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COMMUNITY MENTAL HEALTH IDEOLOGY OF COMMUNITY MENTAL HEALTH SPECIALIST GROUPS IN OKLAHOMA

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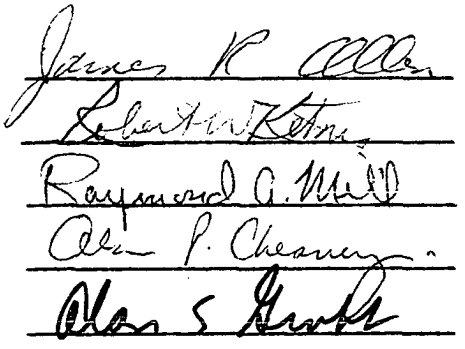

DISSERTATION COMMITTEE

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TABLE OF CONTENTS

LIST OF TABLES

COMMUNITY MENTAL HEALTH IDEOLOGY OF COMMUNITY MENTAL HEALTH SPECIALIST GROUPS IN OKLAHOMA

CHAPTER I

INTRODUCTION

Background of the Problem

The community mental health center program in the United States is entering its second decade as a major part of the mental health service system. For all practical purposes the program began in 1963 with the passage by the Federal Congress of the Community Mental Health Centers Act which provided the financial support for construction of locally planned and operated centers. This support was extended through subsequent legislation to costs for staffing and operating the centers and also provided regulations which were to be followed in the development of service programs.

The need for community centers had been recognized for several years prior to passage of the support bills. The Joint Commission on Mental Illness and Health which had been established in 1955 as a result of the Mental Health Study Act reported to Congress in 1961 that a system of centers, easily accessible to all the people in or near their own communities, was a necessary change in the method of delivery of care. The traditional services provided by state mental hospitals and by

private psychiatric programs had not been able to keep up with the demand. Methods which were too time-consuming for the care givers as well as the client, inequitable distribution of manpower between urban and rural areas, and disenfranchisement of many social classes from adequate care had combined to cause traditional mental health programs to come under extremely critical review.

In many states, attempts were made to provide mental health care through local mental health and child guidance clinics. The problems in the establishment of these services were almost universal to all areas: lack of funds, shortage of professional personnel, and a conflict of philosophy of service. This conflict developed primarily between traditionally trained providers and proponents of a more socially-oriented community mental health ideology.

The federal legislation proposed that local communities develop care-giving systems designed for their individual needs but the same federal regulations required that at least five services, considered essential for adequate community care, be provided if a center were to be eligible for assistance from federal sources. Those services -- in-patient, out-patient, 24-hour emergency, partial hospitalization, and consultation and education -- were viewed by many professional and community leaders as an extension of the traditional system which had already failed to respond to the needs of the people.

The leadership of the mental health profession had proposed, through the report of the Joint Commission on Mental Illness and Health, a strongly conservative program of action for improvement of mental health services. Their recommendations emphasized broad-based

research on etiology and treatment of mental illness, long-range training of all categories of mental health professionals, intensive attention to the needs of the critical mentally ill patient as first priority for service, development of community centers in close association with out-patient departments of general or mental hospitals. The recommendations avoided mental health education for the general public. In short, the profession recommended a course of action which would change very little in its existing approach to the growing problem.

The program which was finally initiated for community mental health came as a response to the address before the Congress by President John F. Kennedy in February, 1963, and the Community Mental Health Centers Act which was signed into law in October of that year. President Kennedy had called for a bold new approach to the problems of mental illness and mental retardation and the centers which were proposed through the federal legislation were more innovative in design than those recommended by the Joint Commission. The emphasis in these centers was to be on service to the people through a variety of programs for prevention, treatment and rehabilitation. The mandate was to seek out and eradicate the causes of mental illness.

The professional staff required to perform the services were chosen, by necessity, from the ranks of the existing mental health service programs and, in many cases, were ill-prepared to deal with the new demands placed on them by a "community" of care-seekers. The professional groups most immediately called on to direct and provide leadership for the new centers were psychiatrists, clinical psychologists,

psychiatric social workers and psychiatric nurses. These professionals had historically functioned as independent units with firmly established roles in relation to other professionals and with well-defined hierarchical positions within the professional community. Community mental health required an orientation for which they had not been educated or trained.

An early development in the staffing patterns of most centers was the inclusion of para-professional and non-professional groups which would aid in filling the gaps created by the critical manpower shortage. These indigenous workers were to have input into program planning in regard to the needs of the local community, be trained in care-giving skills through which they could assist professional staff, and act in the "translator" role for the center in bringing its services to the community. The critical issue was to be the orientation of the training offered to new mental health workers since many of the professionals were not yet attuned to community mental health ideology.

It should be immediately apparent that if a Community Mental Health Center is to be a system based on new and different concepts, the leadership should be able to direct the planning, the operation of programs and the training of staff toward an ideology that would improve chances for success. In this case, however, the new ideas had not yet been proven, the methods had not been developed and staff members had not been trained to function in the new setting.

This study will look at evidence concerning acceptance of a community mental health ideology by staff members of community mental health centers and clinics in Oklahoma and focus attention on training,

both academic and in-service, as a viable tool for re-direction toward an understanding of community mental health concepts.

Review of the Literature

The field of mental health, with all its facets of concern for the professional and the public, is a complex and contradictory subject. This review of the literature attempts to examine pertinent ideas of community mental health history, ideology and practice and new mental health careers which are germane to the development and accomplishment of community mental health centers.

Community Mental Health

It would not be difficult to get lost in the multitude of terms which are used to describe both theory and function of the developing profession called community mental health. The words themselves are sources of and subject to diverse opinion as to their meaning. For example, community is either a place or a concept, a focus or an ideation, a target or a base. Depending on the viewpoint of the writer, it can be any or all of these things. The way out of the morass is to accept the position that the words are not so important as the efforts being expended in their name. Roberts, Halleck and Loeb (1966) prefer "community psychiatry" as the descriptive term for the processes that should be used to achieve the goals that Caplan (1964) calls "preventive psychiatry." Rosenbaum and Zwerling (1964) refer to the field as "social psychiatry." Each is referring to basically the same thing -- a system of ideas, methods, and goals which influence the performance of a mental health service system. This system approaches being antithetical to the traditional model of

psychiatric care which formed around the individualistic theory of man and treated him with "frontier psychology."

Mental health care has, for many years, been directed by the philosophy that mental illness is a private and individual problem, caused or intensified by the client's own weaknesses, and treated by focusing only on the client's lack of ability to cope with situations which confront him. Howard Rome (1966) has described this syndrome as follows:

> This concept, with its image of man alone, confronting his destiny, emphasizes the individual condition and views the environment, both natural and manmade, as a potentially hostile one from which the prudent and the resourceful must at all times be prepared to defend themselves (p. 32).

To enhance this system, the patient could best be cared for privately and in some environment other than his usual one.

Community mental health, on the other hand, is based on a philosophy that can best be summarized in the following statements: mental illness results from a complex interplay between biological, social and psychological events; the social context and interpersonal field in which the individual lives, becomes ill, and recovers is important to understanding and helping; treatment is best when performed close to home; early and effective treatment can prevent more severe mental illness; primary prevention is possible; local responsibility and authority for mental health programs is better than state or federal control; prevention and treatment should be a community concern (Whittington, 1966).

The community mental health movement is seen by some observers as a revolution in psychiatric services (Bellak, 1964; Hobbs, 1964).

The efforts taken by professional leaders toward the development of this "bold new approach" to care for the mentally ill indicated an awareness of the need for change and the early and mid-sixties saw a flood of material being produced to guide the movement.

The history of community mental health has been well-chronicled by Caplan and Caplan (1967) in their study of development of community psychiatry concepts and it is worthy to note that the basic theories that underlie the modern movement are not new to the field. Certain aspects that are now receiving emphasis were developed early in the twentieth century by Beers, who founded his mental hygiene movement on public health principles, and by Meyer, who called for comprehensive programs of prevention, treatment, and aftercare as well as coordinated teamwork between mental health and community agencies. The child guidance clinics of the 1920's were an attempt at making these principles operational.

World War II created critical situations in psychiatric service which demonstrated further need for radical change in care-giving techniques. Large numbers of clients needed short-term assistance in close proximity to their problem environment and the methodology known as "battlefield psychiatry" became a forerunner of many of the approaches to be used in community service systems.

The need for change did not end with the winning of the war and many of the weaknesses of the traditional system were amplified by the increased demands put on it by returning veterans and by reactions to socio-economic adjustments that were occurring in American society. Over-crowded mental hospitals resulted in inadequate treatment

for patients and became little more than custodial centers for the mentally ill. To compound the problem, as expanded definition of types of problems fostered on psychiatry for correction added to the burden on the system. In this regard, Barnes (1966) best describes the situation which was common to all parts of the country:

> Socio-economic factors, new understanding of mental illness, more optimism about treatment, and increasing interest from lay groups who saw delinquency and other aberrant behavior as psychiatric problems combined to create an increased demand for psychiatric and mental health services (p. 102).

The growth of support for community mental health ideology corresponded to the development of change in social consciousness that had occurred after World War II. A humanistic orientation had influenced public and professional sentiment which demonstrated itself in the civil rights movements and anti-war activities on the one hand and in the passage of community mental health legislation as a step toward correcting some of the inequities in social services.

New Mental Health Careers

A study of new careers in mental health must look first at the effects community mental health programs have had on the traditional professions since numerous observers have questioned the role of these disciplines in the new system and have, almost universally, spoken out for radical change in approach to the problems faced by professional teams working in the new settings. Characteristic of the critiques on professional role are those by Dorn (1966) and by Lief and Brotman (1968) which review the changing position of the psychiatrist in community programs. It was originally assumed that the psychiatrist, as head of the mental health care system, should maintain the dominant

position in both clinical and administrative direction of community-based services. Many communities discovered that administration was not the forté of many psychiatrists and that they did not have the necessary skills to deal with the everyday problems of personnel, finance, budgeting, training and public relations. Many of the early programs did not begin to meet the criteria for community mental health programs as envisioned by the theorists, and much of the cause for failure was attributed to the "personal styles of program implementors" (Mehr, 1973).

Accusing only the psychiatrist for misdirecting the center's programs along traditional lines rather than toward more innovative ones would be patently unfair. Each of the professions that were expected to provide the leadership in development of the new scheme was found lacking in essential skills. It is unusual to peruse any of the current journals dealing with mental health services and not find an article which deals with the changing role of the professional. The psychologists were taken to task by Yolles (1966), Jarvis and Nelson (1966), and Rosenblum (1968). The recurring theme is centered on the need to break away from methods of services which isolate the professional from the community and to begin to expand the definition of "client" to be served. Additionally, there is the constant awareness of change in position within the "team" for all its members and the responsibilities that each must assume (New, 1968). The psychologist is encouraged to do more than hide behind the desk in the safety of his office. Setting an example for the other team members by getting out and "getting dirty" is a common call. Similar statements

are made by Albini (1968) and Singer (1971) regarding social workers and the changes they must make in their approach to service.

