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A HELPING SKILLS PROGRAM FOR PARAPROFESSIONALS WORKING IN ADULT PROPRIETARY HOMES

City University of New York D.S.W. 1980

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A HELPING SKILLS PROGRAM FOR PARAPROFESSIONALS WORKING IN ADULT PROPRIETARY HOMES

by

CLEVELAND M. BLACK

A dissertation submitted to the Graduate Faculty in Social Welfare in partial fulfillment of the requirements for the degree of Doctor of Social Welfare, The City University of New York.

1979

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This manuscript has been read and accepted for the Graduate Faculty in Social Welfare in satisfaction of the dissertation requirement for the degree of Doctor of Social Welfare.

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CHAPTER I

INTRODUCTION

Historically, the mental health movement has always struggled to provide the right of self-respect and dignity to the mentally ill. The evolving consciousness of these values has proceeded according to the prevailing attitudes of society at a particular time. Studies have shown that reformers had a profound impact on the development of humanitarian goals for the mentally ill in American society.

The construction of insane asylums in the nineteenth century was a major attempt by reformers to assure more humane treatment to the mentally ill. It was felt that a milieu of kindness would improve the system of care offered the mentally ill. Albert Deutsch and others note three reasons humanitarian goals of the reformers were not met in the nineteenth century. First, as the population increased, so did the proportion of mental illness. Second, the American public placed limits on the economic resources to fund programs of moral treatment. Finally, conspicuously absent was a method of scientific therapy operating in conjunction with the principles of moral treatment.

Because of the above conditions, methods for treating the mentally ill became basically custodial by the end of the nineteenth century. It must be noted, however, that

reformers had been successful in bringing the varied problems of the mentally ill to the attention of the American public. Their effort provided a framework for theorists to explore alternate methods of treatment and involved government at all levels.

The impact of advocacy groups was significant throughout the first half of the twentieth century. They stressed that both private and public resources be provided to improve the care of the mentally ill. They campaigned mainly for alternate systems of care for the institutionalized psychiatric patient. Many of these groups supported an interdisciplinary approach to the delivery of services to the mentally ill. For example, the National Committee for Mental Hygiene became one of the most dominant forces in pinpointing the needs of the mental health movement. With the support of private philanthropy, the National Committee played a leading role in the development of social policy and a scientific framework.

The rejection rate of draftees for military service because of psychiatric problems was high during World War I and II. It prompted the Federal Government to take a more active role in developing programs of treatment for the mentally ill. By 1946, the Federal Government had provided the first opportunity since the construction of the insane asylum to reassess the level of care to the mentally ill. The passage of the National Institute of Mental Health Act enabled both public and private groups to fund programs of prevention, research, and training.

The resident population of large state hospitals continued to be a reality until the late 1950s. The introduction of drug therapy in the 1950s revolutionized the approaches to treatment and the delivery of psychiatric services. Many institutions were able to shift from custodial to therapeutic activity. The utilization of chemotherapy made the psychiatric patient more manageable and less feared by the American public. Many hospitals established transitional facilities as an initial linkage between the hospital and independent community living. The emphasis in the discharge planning was a restoration of self-worth and dignity to the mentally ill.

Reflective of both the public and federal government's objectives were the reduction of hugh patient populations in state hospitals and the development of national policies for the mentally ill. The Joint Commission on Mental Illness was established in 1955 to consider means for accomplishing these goals. The deliberations of the Commission led to the passage of the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. This act introduced an entirely new system of care for the mentally ill.

A concept embodied in the legislation was the care and treatment of the mentally ill in the community. As a result, throughout the nation, there has been a steady decline in the number of mental patients in state institutions. In many instances, patients have been discharged without the

provision of social and psychological support systems necessary for their care.

The discharge of mental patients back to the community has been aided by the intervention of legal resources. Major landmark decisions by the Supreme Court have mandated the discharge of patients not formerly considered for community care--the chronic ex-mental patient.

