NUMBER OF INTERVIEWS