Change in approach was not limited to the mental health profession. The community, too, had new responsibilities in the new programs. Lay-boards of directors and advisors were to be established with representation from all segments of the community, especially consumers, with interests in mental health service. The mandate of the people regarding desired services was to be transmitted through the board to the center and the responsible professionals. If the members of the board were knowledgeable about their own community needs, their direction could be extremely valuable to the mental health workers. As often happened, however, the boards were not sufficiently prepared to offer realistic direction and the programs of the centers reflected only the desire or capability of the staff. The moral mandate discussed by Bockhoven (1966) became neglected because of program limitations.

Without question, one of the most significant developments to come from the community mental health center program was the creation of new disciplines of service. These new career positions came about as a result of the anticipated manpower shortage that had been predicted long before the centers became operational. Albee (1959) had studied the trends in mental health manpower since the end of World War II and had determined that new categories of professionals and non-professionals were sorely needed to meet demands for service.

Terminology, again, enters into the confusion regarding the new mental health workers, and it is sometimes difficult to know

whether the descriptive terms are referring to the same levels of professionalism. Baker (1972) mentions the "mental health associate," Cohen (1973) describes the "collaborative co-professional," Collins (1971) uses the popular terms of "paraprofessional," Hallowitz and Riesmann (1967) cite the "indigenous non-professional," Caplan (1964) prefers "care-giver" and Stuckey (1973) refers to "new professionals." Carver (1973) is somewhat removed from other observers in his use of the term "community counselor" in specifying what Boyette (1972) calls "the new careerist" and Hansel, et al. (1968) have labeled the "mental health expediter." In each case, however, the workers are those who have been selected as volunteers, part-time or full-time employees to assist the professional staff in providing service to the community and whose qualifications as a part of the mental health team are usually lacking in academic preparation.

Few guidelines for utilization of non-professionals were established and each center developed criteria in accordance with its own needs. In some cases the new workers were limited to administrative tasks and were not allowed to perform direct patient service. Other centers designed intensive in-service training programs which exposed the worker to responsibilities in the "helping relationship" and encouraged close contact with center clients. Reissman (1965) suggests there are three considerations each center must face in dealing with non-professional staff utilization: (1) ratio of professional to non-professionals, (2) type of center operation -- community oriented or traditional -- and (3) ideology of supervisory staff toward utilization of the non-professional.

In-service training programs for community mental health will, by logical deduction, reflect the attitude and ideology of the trainer. Those aspects of service considered important by the directors of programs will be emphasized in orientation of new personnel to their jobs, and, conversely, knowledge and skills not held of value will be neglected. If the question is carried to its logical conclusion, the success of community mental health programs will depend on the knowledge and understanding of community mental health ideology attained and adhered to by professional leaders, their willingness to practice that ideology and their ability to pass that orientation on to the "new careerists" for whom they are responsible.

Community Mental Health Ideology

Webster's New Collegiate Dictionary, Seventh Edition, defines ideology as "visionary theorizing" and "a systematic body of concepts about human life or culture." The community mental health ideology defined by Baker and Schulberg, and which is the basis for this study, is a compilation of theories, opinions and concepts which have been expressed by several writers in mental health literature. A concerted effort to determine content areas that were commonly agreed on by exponents of community mental health was undertaken by those researchers and resulted in the development of a Community Mental Health Ideology Scale. The scale was designed to measure the degree of adherence to community ideology and was developed around five content categories which represent the major areas of concern for community mental health. The areas are: (1) a population focus, (2) primary prevention, (3) social treatment goals, (4) comprehensive

continuity of care, and (5) total community involvement (Baker and Schulberg, 1967). These areas reflect an orientation to mental health care that is different from traditional attitude and call for significant change in the approach to mental illness on the part of the professional and the community. The combined categories are, in one sense, an ecological approach to mental health and illness which encompasses the interrelationship of man to his total environment and the interdependence of the various systems which affect the individual.

It appears to this writer that the burden of responsibility for change in the mental health service system is equally shared by the professional and the community, both as individuals and as collective groups. Consumers must adjust their demands on the providers for private care and cooperate with new methods of treatment which are less time consuming. The community-at-large must re-evaluate its position toward the mentally ill and assume responsibility and joint leadership in providing for their needs. Members of the community need to participate in educational programs on mental health and illness, be attentive to ecological approaches to treatment and assume responsibility for social aspects of mental illness etiology which exist within the community (Klein, 1968).

The professional is faced with the greater adjustments in ideology. Even before the methods have been tested or proven, professional disciplines are being asked to lead toward implementation of the new system. Eric Hoffer (1963), in a comment regarding readiness for drastic change stated: "We can never be really prepared for that which is wholly new. We have to adjust ourselves, and every

radical adjustment is a crises in self-esteem: we undergo a test, we have to prove ourselves" (p. 3).

Representative of the value of change in professional role for community mental health workers is described by Howard and Baker (1971) in their study of nurses in mental health programs. The point is well made that "when selection criteria in community mental health programs are based upon individual competence rather than upon membership in a particular discipline, psychiatric nurses can aspire and progress to positions of leadership" (p. 450). The same can be said for members of any of the other professions or for any individual involved in community mental health. The emphasis is on getting the job done without unnecessary concern for whether or not the task falls within the traditional responsibility of any particular professional discipline.

As community mental health ideology effects the performance of care under the aegis of mental health center programs, adjustments in professional role and responsibility will continue so that work tasks carried out by members of the mental health team will fall to those who demonstrate capability independent of their credentials from academic institutions. This is not to say that all levels of care can be performed by all team members, but a growing flexibility in definition of role has created opportunities for para-professionals to be trained in methods and techniques of care which were not available to them before. This same flexibility allows higher-level professionals to relinquish clinical functions and assume other responsibilities in administration, community relations, staff development and in-service

training (Guerney, 1969). Much of the emphasis on changing roles for the professional has been directed toward movement out of purely clinical functions and into community research and evaluation to support program development and guide community lay-representatives in making appropriate decisions on problems which are to receive priority attention.

The fact that community mental health centers exist does not mean an overwhelming acceptance of the ideology on which they were supposedly founded. To the contrary, there is much evidence in the literature to suggest that mental health specialists question the efficacy of community concepts. Glasscote (1969) reports in his appraisal of community mental health centers that few professionals were involved in activities that could be categorized under the basic principle of prevention. He states that "...we found that most of the professionals did not feel that the evidence for the possibility of primary prevention was sufficient to warrant spending much time in pursuit of it" (p. 27). Similar questions have been raised by Berlin (1971) in regard to community activities on the part of center professionals, and Bowen, et al. (1965) suggest that the "team approach" which is basic to the concept of continuity of care may be a myth in attainability. While the problems in manpower development have received extensive attention, there is the underlying resistance from professionals to the expanding role of the non-professional. Boyette, et al. (1972) report that after a decade of attempts to adjust methodologies of service and increase utilization of para-professionals and other agency representatives, the professionals are dissatisfied

with the results and beginning to offer new barriers to the continuity of care principle.

The importance of including professionals from other community agencies within the circle of the mental health team has been widely encouraged. Other human service agencies have begun to make increased demands on professional time from the centers, asking for assistance involving their own internal problems and in making adjustments for their programs which will reflect a better response to community need. Consultation and education with health care services, industry, schools, civic organizations, law enforcement agencies, courts and a myriad of groups has provided the opportunity for the mental health center staff to move out of the confines of their system and into a broader involvement with the community. The community involvement engendered by these relationships is fundamental to community mental health ideology, but the accomplishment of the task is rare. Glasscote (1969) reviewed the problems of staff participation in consultation activities and found that "consultation appeared to be the least understood of the essential services, both in terms of what it is supposed to consist of and what it is supposed to accomplish" (p. 27). The answers to these questions were provided by Caplan (1970) in his comprehensive treatise on the consultation process, but his direction placed the activity in a highly skilled category of service. Professionals did not undertake to perform the service because of lack of understanding and training, and para-professionals were constrained from participation by virtue of their low position in team status.

Much of the literature relating to changing role for

disciplinary groups, utilization of new categories of workers and questions of responsibility for certain kinds of service can be interpreted as a statement of need for re-direction and training toward community mental health concepts. The tenor of most articles is a desire for the community programs to be successful and a realization that early programs have failed to reach the desired goals. The impetus for change within the system already exists but each program will need to allow for natural evolution, based on knowledge of what needs to be done, a willingness to let it happen -- or get out of the way -- and acceptance of responsibility to see that the changes occur.

Training in Community Mental Health

There are two major areas of concern related to training: the orientation and content of academic curricula in which most professionals learn their skills and develop their attitudes, and in-service training for already employed personnel, both professional and para-professional. The problems faced by trainers in in-service programs are compounded by situations which exist in the academic institutions in relation to preparation of professionals for community mental health service. It has already been stated that most professionals were ill-prepared for the jobs they faced in community centers, but they were made responsible for development and service in those programs.

The training they had received in graduate and professional schools was limited in content to those skills considered essential to their own clinical practice. Such skills had become standardized

through historical development of the discipline and were closely regulated by national professional organizations and individual state licensing boards. These boards exercised strict control over minimum requirements for certification for professional practice eligibility, and meeting those requirements left little time for the student to broaden his field of interest into the new community concepts.

Few professional schools had the necessary time or funds to expand their programs to include a curriculum for specialization in community mental health. This fact forced the community centers into having to utilize whoever was available and to provide for re-orientation through in-service training methods. Bernard (1964), Hume (1964) and Sabshin (1965) address themselves to the situations which confront academic institutions in their dilemma of trying to provide adequate numbers of trained professionals to meet the demands of an on-going system of mental health service and, additionally, needing to produce increasing numbers of specialists for a system radically different from the first. Questions that each institution must deal with concern these critical areas: (1) the realistic demand for community oriented courses by students, (2) availability of qualified instructors, (3) added costs of an expanded curriculum at a time when federal support for such programs seems to be decreasing, (4) problems of increased time for specialization after receiving basic essential knowledge and (5) conflicting pressures to produce professionals highly skilled in technical methods, widely conversant with theories of behavioral and social sciences, and flexible in their approach to

the problems they will face - all in a shorter than usual time span.