This study examines the delivery of psychiatric services to chronic ex-mental patients residing in Adult Proprietary Homes in Queens, New York. A majority of the residents in these homes are discharged directly from state institutions. In many instances, they are discharged as part of a deinstitutionalization program or court mandate.

Since 1975 this writer has maintained a concern for the care and treatment of patients discharged to Adult Proprietary Homes. Many of the residents often spent their entire day sitting idly or watching television. Their dress was bizarre and their lack of personal hygiene was often very obvious. Most attempts by residents to engage in communication were ignored or cursorily directed somewhere else. It was not unusual to see residents fighting, being overmedicated, or hallucinating.

Many of the residents living in these homes are indigent. They had no linkages to social support from their own families. Because of their condition and the stereotype of mental illness, they were often limited to the environment of the adult home. The Adult Proprietary Home offered a minimum

social climate for the residents to improve their self-image and interpersonal competence.

The staff, consisting mainly of paraprofessionals, were the major providers of care for the resident population. A significant number of staff seemed embedded in their roles as custodians and received limited support from home administrators in providing humane care. The primary concern of staff was to maintain order and control.

The staff training program described in this study was designed with three main objectives: (1) to increase the staff's knowledge about mental illness, (2) to alter the attitudes of staff concerning mental illness, and (3) to promote group support among trainees as a means of problem solving, group interaction, and organizational change.

The principles of a therapeutic community were utilized as a framework for informing and orienting the staff on the attitudes and behavior appropriate to carrying out their assigned tasks. The training program consisted of two hour classes once a week, occurring between October 25, 1977 and January 10, 1978. The training program extended over a ten week period.

In Chapter II the linkages of the paraprofessional movement to the mental health field is described. As attitudes and social conditions altered the course of mental illness so did the tasks and role of the paraprofessional. Bockoven and Grob assert that paraprofessionals have historically been major providers of care for the mentally ill. Finally, the

impact of community based mental health programs and the paraprofessional are fully discussed.

The various theoretical formulations are highlighted in Chapter III. The appropriateness of using the concept of a therapeutic community as a teaching guide is delineated. The approaches of social learning theory are utilized in carrying out the project. The use of role-playing and modeling, as well as therapeutic communication, team and group support technique were an essential part of this process.

The collaborative planning for the various phases of the program design are described in Chapter IV. Because their level of training was unique to the program setting, issues dealing with feasibility are carefully reviewed. A grant from the Brookdale Center on Aging at Hunter College School of Social Work provided for the inclusion of some incentives in the group support component. A final section of this chapter is devoted to a description of the instruments used in the training program.

Chapter V covers the analysis of data and a discussion of results. A summary of the training program is included in Chapter VI. A list of tables relating to Chapter V is found in Appendix A. Appendix B includes program materials, course outlines, and measuring instruments.

CHAPTER II

PARAPROFESSIONALS IN THE MENTAL HEALTH FIELD

A major outcome of the insane asylums in the nineteenth century was the development of mental health disciplines in the treatment of mental illness. By the end of the nineteenth century, more than thirteen disciplines were involved in the treatment of the mentally ill.[1] Among the emerging vocations was that of psychiatric aide.

The inclusion of the paraprofessional in the mental health field was facilitated by the conditions of manpower needs, the nature of their role, and economics. In his research on mental institutions, Gerald N. Grob depicts two descriptions of the nonprofessional prior to 1850 and after 1860. In the period leading to the Civil War, when the principles of moral treatment were at their highest peak, Grob states:

> They were kind, patient, and considerate; they were able to gain the confidence of patients; they could take even the most vile abuse without responding in kind; they were firm yet honest and open in their dealings with inmates; they were intelligent and informed; and they were completely obedient to the instructions of the superintendent. For as moral treatment succeeded brute force in the management of the insane, so were the positions of the nurse and attendant correspondingly magnified in importance. None should be employed for the delicate and difficult task, the regents of the South Carolina Asylum noted with approval in quoting their counterparts in New York State but well educated persons, of moral worth,