For in-service training programs, the questions are similar to those for universities. Qualified staff to perform the training in content areas other than clinical skills are difficult to find. The time factors in utilization of both professional and para-professional services make it difficult to schedule training sessions, especially when professionals are involved in direct care services to patients for a majority of their time. The content of training programs has been the prerogative of individual centers, with little or no coordination developed within the field to improve the status of para-professionals as a recognized discipline. The career-ladder concept which would provide upward mobility for workers who enter the mental health field as "aides" has received only limited experimentation and very little professional support.

Whatever methods are developed for increasing exposure of students in professional schools to community mental health concepts or expanding the content of in-service training programs from clinical skills to humanistic studies, the basic ideological principles are the same. Claudewell Thomas (1971), on the occasion of the 25th anniversary of the signing of the National Mental Health Act offered the following remarks concerning the future of mental health training:

> Innovative programs in mental health are pulled toward orthodoxy by their inability to relate adequately to mental health in contradistinction to illness. Tomorrow's psychiatrist must be trained to work competently in other systems besides his own. He must be part of a team that can relate to schools, prisons, communities, etc. Each member of the mental health team must be competent to consult with others, both more and less broadly competent than himself. Training programs must train allied health professionals and mental health professionals together so that each

> becomes aware of each other's capability, competence, and inadequacy. The mental health system of the future must contain adequate, competent bridge persons - to general health (broadly defined), to education, to the poor, the black, the alienated, the young, the old - to all people" (p. 63).

Statement of the Problem

The ability of the staff of a mental health service program to provide care for their patients within the context of a community mental health philosophy will depend on the extent to which those individual staff members believe in that philosophy and are willing to practice the ideological concepts of it. Being aware that many community mental health center staff members, both professional and non-professional, have not received orientation to community mental health ideology prior to their employment in community centers, this study endeavors to measure the degree of orientation to such an ideology by persons currently employed in three community mental health centers and in a community social work program. Further, it attempts to test the significance of certain variables in regard to their influence on the acceptance of that ideology.

Hypotheses

This study tested the following hypotheses:

Hypothesis I: There will be significant differences between mean scores on a Community Mental Health Ideology Scale among groups of mental health specialists.

Hypothesis II: Lower mean scores will be attained by groups of mental health professionals who are more closely identified with clinical responsibilities; i.e.

psychiatrists, psychologists, psychiatric social workers, and nurses than will be attained by more recently developed "new professions" groups within mental health services, such as community social workers and mental health aides.

Definitions: For the purposes of this study, the following definitions are used:

Mental health specialist - a person employed in a Community Mental Health Center or Clinic, full or part-time, who provides a mental health service for which he has received special training, academic or in-service, professional or paraprofessional.

Mental health professional - a person qualified by training as a psychiatrist, clinical psychologist, psychiatric social worker or other traditionally recognized mental health discipline.

Community Mental Health Center - a system of mental health services patterned on the recommendation of the National Institute of Mental Health which provides the five "essential services" as the basis of its service organization.

Community Mental Health Clinic - a facility and service system satellite to a mental health center or hospital which coordinates mental health activities in the community it serves.

CHAPTER II

METHODS

The Research Setting

The subjects used in this study are mental health specialists from three mental health centers in Oklahoma and from the Community Services Division of the Oklahoma State Department of Mental Health. Subjects from the Community Services Division are assigned to one of 13 mental health clinics located throughout the state. The primary functions of the specialists in these clinics are supervision of after-care services for released patients from the state's mental hospitals and serving the community as consultants for planning and developing local mental health programs.

The three Community Mental Health Centers from which the majority of subjects were drawn are the only centers currently in operation in the state. Since it is not the intent of this study to compare subject responses as an indication of the philosophy or the effectiveness of the centers, they will not be individually described. The centers are similar in the basic services they provide to their respective communities or catchment areas. The staffing patterns approximate each other in the disciplines that are represented, and each center espouses, through its public relations statements, a strong support for the concepts of community mental health. There is

some variety in the types of programs associated with center operations which is consistent with National Institute of Mental Health guidelines for local planning and offering of services. This difference is evidenced by the diversity of job titles reported by respondents from the centers.

Each of the centers has been in operation throughout all or most of the time span of federal funding support for community mental health center programs and each is the recipient of federal, state and local monies for operation of its facilities and services. The history of each center shows a consistent increase in budget allocations for operational funds, in the number of staff employed, and in the patient-load served through center services. Expansion of services includes those associated programs of school psychology, speech pathology, physical and vocational rehabilitation, and alcohol and drug counseling.

This study is not concerned with attempts to translate ideology into action on the part of the staff members of the mental health centers and clinics from which the subjects were drawn and no evaluation of existing programs is made, but rather it is addressed to a review of staff orientation to community mental health ideology. The staff populations of the centers and clinics included in this study represent the majority of persons within the disciplines in question who now work in community mental health programs in the State of Oklahoma and were considered to be the most appropriate sources for data.

The Instruments

Data for this study were collected through two instruments:

a Community Mental Health Ideology Scale and a self-administered questionnaire. The questionnaire was designed to collect basic demographic information and data related to education, community mental health work experience and some personal opinions related to in-service training of professional and para-professional staffs.

The Community Mental Health Ideology Scale was developed by Drs. Baker and Schulberg at the Laboratory of Community Psychiatry, Harvard Medical School in 1967. Its use is for measurement of the degree of adherence an individual has for a community mental health ideology which they have defined as having the basic concepts of population focus, primary prevention, social treatment goals, comprehensive continuity of care and total community involvement (Baker and Schulberg, 1967).

The scale is designed in Likert format with 38 items (19 positive and 19 negatively oriented) which calls for selection of one of six response categories ranging from strong agreement to strong disagreement for each item. Strong agreement with an item is scored 7 on positively worded items and strong disagreement is scored 1. The scoring values are reversed for negatively oriented items. Items that receive no response are given a value of 4. The Scale score for an individual is the total of the values for all the 38 items with a possible range of 38 to 266.

The authors report reliability for the Scale to be high ($r = .94$) for their respondent group and also for split-half ($r = .95$) and test-retest ($r = .92$) analysis. The tests of validity for the Scale to discriminate groups of mental health specialists in their degree

of orientation to community mental health ideology are reported to be of statistical significance (Baker and Schulberg, 1967).

In addition to research conducted by Baker and Schulberg, the Community Mental Health Ideology Scale has been used by other researchers in their studies of ideology among mental health professionals. Langston (1970) looked at professional discipline groups in mental health centers in Texas and found psychiatrists to be the least oriented toward community mental health among the groups he studied. A study of para-professionals and community mental health orientation was conducted by Poovathumkal (1973) which compared Scale scores from 25 para-professionals in Chicago community mental health centers with a community psychology group which Baker and Schulberg used in their original study. Significant differences were reported with para-professionals achieving predicted lower scores.

It appears that the Community Mental Health Ideology Scale is successful in measuring group adherence to the belief system characterized in the literature as "community mental health" and the ability to determine that orientation should offer great hope to community mental health program planners and practitioners.

The Sample

The total professional and para-professional staff of three community mental health centers and the members of a division of community services of a state-wide mental health department were asked to participate, on a volunteer basis, as subjects for this study. The staff members represented the professions of psychiatry, psychology, social work, nursing, and the new category of non-professional mental

health workers. Members of related professions such as school and pastoral counseling, speech pathology, and physical and occupational therapy were also represented.

Distribution of material for collection of data differed among the groups and depended both on geographical dispersion of subjects and on internal procedures for communications in the four administrative units. Since there was to be no attempt to compare centers with each other, the different methods of distribution was not considered critical to the analysis of the data. For two groups, material was mailed directly to each individual subject whose identity had been provided by the administrator of his program. In each of these two cases, this method was considered best because of the wide geographic separation of the subjects from the administrative headquarters of his program. In the other two populations, distribution was accomplished by making the material available at a central location within the center headquarters. In each case the material included a brief statement of instructions for self-administration of the instruments, a Community Mental Health Ideology Scale form (See Appendix A), a questionnaire (See Appendix B), and a self-addressed, stamped envelope for return of the material directly to this writer.

Of the 207 potential subjects, 176 received or voluntarily accepted research materials. Of this number 97 (54%) returned both the questionnaire and the Scale form. Returns were received from the following professional disciplines: psychiatrists (Group 1, N = 9); psychologists (Group 2, N = 15); psychiatric social workers (Group 3, N = 20); community social workers (Group 4, N = 15), allied

professionals (Group 5, N = 24); and para-professionals (Group 6, N = 14). In the total sample, 40 respondents were male (41%), 52 were female (54%), and five (5%) did not report their sex identification. The average age was 35.9 years and the average time for length of service was 4.5 years with a range of from one month to 15 years.

Educational information reported shows that 19 held doctor's degrees (20%), 49 had master's degrees (51%), 11 earned bachelor's degrees (11%), seven completed one or more years of college but earned no degree (7%), six were high school graduates with no further formal education (6%) and three did not complete a high school education (3%). Two subjects (2%) did not report education attainment level. Of the 81 subjects who reported the location of schools attended, 51 (63%) earned degrees or attended schools in the State of Oklahoma and 30 (37%) received their education in other states.

The work activities and time spent in each is reported as follows: Direct Service - 56%; Indirect Service - 15%; Consultation and Education - 15%; Administration - 10%; and Staff Development - 4%. Thirty-eight subjects reported participation in work-related professional or in-service training programs of at least one week duration.

The mean total score on the Community Mental Health Ideology (CMHI) Scale for the total research population was 210.30 with a range from 135 to 257.

The following information describes the six professional discipline groups which are the basis for study in this research.

Group 1

Group 1 (N = 9) consists of psychiatrists from three Community Mental Health Centers. Seven subjects are male (78%), one is female (11%) and one did not report sex identification. The average age for psychiatrists is 42.2 years and the average time for length of service is 5.7 years with a range from six months to 15 years.

Each of the subjects in this group holds a doctor's degree, of which three (33%) were earned in Oklahoma, five (56%) were taken in other states and one (11%) location of school attended was not reported.

The work activities and time spent in each is reported as follows: Direct Services - 59%; Indirect Services - 11%; Consultation and Education - 8%; Administration - 18%; and Staff Development - 4%. Two subjects (22%) reported participation in work-related professional or in-service training programs of at least one week duration.

The mean total score on the Community Mental Health Ideology (CMHI) scale for this group was 192.44 with a range from 149 to 241.

Group 2

Group 2 subjects (N = 15) are psychologists from the three community centers. There are nine males (60%) and five females (33%). One subject (7%) did not report sex identification. Seven (47%) hold doctorates, seven (47%) have master's degrees and one (6%) has a bachelor's degree. Ten of the degrees were earned in Oklahoma schools (67%) and five (33%) were taken elsewhere. The average age for Group 2 is 40.0 years and the average length of service is 4.3 years with a range from four months to eight years.