> satuated by a high sense of duty, and possessing sound discriminating judgement, firmness, sweetness of temper, conciliatory manners, unwearied patience, and inexhaustible kindness.[2]

The latter half of the nineteenth century saw a dramatic decline in efforts to maintain an emphasis on the social influences of hospital life as curative agents.[3] The role of the nonprofessional suffered likewise, as Grob indicates:

> As institutions increased in size the problem was exacerbated by the fact that more and more responsibility fell on the shoulders of attendants, since the number of physicians in most institutions did not increase as rapidly as the number of patients. The growth of the responsibilities of attendants and nurses was not accompanied by efforts to upgrade the caliber of those hired and to provide some type of training. Although many institutions had a few faithful and competent persons, the norm was an extraordinary high turnover rate that often ran between one-third and one-half of the staff annually. The positions of attendants and nurses were demanding ones; individuals who occupied them had to work long hours and were required to live on the hospital grounds.[4]

Harold L. Wilensky and Charles N. Lebeaux suggest that shifts in occupational roles can result from industrialization. "In so far as industrialization brings increased specialization involving work simplification, the evidence suggests a large class of 'de-humanized' workers, men who are alienated from their work and from the industrial way of life."[5] They further add that, ". . . work changes with changing technology and the pace of change accelerates; the division of labor is complex; and work is assigned more often on the basis of ability. Industrialization makes the shift away from traditional criteria of work assignments inevitable."[6]

The establishment of professional organizations in the

early 1800s placed greater limits on the role of the paraprofessional. "Nearly all major professions began with the banding together of practitioners who delivered services in the market place. Aspiring neophytes apprenticed themselves to these practicing professionals and after a number of years of apprenticeship, would strike out on their own."[7]

As scientific psychiatry took root in America in the 1900s, the role of the paraprofessional continued to be viewed as basically custodial. Bockoven describes this role:

> Absence of the treatment motif in mental hospitals places all professional personnel in a contradictory role, but it is the attendant who occupies the most difficult and frustrating position. He serves as guard and task-master whose duty it is to preserve order by restricting patient's spontaneous movements for a minimum and by closely supervising any duty he directs the patient to perform. He is the most important person in the patient's life, but his position in the hospital hierarchy is the lowest order. He is subjected to a rigid discipline which requires him to maintain an impersonal relationship with patients and holds him responsible for any mishap which occurs. He must constantly be on the lookout lest some patient acquire a bit of glass, a length of rope, a sliver of wood, or a supply of matches; for every patient is suspect of harboring violent tendencies or desires to escape. He must restrict conversation between the patients lest altercations result. He is fulfilling his duties well if he is observed to be presiding over a scene of somber silence when the supervisor, nurse, or physician "trips" through his ward. All told, his task is a thankless one, for like the patient he remains in good standing only as long as there are no mishaps. There is no way he can progress or better himself. At best, his prospect is the monotony of uneventful life on a 'well-managed' ward. His very acceptance of low pay bespeaks in his own mind and in the mind of others that his work is little respected. And in the public mind his capacity to endure close association with the fancied depravity of the mentally ill places him in the category as uniquely stigmatized as mental illness itself.[8]

The stress on the medical model as a concept for treating mental illness assigned the treatment of patients to professionals. This model of treatment limited opportunities for the paraprofessional to gain knowledge and participate in a meaningful manner. In fact, this condition often meant a high turnover of psychiatric aides. Some institutions, however, did attempt to provide some form of in-service training for the paraprofessional.

As early as 1882, asylums opened training schools for psychiatric nurses. This paved the way for many paraprofessionals to upgrade their skills and move to new positions. It did not alter the role of the paraprofessional unable to take advantage of education and training programs. By 1935 there were seventy training schools for nurses sponsored by mental institutions, and they recruited primarily from the attendant staff.