The psychologists spend 68% of their time in Direct Services; 8% in Indirect Services; 17% in Consultation and Education; 6% in Administration and 1% in Staff Development. Six subjects (40%) have participated in work-related training programs.

The mean total score of the CMHI Scale for Group 2 is 212.66 with a range of 188 to 252.

Group 3

Psychiatric social workers who work in the three community centers are included in Group 3 (N = 20). There are six males (30%), 13 females (65%) and one (5%) sex identification not reported. The average is 35.0 years and average length of employment is 4.0 years with a range from three months to seven and one-half years.

The educational attainment level for this group shows 19 master's degrees (95%) and one bachelor's degree (5%) of which 11 (55%) were earned in Oklahoma schools and nine (45%) in other states.

The psychiatric social workers reported spending 59% of their time in Direct Services; 17% in Indirect Services; 6% in Consultation and Education; 7% in Administration; and 9% in Staff Development. The remaining 2% of time was not reported. Eight subjects (40%) have participated in in-service training programs.

The mean total score on the CMHI Scale was 215.40 with a range from 183 to 252.

Group 4

This group (N = 15) consists of social workers from the Community Services Division of the State Department of Mental Health

who are employed in community clinics throughout the state. Returns were received from seven males (47%), seven females (47%) and one subject (6%) who did not complete that portion of the questionnaire. The average age is 31.3 years and average length of employment is 3.8 years with a range from two months to 10 years.

Thirteen subjects hold master's degrees (86%), one has a bachelor's degree (6%) and one did not report this information. Ten subjects (67%) attended Oklahoma schools, five (26%) attended out-of-state schools and one location (6%) was not reported.

Work activities and time spent in each is as follows: Direct Service - 42%; Indirect Service - 20%; Consultation and Education - 23%; Administration - 7%; and Staff Development - 6%. The activities for the remaining 2% of time were not reported. Attendance at in-service and professional training programs was reported by six subjects (40%).

The CMHI Scale scores for this group range from 170 to 257 with a mean of 224.86.

Group 5

The subjects in this group (N = 24) are staff members of the three community centers who represent professions not traditionally associated with or limited to mental health care. These allied professionals -- speech pathologists, rehabilitation therapists, school counselors, administrators, and drug and alcohol counselors perform services associated with locally developed programs. The group consists of nine males (38%), 14 females (58%) and one subject (4%) who did not specify sex identification. The average age is 35.0 years

and the average length of employment is 4.5 years with a range from one month to 10 years.

This group shows a wide range of educational attainment with three (13%) having doctor's degrees, 10 (42%) with master's degrees, seven (28%) having bachelor's degrees, and three (13%) who attended one or more years of college with no degree completed. One subject (4%) has a high school diploma and no further academic education. Sixteen subjects (67%) attended Oklahoma schools, six (25%) were educated in other states, and two (8%) did not report school location.

The allied professionals reported 98% of their work time in the following activities: Direct Services - 43%; Indirect Service - 13%; Consultation and Education - 24%; Administration - 16%; and Staff Development - 2%. Attendance at professional training or in-service training programs was reported by 11 subjects (46%) in this group.

The mean total score on the CMHI Scale was 216.00 with a range from 184 to 255.

Group 6

Para-professional staff members of the three community centers are included in Group 6 (N = 14). There are two males (14%) and 12 females (86%) with an average age of 35.7 years and an average length of employment of 4.2 years with a range from six months to seven and one-half years.

One subject (7%) holds a bachelor's degree, four (29%) have completed one or more years of college, five (36%) have high school diplomas, and three (21%) did not complete a high school education.

One subject (7%) did not report education experience. Only two subjects reported location of school attended.

The members of this group reported spending the following amounts of time in these work activities: Direct Service - 73%; Indirect Service - 18%; Consultation and Education - 4%; Administration - 4%; and Staff Development - 1%. Five subjects (36%) have participated in in-service training programs.

The mean total score on the Community Mental Health Ideology Scale for para-professionals was 186.57 with a range from 135 to 222.

CHAPTER III

FINDINGS: ANALYSIS OF DATA

Returns for the four populations were sorted into six groups according to professional discipline for comparison. The Community Mental Health Ideology (CMHI) Scale forms were scored using templates provided by the publisher and the raw score for each subject was determined by addition of the 38 item responses. Mean scores for the six groups were calculated and the range of group scores was recorded (See Table 1).

The self-administered questionnaires were coded and responses recorded for each of the six groups. Those demographic, educational and work-experience data considered appropriate for statistical analysis have been described in Chapter II and are summarized in Appendix C.

Statistical Data

The mean total scores on the CMHI Scale for the six groups was analyzed using parametric methods for measurement of central tendency and dispersion. An analysis of variance was conducted to test for between-group and within-group differences. The results were found to be significant at $<.01$ level (See Table 2).

Mean total scores and range of scores for the six comparison

TABLE 1

BASIC CMHI SCALE DATA FOR MENTAL HEALTH SPECIALIST GROUPS

Group	N	Mean Score	S.D.	Range
1 - Psychiatrists	9	192.44	29.31	149-241
2 - Psychologists	15	212.66	20.03	188-252
3 - Psychiatric Social Workers	20	215.40	20.52	183-252
4 - Community Social Workers	15	224.86	20.28	170-257
5 - Allied Professionals	24	216.00	19.33	184-255
6 - Para-professionals	14	186.57	23.47	135-222

TABLE 2

ANALYSIS OF VARIANCE OF CMHI SCALE SCORES FOR MENTAL HEALTH SPECIALIST GROUPS

Source of Variation	Sum of Squares	df	Mean Square	F
Between Groups	15,318.81	8	3,063.76	6.64[a]
Within Groups	42,009.51	91	461.64	
Total	57,328.32			

[a] $p < .01$

groups reported in Table 1 indicate two clusters of groups with comparatively similar responses to the CMHI Scale. Groups 1 and 6 had lower mean scores and a lower range of responses to the 38 item scale. A comparison of Groups 2, 3, and 5 reveal a closely similar mean score attainment and response range. Only Group 4 had a mean score and response range which were not obviously comparable to any other group.

The Duncan's New Multiple Range test, a statistic which uses estimated variance for all comparison groups rather than the population variance, indicates the differences in mean total scores to be between Group 1 -- Psychiatrists -- and all other groups except Group 6 -- Para-professionals, and between Group 6 and all other groups except Group 1. No significant differences were found in total mean scores on the CMHI Scale for Groups 2, 3, 4 and 5 when compared to each other (See Table 3).

TABLE 3

DUNCAN'S NEW MULTIPLE RANGE TEST

	4	5	3	2	1	6
4	-	-	-	-	*	*
5		-	-	-	*	*
3			-	-	*	*
2				-	*	*
1					-	-
6						-

* Means significantly different
\- Means not significantly different

The student's t-test was utilized for comparing interpair differences of CMHI Scale mean scores for the groups. The same significant differences reported by the Duncan's test were found in the results of the t-tests. Strong tendency toward significance in mean scores for Group 4 - Community Social Workers - was found when tested against mean scores for Groups 2 and 3 (See Table 4).

TABLE 4

T-TESTS OF INTERPAIR DIFFERENCES OF MEAN SCORES ON CMHI SCALE FOR MENTAL HEALTH SPECIALIST GROUPS

Group	1	2	3	4	5	6
1 - Psychiatrists	--	1.92[a]	2.34[a]	3.06[b]	2.60[b]	0.51
2 - Psychologists			0.38	1.60[c]	0.50	3.12[b]
3 - Psychiatric Social Workers				1.32[c]	0.10	3.68[b]
4 - Community Social Workers					1.33[c]	4.55[b]
5 - Allied Professionals						4.07[b]
6 - Para-professionals						--

(Numbers across correspond with numbered groups in left column)

[a] $p < .05$
[b] $p < .01$
[c] Strong tendency toward significance at $< .05$ level

The Pearson Product-Moment Correlation Coefficients between the CMHI Scale scores and age (r = -.044), recentness of education experience (r = .111), level of education achieved (r = .281), length of employment (r = -.098), participation in in-service training programs (r = -.003) and percentage of work time spent in direct service activities (r = 0.150), suggest that each of these variables had negligible influence on Scale scores.

Non-Statistical Data

Certain information provided by subjects on the questionnaire was not considered quantifiable or appropriate for statistical analysis. This material concerned the personal opinions of the respondents toward content of in-service training programs, the concept of "community" in community mental health, and desired adjustment or changes in community mental health service systems.

In-Service Training

Subjects were asked to suggest high priority content areas which should be included in programs for community mental health workers. No definition was provided for "mental health workers" and no limits were placed on the concepts which might be considered appropriate for in-service training, thus allowing each subject the freedom to respond within his own limits.

Typical responses offered a variety of subject matter which could be included in training. Those kinds of programs which were oriented toward specific skills training were common suggestions with content area usually reflecting problem areas in the discipline of the respondent, i.e., community social workers suggested programs related

to consultation skills and community organization; psychologists called for group treatment process training, especially the Transactional Analysis approach; psychiatric social workers recommended courses in crises intervention, counseling with special target groups such as alcoholics and drug abusers and special courses in diagnostic evaluation. Many of the para-professionals expressed an interest in courses which could improve their skills in dealing with specific kinds of patients and in understanding behavior. How to "be a good listener" was a common concern for the para-professional subject.

Frequency of responses in two major categories were studied to determine if content of desired training would suggest an influence on CMHI Scale scores. The categories were (1) skills development and (2) community relations. The t-tests were calculated between CMHI scores of 62 subjects who suggested skills development training and 27 subjects who emphasized a need for community aspects. The results ($t = -1.20$) were determined to be non-significant.

There were numerous suggestions for inter-disciplinary training programs with an emphasis on understanding the role of other professionals - or having other professionals understand the role of the respondent. Another popular suggestion dealt with inclusion of theoretical discussions in training, especially contrasting the medical model of treatment to the concept of prevention of mental illness. Inter-agency cooperation for continuity of care was recommended as an example where in-service training programs could be expanded to include more than intra-agency staff members.

Respondents in all groups included suggestions for courses

in self-awareness, enhancing self-concepts and personal development for both the patients and the staff.

Concept of Community

Each subject was asked to provide his own definition of "community" as it relates to community mental health. The view that each respondent holds of the community might be used to better understand his ideological position and to give some insight into previously expressed ideas for training.

One consistent response to the question on definition of community reflected a geographic orientation. Most subjects included within their definitions a limit of area prescribed within geo-political boundaries, such as city limits, county lines or catchment areas. The next most frequent comment related to populations, either by numbers or group identifications which were considered eligible for service from the mental health center or clinic. Within this same context, social institutions such as family, school, church and neighborhood was considered an integral part of the community definition. Other service agencies which are frequently included in the network for continuity of care such as courts, welfare departments, police departments, and volunteer organizations were occasionally included.

An orientation to community which received some attention was the concept of interaction between population groups toward a common goal of good mental health. Factors of social, economic and environmental influence were included as having significant function within the "community."

A comparison was made between subjects whose definition of

community was strongly oriented to geo-political limits (N = 47, Mean = 209.10) and subjects who included an awareness of interacting systems within their definition (N = 30, Mean = 217.40). The results (t = -1.54) were not significant within the limits considered necessary for this study.

Changes in Mental Health Services

The third question to which subjects were asked to respond related to areas of service or situations within the mental health service system which they felt could be improved. The most frequent responses was in the area of community education toward a better understanding of mental illness. Closely related to this subject was the inclusion of "educating the public" about the purpose and function of the mental health center.

An expansion of services to a wide population was encouraged by adjusting methods of treatment and moving many activities out of the confines of the center, per se, and into other aspects of community life. An example of this approach is the suggestion of expanding the mental health "team" to a wide variety of community members and placing a greater emphasis on preventive programs rather than on treatment. The image of the mental health center as a service only to the poor elicited several recommendations regarding a concerted effort to expand services for all economic levels in the community and to initiate an active public relations program to remedy many of the misconceptions the community seems to have about the center and the population it serves.

There were many suggestions concerning internal operations

of programs. Internal communications, decision making, consultation for professional staff, program funding, increasing size of staff, re-orientation to a wider range of services and in-service training were among the areas where adjustments or changes were needed.

Hypothesis I

The first hypothesis presented a prediction that significant differences in the mean total scores on a Community Mental Health Ideology Scale would occur for known groups of mental health specialists. This scale was developed for the specific purpose of "measuring an individual's degree of adherence to community mental health ideology" (Baker and Schulberg, 1967, p. 217).

The difference in mean scores among groups was predicted because of the reported contrast in orientation to traditional and community services similar groups had demonstrated in mental health programs in the past decade.

A statistical analysis of data, using the techniques of analysis of variance, Duncan's New Multiple Range test and the t-test for independent means produced related results and indicate significant differences do exist between some groups. The differences between Group 1 and Group 2 ($t = 1.92$, $p < .05$), between Group 1 and Group 3 ($t = 2.34$, $p < .05$), between Group 1 and Group 4 ($t = 3.06$, $p < .01$) and between Group 1 and Group 5 ($t = 2.60$, $p < .01$) support the hypothesis. Further support is found in comparing mean scores of Group 6 with Group 2 ($t = 3.12$, $p < 0.1$), Groups 6 with Group 3 ($t = 3.68$, $p < .01$), Group 6 with Group 4 ($t = 4.55$, $p < .01$) and Group 6 with Group 5 ($t = 4.07$, $p < .01$).

Comparison of mean scores for Group 4 with the mean scores of Groups 2, 3, and 5 were not found to be significant in this study ($p < .10$) but produced a strong tendency toward significance at an acceptable level. No differences were found when comparing mean scores of Groups 1 and 6, 2 and 3, 2 and 5, and 3 and 5.

Based on the presented evidence, the hypothesis is accepted -- with the noted exceptions.

Hypothesis II

This hypothesis predicted a directional difference in mean scores for mental health specialist groups. It was expected that professional groups which had been closely identified with traditional mental health service systems -- psychiatrists, psychologists and psychiatric social workers -- would achieve lower mean scores than those groups which have more recently been introduced into the mental health services -- community social workers, allied professionals and para-professionals.

While it was determined that several of these groups did attain significantly different mean scores on the CMHI Scale in the predicted direction, the critical comparison of Group 6 to Group 1 -- para-professionals to psychiatrists -- failed to produce significant results and the hypothesis is rejected. The rank ordering of groups by mean total scores shows results which are inconsistent with expected ranking implied in the hypothesis. Rank orders, both expected and achieved, are presented in Table 5.

TABLE 5

RANK ORDER OF MENTAL HEALTH SPECIALIST GROUPS
BY CMHI SCALE SCORE

Group	Mean Score	Expected Rank	Actual Rank
1 - Psychiatrists	192.44	6	5
2 - Psychologists	212.66	5	4
3 - Psychiatric Social Workers	215.40	4	3
4 - Community Social Workers	224.86	3	1
5 - Allied Professionals	216.00	2	2
6 - Para-Professionals	186.57	1	6

CHAPTER IV

DISCUSSION

This study was conducted to examine existing orientation to a community mental health ideology among mental health specialists in Oklahoma. The ultimate purpose was to focus attention on current expressions of agreement or disagreement with that ideology and to translate those expressions into a statement concerning in-service training programs for mental health specialists.

The review of the literature revealed a consistent pattern of concern within the new field of community mental health which called attention to several transitional problems that occurred during the first decade of the history of community mental health centers. Those problems were: (1) the conflict in ideology between traditional mental health and community-oriented programs, (2) the changing role of the various mental health professional disciplines in the new work environment and (3) the development of new services to meet community need.

The fundamental principles which differentiate community mental health from traditional mental health care are commonly accepted, at least in definition, by the advocates of this "third psychiatric revolution" and this research measured the degree of acceptance of those principles in selected populations.

The results of the research indicate that some of the

assumptions made by this writer in postulating the study were valid and a strong need for in-service training programs exists within the community mental health service system in this state. This knowledge can be expected to be of value in efforts to translate intellectual agreement into affirmative action.

Hypothesis I

The mental health field has historically been the domain of trained professionals, each with his own skills, responsibilities and hierarchical position in the system. The strictly defined academic preparation each discipline required of its practitioners fostered a separation of roles which perpetuated itself until the early 1960's. With the advent of a new system of service called "community mental health," these professions were asked to make radical adjustment in their approaches to service. These adjustments would (1) require provision of treatment in environments foreign to those for which they were trained, (2) expand the definition of "client" beyond the individual patient to whole populations for whom responsibility must be taken, (3) re-direct the orientation of treatment from personality reconstruction to social adjustment, (4) create a team approach to patient service which recognized the merit of lesser-trained specialists and other professions as having value to the care-giving process, and (5) necessitate the moving away from isolationism and into a consortium of community agencies with a common concern -- the mental health of the community. Underlying the entire change process was the most radical idea of all -- that it might be possible to prevent mental illness, and considerable effort should be expended toward that goal.

The need for services from such a system were too critical to wait until a new generation of professionals could be trained for the tasks and the burden fell to the existing disciplines to provide the leadership in development of programs and, at the same time, perform the required services.

The first hypothesis predicted that members of the disciplines represented on the community mental health teams in Oklahoma would have different degrees of orientation to the ideological principles which are basic to their service system. These differences were predicted on the information available in mental health literature concerning the content of academic curricula for the various professions, on reports regarding "role transition" within the disciplines during the past decade, and on personal observations of community mental health specialists in their work activities within the system. It was anticipated that the contrast in orientation to service contained within the various curricula, the demonstrated acceptance or resistance to role change and the participation in activities characteristic of good community mental health would be reflected in responses to the Community Mental Health Ideology (CMHI) Scale.

Sufficient evidence was found to support the hypothesis and to accept it within pre-determined limits. Two groups, psychiatrists and para-professionals, demonstrated significantly different responses from each of the other four comparison groups and one group, community social workers, had scores which were near enough to the significance limits to be worthy of note (See Table 4). Of the 15 possible inter-pair comparisons, eight were found to be different at probability

levels $< .05$ and three were noted as tending toward significance at the same level.

The mean scores for all comparison groups in this study are relatively high when compared to the possible range of scores on the CMHI Scale and the results seem to indicate that strong agreement with the concepts of community mental health ideology exists among the mental health specialists in Oklahoma. A different impression is received when comparing scores for these groups with results in other studies. In the original research for the development of the CMHI Scale, Baker and Schulberg used nine comparison groups which were selected for their assumed differences in orientation to community mental health. Four of the groups were expected to hold a strong agreement with the defined concepts, three groups consisted of a random sample from professional mental health organizations, and two groups were expected to show a negative orientation to community mental health concepts (Baker and Schulberg, 1967).

The mean scores for Groups 1 and 6 in this study rank lower than the mean score for any group reported by Baker and Schulberg and all Oklahoma specialist groups attained a mean score which ranks below that of the original comparison groups which were selected for their assumed strong orientation to community mental health.

The fact that the disciplinary group which represents the leadership of the community mental health profession in Oklahoma demonstrated a significantly lower orientation to community mental health ideology than most other disciplines sampled in this and other studies raises serious questions on the direction of service programs

in this state.

Hypothesis II

The directional difference for mean scores of the six specialist groups was predicted on the following assumptions: (1) members of traditional mental health professions would be less oriented to community mental health ideology than would more recently identified mental health careerists; (2) the mean total scores of the six groups would rank inversely with their position within the mental health organizational hierarchy and (3) a logical association between time spent in certain work activities and community mental health ideology could be demonstrated.

For the purposes of this study, the critical comparisons are between the scores of Group 1 and Group 6. The expectation was that psychiatrists would demonstrate the lowest degree of orientation to community mental health and that para-professionals would show the highest. The prediction for psychiatrists was based on the traditional orientation of their professional preparation and their reported resistance to change in professional role within the community mental health center setting. The para-professional position was predicted on the assumption that their orientation to the field of mental health had been conducted by "community mental health" professionals in in-service training programs and the expectation that their work activities would reflect a strong community involvement.

The assumptions and expectations concerning para-professionals were inaccurate. They receive little or no training in community mental health principles and nine of the 14 subjects in this group reported

having no in-service training of any kind during their employment history. The remaining five subjects reported participation in training programs ranging in length from one to 12 weeks. Interviews, conducted informally with some respondents, revealed that training was not an integral part of the para-professional program. The consensus of those interviewed was that "training" consisted primarily of an orientation to program operations and was, in a sense, a guided tour of "who does what and where." The technical skills developed by the "trainee" are obtained in on-the-job activities under supervision of an appropriate professional.

The amount of time spent in community contact activities by the para-professional varies with his assignment in center service programs, but it was apparent from the data that utilization of para-professionals was not consistent with theories which advocated the formation of the "new career" categories. The value of having indigenous mental health workers in the community, having knowledge and being a part of the interacting systems, recognizing and relating to the bases of power and decision, and being able to interpret community dynamics for the professional provider has been neglected. It seems that the lack of orientation to community work for the para-professional is a reflection of the attitude of professional staff toward this type of activity. It is fundamental to the concept of total community involvement that the mental health specialist consider the input from the community as being valuable to program planning and service. It is a new experience for mental health professionals to look beyond their own discipline when determining the course of action to be taken in

providing care to a patient. If the responsible leader does not have the experience in seeking input from concerned sources in the community, he will also lack the ability to train the para-professional in performing the task.