Prior to and after World War II, the paraprofessional continued to be the largest provider of services to the mentally ill. In a survey conducted by Alan Gartner, it is noted that with the "New Deal" programs, notably, the Social Security Act of 1935, the Works Progress Administration, and National Youth Administration, paraprofessionals were employed in other service areas in large numbers.[9]

The events of World War II and the creation of the National Institute of Mental Health in 1946 initiated a beginning effort towards upgrading the skills of the nonprofessional in the mental health field. Through the National

Institute of Mental Health, agencies were able to obtain specific funding for training of paraprofessionals. Many of the experimental and special training programs were developed specifically for nonprofessionals.

Robert Ellsworth's study conducted at Fort Meade demonstrated that paraprofessionals, given the learning resources, could provide varied therapeutic roles in the hospitals treating the mentally ill. Ellsworth noted that many questions were being raised about the utilization of the psychiatric aide but few had translated these questions into an operational program.[10]

Four important outcomes from Ellsworth's study have provided a framework for the development of other training programs.[11]

(1) Psychiatric aides could be responsive if the structure of the organization includes them and recognizes the competence that the nonprofessional has already acquired through his own life experience.

(2) The responsibility of the professional becomes one of developing and enhancing the skills of the nonprofessional. Without the help of the professional, the nonprofessional can not achieve a high level of treatment effectiveness.

(3) The climate should provide rewards for the paraprofessional's activity. This would promote personal enthusiasm and involvement in their work.

(4) The organization must assume basically that the

non-professional can play an important therapeutic role.

The literature suggests that paraprofessionals, in general, were always adversely effected by the labor market and their education, inexperience, and training. Conditions in the 1960s created national social policies that were particularly concerned with the nation's untrained manpower pool. Two of the most meaningful legislative acts included the Scheuer amendments to the Economic Opportunity Act of 1964 and the Kennedy-Harris amendments to the Social Security Act of 1935.

Leonard Schneiderman describes the elements of these amendments: "The Scheuer amendments required that all programming funded by the Office of Economic Opportunity include provision for the creation of entry-level job opportunities for advancement. The Kennedy-Harris amendments required that all public welfare agencies include the use of paraprofessionals with preference given to clients in their personnel plans by July 1, 1969."[12]

Specific to the nonprofessional in the mental health field was the passage of the Community Mental Health Act of 1963. This act revolutionized the delivery of services and the utilization of manpower in the treatment of the mentally ill. The amendments of this act project the construction of 2000 Community Mental Health Centers. George Albee in Mental Health Manpower Trends indicates that between 80,000 and 90,000 attendants and aides are employed in the mental health

field. In his report to the Joint Commission on Mental Illness and Health he envisioned no shortage of manpower for this category of staff.

The nonprofessional is definitely an entity within the framework of the Community Mental Health Centers organization. It is probably in this area that nonprofessional potential is greatest. Marvin Karno and Donald A. Schwartz stress that training must be a prominent theme:

> As community mental health programs began to be established in improverished and ethnic minority communities, it became apparent that white, Anglo-American, English speaking only professionals were often very limited in their sensitivity to understanding of, comfort in and communicative skills with such communities. The initial use of indigenous volunteers, under the direction of professionals, helped provide the concept of the paraprofessional in community mental health. In recent years, with federal, state and local support a host of training programs has emerged, designed to teach a wide variety of basic interviewing, counseling and reality assisting skills to emotionally mature and motivated lay individuals in order to prepare them to take on 'assisting' or paraprofessional roles in community mental health agencies. Such programs have been particularly aimed at training representatives from low income minority group communities in this country.
>
> The length, variety, nature, and quality of the training given has varied immensely; no national and almost no state standards have been established; and many problems as well as some well publicized successes have resulted from such efforts.[13]

In 1970 Francine Sobey published in <u>The Nonprofessional in Mental Health</u>, the results of 185 National Institute of Mental Health funded projects involving the utilization of the nonprofessional. Sobey discovered that a majority of those surveyed felt that training was a key issue and that training provided to paraprofessionals should be conceived

and planned as an entity, rather than as separate unrelated units.