The para-professionals participating in this study do not see community activities as a part of their function. Work activities reported by this group shows 73 percent of their time being spent in direct services to individual patients and an additional 18 percent of time in activities categorized as indirect care. Those activities do not allow sufficient time for "community" service and the inherent nature of the individualistic approach to patient care provides little opportunity for learning the concepts and methods required for good community mental health programs.

The hypothesis was rejected when mean total scores for Groups 1 and 6 were determined to be not significantly different from each other and when analysis showed the mean score for Group 6 to be significantly lower than the mean scores for Groups 2, 3, 4 and 5. The ranking of scores for the six groups shows para-professionals to be in the exact opposite position from that predicted (See Table 5).

Even though the results of data analysis led to the rejection of the second hypothesis, some of the comparisons of group mean scores indicate significant differences in the predicted directions. The three professional groups most often identified with mental health services -- psychiatrists, clinical psychologists and psychiatric social workers -- were represented by subjects who achieved scores which were fifth, fourth and third in ranking order. If the unpredicted rank

achievement of Group 6 had not occurred, the expected rank positions of these three groups would have been achieved and the hypothesis could have been accepted. These three groups were considered to have the least agreement with community mental health ideology by virtue of their long association with traditional mental health care systems, the orientation of their academic training and their demonstrated resistance to changing "professional role" within the context of the community mental health team. These contentions are supported throughout the literature of the first decade of community mental health centers and were observed among mental health specialists.

The achievement of highest rank for mean scores of Group 4 was not predicted because of the suspected influence of their academic training. The subjects in this group had participated in academic programs similar to those of the psychiatric social workers and 13 of 15 subjects hold master's degrees in Social Work. It was anticipated that the work environment in which these subjects performed their services would have an elevating influence of CMHI Scale scores but that degree of influence was underestimated.

It would be worthwhile to study the factors which affect the differences in orientation to community mental health for specialists who work closely with community groups and those who do not. The peer group influence in a traditional service system could be expected to have a strong influence on limiting the community-oriented activities of workers, especially if those activities are held in low esteem by the group leaders. On the other hand, the community social worker who functions more independently from other mental health specialists and

whose reference group is made up of members from non-mental health professions might be expected to make a more radical adjustment in personal attitude toward his professional role.

The contrast between stated agreement with community mental health ideology, as demonstrated by the CMHI Scale scores, and the inclination toward "traditional" services was observed in all groups. In an effort to find explanations for this inconsistency, theories of motivation and behavior which could present some insight were examined. The cognitive dissonance theory of Leon Festinger (1957) appears to have some applicability. The basic hypotheses are: (1) dissonance is psychologically uncomfortable and will provide motivation toward consonance; and (2) a person will avoid dissonant situations and information while trying to achieve consonance. The cognitive elements are knowledge, opinion, or belief concerning the environment, oneself, or one's behavior. Consonance, the preferred state or condition, is achieved when the cognitive elements are compatible with the individual's "reality." This reality can be physical, social or psychological. Dissonance occurs when the cognitive elements do not correspond to the individual's interpretation of reality (Festinger, 1957).

Festinger goes on to state that dissonance can arise from (1) logical inconsistency, (2) cultural mores, (3) specific opinion being included in a more general opinion, and (4) past experience of the individual. The degree of dissonance will depend on the importance of the cognitive elements which are in conflict. When the magnitude of the dissonant elements equals or exceeds the magnitude of the consonance, change occurs and dissonance is eliminated.

The basic premise of the Festinger theory is that an individual will resist basic change so long as that resistance is psychologically possible. He will attempt to reinforce the cognitive elements with new ones which are compatible with his action, or he may make adjustments in his environment or his behavior which reduce dissonance.

Translating the cognitive dissonance theory into practical application for this study, the following points are considered pertinent: (1) cognitive elements which might be dissonant for one individual may be consonant for another; (2) the theory is more appropriate to studies of individuals rather than groups; and (3) the application of the theory seems more appropriate in statements of experience rather than prediction.

The expected dissonance between the elements of community mental health ideology and traditional practice does not appear significant for subjects in this study. The reduction of dissonance appears, by subjective evaluation, to have been accomplished by a combination of adding new cognitive elements in support of tradition, adjustments in behavior within the professional role, and in controlling the environment in which the dissonance might have developed. Interviews with subjects in each of the specialist groups revealed a personal awareness that there had been some early dissonance between the knowledge of basic principles of traditional service and the expectation for performing community services. There were, however, numerous criticisms of community mental health which could be added to the cognitive elements in support of the traditional position and change was not required.

Within the work environment of the centers, some staff members were aware that community mental health was supposed to be a different service model from the one for which they were trained. The obvious source for direction of the staff was the example of the leadership, the psychiatrists. That example supported the cognitive element of traditional role within the medical model. The elements which would have supported a dissonant position such as community pressures or ideological "theorizing" were given negligible attention.

Behavior adjustments were necessary only if the dissonant elements became strong enough to call public attention to short-comings in the service system. These adjustments were usually exemplified by some professional staff members performing consultation and education programs for other community agencies. The programs consumed little time and served to relieve some of the "need" for community involvement.

Additional environmental control was exercised by establishing the community mental health service system with a strong "facilities" definition within the community. The clients were required to travel to those facilities to seek assistance rather than having services available through inter-related agencies. When pressures of dissonance increased, services were offered in out-reach offices or satellite clinics which were mostly duplications or extensions of those services which were available in the parent center.

A general observation regarding the influence of the cognitive dissonance theory as it applies to mental health specialist groups who work in community mental health centers in Oklahoma leads to the

conclusion that consonance has been reached by these groups. There is no apparent conflict between community mental health ideology and the opinions regarding behavior or performance by the staff members. The elements of knowledge, behavior and environment have been brought into a consonant relationship so that the "logical" explanation can be offered: I am a trained mental health specialist; I work in a Community Mental Health Center; the work I do is compatible with the work of other specialists in this center; therefore, the work I do is community mental health.

The fact that community social workers attained the highest mean score on the CMHI Scale may relfect a greater influence of dissonant elements on that group than any other. The data for that group show less professional time spent in direct patient care and more time in community activities. The subjects in this group work in mental health clinics which are isolated from other mental health specialists. The influence of community pressures for non-traditional services would be more difficult to resist without the added elements of support from other professionals. Additionally, the community social workers expressed more interest in gaining further knowledge of community concepts than did other subjects. This leads to the tentative conclusion that the efforts to resolve dissonance have resulted in a noticeable movement toward change for that group of subjects.

Demographic Data

Descriptions of the populations included in this study and the groups which were compared to test the hypotheses contain information regarding sex, age, length of employment, educational attainment,

location of educational experience and time spent in various work activities. These categories of information were considered essential for adequate analysis of differential causes in scores on the Community Mental Health Ideology Scale.

Baker and Schulberg (1967) reported finding positive correlations between CMHI Scale scores and age, and between Scale scores and the date of highest academic degree attained. These correlations indicated that younger respondents were more likely to attain higher scores on the Scale and that recently trained subjects were "more likely to have been socialized to a community mental health orientation" (p. 224). Poovathumkal (1973) reported insignificant results in this test for correlation of scores and age with para-professionals.

The tests performed in this study to determine association between identified variables and CMHI Scale scores produced insignificant results. Neither age, date of highest degree, level of educational attainment, location of school, length of employment or participation in in-service training programs had significant influence on Scale scores.

The fact that no relationship exists between date of highest degree and Scale score may be an area of concern for schools of professional training in this state. It seems logical that an association between these two factors should be found in studies of community mental health professionals, if sufficient effort is being expended in our academic institutions to adequately prepare students to meet the challenges of the new service system. The lack of obvious indications that new professionals are being properly oriented to community mental

health principles places a greater burden on planners of community programs and on the administrators within individual community centers. They must assume the responsibility for orientation of their own personnel and provide the necessary opportunity for training which will strengthen the community programs. Valuable time must be allotted to the task of broad-based education which could, and should be carried out as a part of the professional education of the specialist. Duplication of effort is a wasteful process and it is an unnecessary burden for community programs to have to do the work of the school in preparing the specialist for the job to be done.

Non-Statistical Data

The geo-political orientation to "community" which was included in the definition of community mental health by the majority of subjects in this study was not unexpected. The emphasis on clinical service that is apparent from reports of time spent in specific work activities almost requires that mental health center personnel limit their availability to a strictly defined population in order to control the patient load which can be effectively served. Those limite are most easily established by using existing political boundaries. The catchment area concept was included within the federal guidelines for service so that each center could be easily identified by the community as the appropriate source for assistance in mental health care. It was anticipated that the entire geographical area of the United States would ultimately be served by a community mental health center and that services would be available to the total population.

The results of the limitation of service to those individuals

who reside within a particular geographic area have been to restrict the availability of service to some people and to further divide the professional providers into smaller cliques who need only be concerned for "their own people." The fact that comprehensive coverage of the population has not been achieved seems to have made little difference to the functional activities of the centers which continue to disenfranchise population groups who do not live within a center's catchment area.

Concomitant with the geographic orientation, many of the definitions of community implied an association between the mental health center and the community which is typical of the medical model of service. Many subjects viewed the center as independent in its role of provider of mental health care and services and saw the community, its groups, and individuals only as potential clients. There was little expression of the awareness of the concept that the center was or could be an active part of the social action system of the community; while there was some awareness of a need for interaction between the center and other service agencies, the center was consistently viewed only as provider of information and assistance. No indication was given that the mental health professional might learn or benefit from the experiences of the other agencies. A fairly typical example of this viewpoint was: "...a two way interaction between the center and the community. That is, the community coming to the center for service and the staff of the center going into the community for dissemination of information and community education."

The effort to define "community" within a context that is

acceptable to care-givers most frequently results in a limited focus, centered around "concretely existing aggregations of people" (Howe, 1964, p. 19). It is more easily comprehended if the definition includes those tangible aspects of geography, populations, organizations, agencies, functional groupings and associations, even though those components may be so intertwined as to make a distinctive recognition impossible. The federal guidelines for community mental health centers may have been most responsible for placing the limiting factors on community definition when it included population size as a criteria for community service. The "catchment area" for which a center was to be responsible was defined as having from 75,000 to 200,000 people. The states, which included mental health centers in their comprehensive plans for mental health program development, found an easy solution to determining boundaries for these catchment areas by selecting the appropriate political boundaries of city limits, county lines, or multi-political units. In major metropolitan areas, arbitrary boundaries were formed around the required numbers of people with seemingly little attention given to social or cultural development.

Many of the publications considered authoritative in community mental health contain definitions which reflect the limited orientation. Roberts, Halleck and Loeb (1966) suggest that "community refers to a specified population, which may be contained within geographical boundaries, be related by common functional role or activity, or possess some feature that defines it as a unit" (p. 7). The Joint Commission on Mental Illness and Health had also included a suggestion for population limitation in its proposal for community mental health

clinics.

The problem with concrete definitions for a concept of community is implication of a one-way relationship between the community and the center. The relationship is based on viewing the community as a potential client which is or will be in need of service; service which only the center is capable of providing.

Louisa Howe (1964) has attempted to move the concept of community out of the restrictions which usually accompany its usage and into a more abstract, analytic level. She suggests the following advantage:

> It can then be seen as a dimension of human behavior, a component of man's view of himself and his fellows. If this step is taken it may be easier to avoid the 'fallacy of misplaced concreteness' which bedevils so many attempts at community analysis, and which repeatedly leads to the perplexed query, 'What is a community?' (p. 19).

Howe further suggests the importance of applying the concept of community at the symbolic level of man's interaction with his total environment. The "common destiny" faced by those involved in the interactions places them within the "community" concept.

In summary, the perception of community by mental health specialists in Oklahoma is not noticeably different from that of most other professionals who are reported in the literature. They consider themselves as providers of service, secure in their role of "expert" within the community and willing to provide care to individuals and groups who seek their assistance. They provide individualized patient care through diverse methodologies and are available to assist other agencies as consultants in problems related to mental illness. They do not see themselves or their center as an integral part of the day-to-day life of the community and express little interest in programs of

prevention of mental illness or maintenance of good mental health.

These statements are not intended to be critical of the services performed by mental health centers or their staff members, and the quality of care provided is not questioned. It can be stated, however, that from subjective and objective analyses of data received, the community mental health specialist groups included in this study provide services which are traditional in their orientation and do not consistently adhere to the principles of community mental health as defined in this study.

In-Service Training

A statement concerning the need for in-service training within the community mental health systems which exist in Oklahoma is a subjective one on the part of this writer. Since the decision for inclusion of in-service training within the activities of a program's personnel services is an administrative prerogative, an evaluation of those programs would have to be conducted before objective statements could be presented. No such evaluations have been included within the scope of this study and the recommendations presented here are merely based on inferences from the data.

The mental health specialists included in this study spend little time participating in training programs, either as students or instructors. Of the six comparison groups, psychiatric social workers reported the highest percentage of time in staff development activities -- nine percent. It was determined through subsequent interviews that these activities are almost entirely supervision of individual on-the-job training. The content of these learning experiences is

heavily oriented to specific skills development of the para-professional and deal with traditional methodologies of care-giving. The amounts of time reported by other specialist groups for staff development appear to be for programs of a similar nature.

It is interesting to note that para-professionals did not seem to consider these supervised activities as in-service training since nine of the 14 subjects in that group reported no participation in in-service training programs.

The para-professional is most often the group of employees considered in greatest need of training. Their orientation to the field, knowledge of the professional language, and technical skills in performing their duties are the responsibility of their employer. It is not unusual for higher level professionals to fail to look beyond these requirements; consequently their training is frequently limited to these areas.

The successful utilization of para-professional personnel in a community mental health program requires the expansion of their realm of activity beyond traditional roles. It is of little value to "vocationalize" their education. The results of such training provides only supplemental personnel to perform tasks which the professionals find unattractive or mundane. Nothing is achieved toward a goal of improvement of human services. The para-professional becomes isolated at the bottom of the professional ladder, with little opportunity for advancement. In addition to the unnecessary waste in limiting the opportunity for "career ladder" movement of the para-professional, the impetus for change in role is denied to upper-level professional groups. As long

as the emphasis on direct patient care prevails and the burden of that care is the responsibility of the "qualified" professional, there will be no chance for that individual to escape the trap of being segregated from the community because of time-consuming patient care.

The work activities of the mental health specialists included in this study are heavily oriented toward treatment services for the mentally ill. It appears that little time or effort is expended in programs which could be categorized as preventive or early intervention activities. This orientation to service seems to reflect a resistance to true adherence to community mental health ideology. The question must be raised on whether or not the mental health centers and clinics, and the specialists employed in them, are sincerely interested in developing innovative programs in mental health care or merely providing traditional services in a new setting.

The value of in-service training programs is not restricted to lower-level professions. If the obvious contrast between community mental health services and traditional care is accepted, it would seem equally apparent that all levels of community mental health professionals could benefit from participation in programs which emphasize the new concepts.

The reported participation in professional and in-service training programs by members of the specialist groups studied is somewhat alarming to an advocate of in-service training as a viable tool in improving the effectiveness of community programs. More than half of each specialist group reports no participation in training since beginning employment in their community programs. The

implications of this information support the earlier contention that orientation to community mental health ideology may not be an integral part of the working philosophy of mental health professionals in Oklahoma.

Needs for Further Study

There are two areas of major concern which should be thoroughly researched in relation to community mental health ideology and community mental health programs. The long-range plan for development of community mental health programs is the independent responsibility of each state. A study of the coordination between the curricula in professional schools and the requirements of new programs for qualified staff with "appropriate" orientation should be conducted.

A second area where further study would be helpful relates to experimental programs of service which are radically different from the medical model on which most community mental health services are based. It is a subjective opinion of the author that a dual-system of services, one clinical and one social, appears to be developing and that the emphasis on social change which is receiving serious attention in current literature may reflect a more accurate appraisal of human service needs than does the community mental health center system.

Some Future Possibilities

Significant changes have occurred in treatment methods which have allowed for a more liberal approach to care by the professional providers. Chemotherapy has aided in reducing the populations of

mental hospitals by providing a method of treatment within the community setting and permitting the "patient" to continue to function in or near his normal environment. Partial-hospitalization programs have created a setting in which the client can spend part of his day in a therapeutic surrounding and still maintain a close association with his family and friends during the remainder of his usual daily schedule. Expansion of group-oriented treatment programs have increased the number of patients seen by professional care-givers and made the consumer and the community more aware of the prevalence of mental health problems. However, the "third psychiatric revolution" may be short-lived. The first decade of service by community mental health centers has raised serious questions concerning the adaptability of mental health professionals to new work situations, the responsiveness of community mental health programs to community needs, and the effectiveness of community mental health center services in meeting the mandate to eradicate the causes of mental illness.

Much of the resistance to change by the professionals appears to follow a consistent pattern, long established within the mental health field. Ruth Caplan (1969), in her comprehensive study of reform within the mental health systems of the 19th century, entitled one of her chapters "The Psychiatrists' Initial Response to Criticism: Evasion, Denial and Counterattack." The descriptions which she gives of the efforts among "alienists" to negate the developing criticisms of mental hospitals could well be applied to modern situations in psychiatry and community mental health. The first response was a defense of the status quo and an inability to admit fault within the

predominant profession. Professional guilds were formed which provided support against critics and which fostered an environment of mutual admiration among its members. Dissenters in the profession were ridiculed for their variant ideas and for their lack of loyalty to the fundamental principles of the alienist profession. The continued pressure, both internal and external, caused splinter groups to form which considered themselves more responsive to public needs and demands. The support they received for their innovative ideas and plans caused greater numbers of their colleagues to "climb on the band wagon" and a greater schism developed between traditional and "modern system" advocates. The developing theories became accepted within the professional community and radical changes occurred in the orientation of the mental health systems (R. Caplan, 1969).

A remarkable similarity exists between the historical chronicle of mental health in the latter part of the 19th century and the current transition toward community mental health which began after World War II. Ms. Caplan reports a near cyclical pattern in mental health services as they attempt to adjust to changing public demand and the community mental health movement of the past decade appears to be such a response. The major criticisms of the community-oriented mental health services, as they have developed, is that they are not yet significantly different from traditional services and their ability to meet the mental health needs of the community is only slightly more effective than programs which existed prior to their inception.

Special appreciation should be given to the efforts which have been undertaken by the mental health professional to meet the

challenges which have been imposed, but it may be that the attempts to solve the problems of mental health are not within the capability of a therapeutically-oriented profession. It is certainly logical to assume that programs which treat only the mentally ill will have no effect on preventing others from becoming ill.

Raquel Cohen, in a presentation to the 126th annual meeting of the American Psychiatric Association in May, 1973, compared the models of mental health care which are most widely used in this country. As a part of her remarks she included a "human services" model which might well replace the community mental health center programs as the focus for first-line care. One of the characteristics of the human services model is the emphasis on interdisciplinary manpower teams which will assume the responsibility for planning, administration and performance of services. The services proposed are strongly oriented to interpersonal and social action -- counseling, advice, advocacy, community-control, community organization and community development -- with decentralized, deinstitutionalized and transitional facilities available which can be immediately adjusted to provide comprehensive, integrated, accessible, continuous and accountable services. The goals of the human services programs are interventions in the intra- and inter-organizational structures and environment which effect the psycho-social development of the individual (Cohen, 1973 a).

Experimental programs in community mental health in which a human services orientation has replaced the treatment model as the focus of primary emphasis are currently being conducted. The Houston, Texas Mental Health Authority has closed seven of its ten community

mental health centers and created teams of community workers, all considered professional but with varying types and levels of skills, who live in and function as a part of a neighborhood community. Their one major mandate is to reduce the commitment rate to mental hospitals from their areas and to develop inter-related local services which will respond to and meet the needs of the people they serve. Early evaluations report favorable response from the community and a deepening commitment from the staff for this type of program (Carver, 1973).

The development of a dual system of service, one attempting to correct problems which contribute to mental illness and the other treating the mental illness caused by those problems, reflects the inability of one system or model to perform the entire task. Additionally, the burdens of responsibility are too great for one system to assume. The ultimate need is for a totally new concept of service, utilizing whatever resources are available -- health, education, welfare -- and at whatever levels -- pro, para- and non-professional -- in a social action movement which is accountable to the people it serves. The total burden should not be left to the mental health "professional" and neither should that profession be made the scapegoat for failures which have occurred. The task is to learn from the mistakes that have been made and to move on to a more responsive effort in caring for those who need.

SUMMARY

This research looked at groups of mental health specialists in Oklahoma who provide services through community mental health centers and clinics. The subjects for the study were asked to provide

demographic, education and work experience information through a self-administered questionnaire and to respond to a Community Mental Health Ideology Scale. The scale measures adherence to community mental health ideology by assigning values to responses to 38 items constructed on commonly accepted concepts.

The hypotheses proposed that significant differences would occur in mean total scores for the six comparison groups selected as representative of mental health specialists in Oklahoma and that those professionals in disciplines more closely related to clinical practice would achieve lower mean scores than would categories of new professions. The first hypothesis was accepted after statistical analysis showed significant differences in total mean scores did occur in the majority of comparisons. The second hypothesis was rejected when directional differences did not correspond to predictions.

There was no attempt to evaluate effectiveness of performance by individuals, professional groups or centers where the subjects were employed. It was determined, however, that the mental health centers are similar in their stated philosophy of service, in types of programs and services offered to the community, and in their organizational structure.

Information provided by subjects in the study showed a much lower participation in in-service training and staff development programs than had been expected. Reports of work time spent in various activities indicate the majority of professional care is directed toward the mentally ill and significantly less time is spent in preventive and early intervention programs. Content areas for

in-service training programs suggested by the respondents were heavily oriented toward specific clinical skills training.

The combination of factors reported above leads to the conclusion that mental health specialists in Oklahoma are not so favorably oriented to community mental health ideology as their scores on the CMHI Scale might indicate and that definite need exists within the mental health service systems in this state to encourage adherence to community mental health concepts.

BIBLIOGRAPHY

Albee, G. Mental health manpower trends. New York: Basic Books, 1959.

Albini, J. L. The role of the social workers in an experimental community mental health center: experiences and future implication. Community Mental Health Journal, 1968, 4, 111-119.

Baker, E. The mental health associate: a new approach in mental health. Community Mental Health Journal, 1972, 8, 281-291.

Baker, F. and H. Schulberg. The development of a community mental health ideology scale. Community Mental Health Journal, 1967, 3, 216-225.

Barnes, R. Developing a mental health program. In L. Roberts, S. Halleck and M. Loeb (Eds.) Community psychiatry. Madison: The University of Wisconsin Press, 1966, 101-113.

Bellak, L. (Ed.) Handbook of community psychiatry and community mental health. New York: Grune and Stratton, 1964.

Berlin, I. Professionals' participation in community activities: it is part of the job? American Journal of Orthopsychiatry, 1971, 41, 494-500.

Bernard, V. Education for community psychiatry in a university medical center. In L. Bellak (Ed.) Handbook of community psychiatry and community mental health. New York: Grune and Stratton, 1964, 82-123.

Bowen, W., D. Marler and L. Androes. The psychiatric team: myth and mystique. American Journal of Psychiatry, 1965, 122, 687-690.

Bockoven, J. The moral mandate of community psychiatry in America. Psychiatric Opinion, 1966, 3, 24-39.

Boyette, R., et al. The plight of the new careerist: a bright horizon overshadowed by a dark cloud. American Journal of Orthopsychiatry, 1972, 42, 596-602.

Caplan, G. Principles of preventive psychiatry. New York: Basic Books, 1964.

Caplan, G. Theory and practice of mental health consultation. New York: Basic Books, 1970.

Caplan, G. and R. Caplan. Development of community psychiatry concepts in the United States. In A. Freedman and H. Kaplan (Eds.) Comprehensive textbook of psychiatry. Baltimore: Williams and Wilkins, 1967, 1499-1516.

Caplan, R. Psychiatry and the community in nineteenth-century America. New York: Basic Books, 1969.

Carver, J. Personal communication, 1973.

Cohen, R. The collaborative co-professional: developing a new mental health role. Hospital and Community Psychiatry, 1973, 24, 242-246.

Cohen, R. Models in search of community mental health programs (The function of psychiatrists as a variable). Speech presented at the 126th Annual Meeting of the American Psychiatric Association, Honolulu, Hawaii, May, 1973 a.

Collins, J. The paraprofessional: manpower issues in the mental health field. Hospital and Community Psychiatry, 1971, 22, 362-366.

Dorn, R. The role of the psychoanalyst in community mental health. Community Mental Health Journal, 1966, 2, 47-54.

Festinger, L. A theory of cognitive dissonance. Palo Alto, Calif.: Stanford University Press, 1957.

Glasscote, R., et al. The community mental health center: an interim appraisal. Washington, D. C.: Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, 1969.

Guerney, B. (Ed.) Psychotherapeutic agents: new roles for non-professionals, parents and teachers. New York: Holt, Rinehart and Winston, 1969.

Hallowitz, E. and F. Reissman. The role of the indigenous non-professional in a community mental health neighborhood service center program. American Journal of Orthopsychiatry, 1967, 37, 766-778.

Hansell, N., M. Wodarczyk and H. Visotsky. The mental health expediter. Archives of General Psychiatry, 1968, 18, 392-399.

Hobbs, N. Mental health's third revolution. American Journal of Orthopsychiatry, 1964, 34, 822-833.

Hoffer, E. The ordeal of change. New York: Harper and Row, 1963.

Howard, L. and F. Baker. Ideology and role function of the nurse in community mental health. Nursing Research, 1971, 5, 450-454.

Howe, L. The concept of community: some implications for the development of community psychiatry. In L. Bellak (Ed.) Handbook of community psychiatry and community mental health. New York: Grune and Stratton, 1964, 16-46.

Hume, P. Principles and practice of community psychiatry: the role and training of the specialist in community psychiatry. In L. Bellak (Ed.) Handbook of community psychiatry and community mental health. New York: Grune and Stratton, 1964, 65-82.

Jarvis, P. and S. Nelson. The therapeutic community and new roles for clinical psychologists. American Psychologist, 1966, 21, 524-529.

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

Klein, D. Community dynamics and mental health. New York: Wiley and Sons, 1968.

Langston, R. Community mental health centers and community mental health ideology. Community Mental Health Journal, 1970, 6, 387-392.

Lief, V. and R. Brotman. The psychiatrist and community mental health practice. Community Mental Health Journal, 1968, 4, 134-143.

Mehr, J. Personal styles of program implementors: a case study in community mental health failures. Hospital and Community Psychiatry, 1973, 24, 406-409.

New, P. An analysis of the concept of teamwork. Community Mental Health Journal, 1968, 4, 326-333.

Poovathumkal, C. Community mental health ideology scale standing of paraprofessionals. Community Mental Health Journal, 1973, 2, 108-115.

Reissman, F. Strategies and suggestions for training nonprofessionals. Community Mental Health Journal, 1965, 3, 103-110.

Roberts, L., S. Halleck and M. Loeb (Eds.) Community psychiatry. Madison: The University of Wisconsin Press, 1966.

Rome, H. Barriers to the establishment of comprehensive community mental health centers. In L. Roberts, S. Halleck and M. Loeb (Eds.) Community psychiatry. Madison: The University of Wisconsin Press, 1966, 31-55.

Rosenbaum, M. and I. Zwerling. The impact of social psychiatry on a psychoanalytically-oriented department of psychiatry. Archives of General Psychiatry, 1964, 11, 31-39.

Rosenblum, G. The new role of the clinical psychologist in a community mental health center. Community Mental Health Journal, 1968, 4, 403-410.

Sabshin, M. Theory and practice of community psychiatry training in the medical school setting. In S. Golston (Ed.) Concepts of community psychiatry. Washington, D. C.: U. S. Department of Health, Education and Welfare, 1965, 49-56.

Singer, G. The social worker's role in a community mental health program. Hospital and Community Psychiatry, 1971, 22, 246-247.

Stuckey, G. Challenges in mental health for new professionals. American Journal of Orthopsychiatry, 1973, 43, 164-167.

Thomas, C. Innovations in training for community mental health practice. In Mental health challenges: past and future. Proceedings of a Conference on the Twenty-Fifth Anniversary of the National Mental Health Act, Washington, D. C., June, 1971, 63.

Whittington, H. The ideation basis of a state program for community mental health services. In L. Roberts, S. Halleck and M. Loeb (Eds.) Community psychiatry. Madison: The University of Wisconsin Press, 1966, 115-131.

Yolles, S. The role of the psychologist in comprehensive community mental health centers. American Psychologist, 1966, 21, 37-41.

APPENDIX A

PLEASE NOTE:

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UNIVERSITY MICROFILMS

APPENDIX B

QUESTIONNAIRE

1. My job title is: _____

2. Sex:

   Male _____
   Female _____

3. Age:

   Under 21 _____
   21-25 _____
   26-30 _____
   31-35 _____
   36-40 _____
   41-45 _____
   46-50 _____
   51-55 _____
   56-60 _____
   61-65 _____
   Over 65 _____

4. Race:

   Caucasian _____
   Negro _____
   Indian _____
   Oriental _____
   Other _____

5. Education: (Check one which represents your highest level of attainment).

   _____ High School Incomplete
   _____ High School Graduate
   _____ One or more years of college
   _____ Bachelor's Degree
   _____ Master's Degree
   _____ Doctor's Degree

6. I hold the following academic degree(s) and/or professional licenses:

Degree or License	Year Earned	Major Field of Study	Granting Institution

7. I have been employed in a Community Mental Health program for

   _____ months.

8. I have completed the following advanced professional training courses since beginning work in Community Mental Health:

Course Title or Content Area	Year Taken	Length of Course	Location of Training Site

9. On the last working day before filling out this questionnaire, I spent my working time in the following activities:

Activity	% of time
a. Direct Patient Care	_____
b. Indirect Service	_____
c. Consultation and Education	_____
d. Administration	_____
e. Staff Development	_____

10. (a) If you had the opportunity to design an in-service training program for Community Mental Health Workers, what concepts would you give high priority to?

(b) What is your own working definition of "community" in Community Mental Health?

(c) What changes would you, as a Community Mental Health professional, like to see occur in Community Mental Health Service systems?

PLEASE COMPLETE THE FOLLOWING CMHI SCALE FROM YOUR PERSONAL POINT OF VIEW.

APPENDIX C

SUMMARY OF GROUP DATA

Group	1	2	3	4	5	6
N	9	15	20	15	24	14
Sex:						
Male	7	9	6	7	9	2
Female	1	5	13	7	14	12
Unknown	1	1	1	1	1	0
Education:						
Doctorates	9	7			3	
Masters		7	19	13	10	
Bachelors		1	1	1	7	1
Some College - no degree					3	4
High school graduate					1	5
Non High School graduate						3
Unknown				1		1
Work Activities:						
Direct Service	59%	68%	59%	42%	43%	73%
Indirect Service	11	8	17	20	13	18
Consultation and Education	8	17	6	23	24	4
Administration	18	6	7	7	16	4
Staff Development	4	1	9	6	2	1
Average age (years)	42.2	40.0	35.0	31.3	35.0	35.7
Average Length of Employment (years)	5.7	4.3	4.0	3.8	4.5	4.2
Mean CMHI Score	192.44	212.66	215.59	224.86	216.0	186.57