Another interesting result of her survey indicated the following:

> Considering all projects together, the overall ratio is six nonprofessional persons to one professional (6:1). The majority of projects (29 percent) employed more nonprofessionals than professionals. For all projects combined, the overall ratio is eight work hours of nonprofessional time to one work hour of professional time (8:1). Considering paid nonprofessional hours separately, this ratio is six hours to one professional work hour. Most of the volunteers typically work fewer hours per week than their paid counterparts, the ratio of volunteer hours to professional hours is therefore considerably lower than that of paid nonprofessionals.14

The design of future training programs for the paraprofessional in all fields is a basic issue for program planners and administrators. The importance of training for the paraprofessional was a major theme at a conference of the National Association of Social Workers and the American Psychological Association held in May of 1967. The trend is focused on the subjects of "content and form." Gertrude S. Goldberg, a participant at the conference, offers her analysis:

> The style and format of most training programs have been based on the assumed learning characteristics of the nonprofessionals and their need for phased training, the acquisition of skills functionally related to tasks, in an active style of teaching, and frequent reinforcement and minimization of anxiety. Peer learning and such group techniques as job situation and role playing are popular. However, in view of the fact that most nonprofessionals have been creamed in terms of educational attainments, one wonders whether on the one hand the training is unnecessarily diluted or devoid of conceptual material, or whether the learning characteristics of the group which has thus far comprised the

> nonprofessional corps are really so special after all. An unscholastic approach may be more compatible with the learning style of most people, particularly when they are being trained for a job. On the other hand, it is a mistake to gear training to one style of learning in view of the increasing evidence that the lower classes may exhibit a greater range of behavior and of conceptual levels than the middle classes. Finally, it may be important to think in terms of goals rather than learning styles, in which case the quick, nondidactic method may be appropriate for the job at hand, especially at the entry level, and the more discursive, conceptually oriented approach more compatible with subsequent education for upgrading.[15]

It should be noted that the Social and Rehabilitation Service Unit of HEW published, in 1974, a comprehensive research report on the paraprofessionals. This report attempted to include a chronological overview of the paraprofessional movement in a variety of programs. They found that a major problem in training the paraprofessional was the ability to train the paraprofessional without destroying the uniqueness of the individual to the agency. The report emphasized several important points:

> If the purpose of paraprofessional utilization is clearly that of task relief for the professionals, this strategy can be expected to produce many useful suggestions. If, however, the paraprofessionals are to be used autonomously as outreach workers or advocates to change the direction of services, some resistance to defining the requisite tasks may be expected. Before embarking on participation of staff in redefining jobs and roles, trainers and planners should provide participating workers with technical tools and guidance, and prepare them to cope with the conflicts which can be expected to arise. If the principle of staff involvement is followed, it seems unwise to include one group of workers and exclude another, especially when both are equally interested in the outcome.[16]

Many professionals feel that because of the mass of existing programs utilizing nonprofessionals, the inclusion

of group support techniques is vital. This view is supported in the research of Reissman et al. This area of training has been much discussed in the literature and David Hardcastle offers this view:

> The indigenous nonprofessional is subjected to the same strains as other employees. However, he is not equally equipped to cope with them. He has no middle class grounding in abstract role behavior nor has he been socialized to handle organizational stress. In fact, he was hired specifically because he lacked a middle-class background or professional orientation.[17]

Frank Riessman illustrates in his article, "Strategies and Suggestions for Training Nonprofessionals," that the nonprofessional will learn from a special series of group meetings that can be held. Reissman suggests that a dimension of training should include group discussion about general problems being experienced: on the job problems with professionals, problems with other agencies, problems with their own marginality, problems stemming from competition with each other and annoyance with the type of supervision that they are receiving. He feels that the relevance of the training will be more evident to the nonprofessionals if the components of personality and the individual are included with the tasks of the group.[18]

Many studies have concluded that training and structure which provide group support techniques have enhanced the role, status, and contribution of the nonprofessional significantly. One such project was the Institute for Youth Studies at Howard University. The implementors of this project chose the "core group" as a vehicle for promoting

change. Klein describes the operation of the core groups:

> The core group, then, is a multipurpose instrument. In it, the trainee learns more about himself, the community, and the world he lives in. In addition it gives him a better chance to relate the specifics of what he is doing on the job to broader considerations. He also acquires basic training in those skills and aspects of knowledge that would potentially make him a useful addition to any one of a variety of human service positions. This includes observational and recording skills, use of supervision, pattern and function of community services, and interpersonal relations.[19]

Some projects have gone through considerable experimentation to obtain a balanced curriculum for attaining the goals of paraprofessional assimilation. Most training programs for paraprofessionals do not succeed according to Lonnie E. Mitchell because planners do not consider the implications for the individual, the organization of institutions, the social organization, and the future of society.[20]

In summary, the literature fully documents the impact of social forces upon the development of paraprofessionals in mental health. It demonstrates how this manpower group was not considered in the original plans of the asylums. No one knew at that time that institutionalization would be so extreme. The paraprofessionals, unlike the professionals, entered this new service area without a constituency or needed skill. The increasing shift towards a technological society resulted in huge professional manpower shortages which have affected the utilization of the paraprofessional.

In the 1960s the Federal Government viewed the problem of the paraprofessional as a national social problem.

Through the passage of significant legislation, economic resources for training, hiring, and educating more paraprofessionals were provided. This intervention has created a "new provider of service."

An important issue in the future will center around the professional bridging the gap towards the paraprofessional. A case in point is the situation created by the Community Mental Health Act and the controversy on the treatment process. Some centers have already designed innovative programs to cope with this potential problem.

Footnotes

[1]H. A. Bunker, "The Mental Health Disciplines," Hospital and Community Psychiatry 27 (July 1976): 479-505.

[2]Gerald N. Grob, Mental Institutions in America (New York: The Free Press, 1973), p. 211.

[3]Sanbourne, J. Bockoven, Moral Treatment in Community Mental Health (New York: Springer Publishing Co., 1972), p. 86.

[4]Gerald N. Grob, Mental Institutions in America, p. 215.

[5]Harold L. Wilensky and Charles N. Lebeaux, Industrial Society and Social Welfare (New York: Russell Sage Foundation, 1958), p. 61.

[6]Ibid., p. 63.

[7]George W. Albee and Denis Wissim, "Clinical Psychology," Hospital and Community Psychiatry 27 (July 1976): 496.

[8]Sanbourne J. Bockoven, Moral Treatment in Community Mental Health, p. 106.

[9]Alan Gartner, Paraprofessionals and Their Performance (New York: Praeger Publishers, 1971), p. 4.

[10]Robert B. Ellsworth, Nonprofessionals in Psychiatric Rehabilitation (New York: Appleton-Century-Crofts, 1968), p. 13.

[11]Ibid., pp. 167-174.

[12]Encyclopedia of Social Work, 1971 ed., s.v. "Profession of Social Work: Aides," by Leonard Schneiderman.

[13]Marvin Karno and Donald A. Schwartz, Community Mental Health: Reflections and Explorations (New York: Spectrum Publications, Inc., 1974), pp. 170-171.

[14]Francine Sobey, The Nonprofessional Revolution in Mental Health (New York: Columbia University Press, 1970), p. 13.

[15]Gertrude S. Goldberg, "Nonprofessionals in Human Services," in Nonprofessionals in the Human Services, ed. Charles Grosser (San Francisco: Jossey-Bass, Inc., 1971), p. 26.

[16]Social and Rehabilitation Services, U.S. Department of Health, Education and Welfare, Research Report No. 3, April 1974, p. 88.

[17]David Hardcastle, "The Indigenous Nonprofessional in the Social Service Bureaucracy: A Critical Examination," Social Work 16 (April 1971): 59.

[18]Frank Reissman, "Strategies and Suggestions for Training Nonprofessionals," Community Mental Health Journal 3 (Summer 1967): 105-106.

[19]William Klein, "The Training of Human Service Aides," in Emergent Approaches to Mental Health Problems, ed. Emory L. Cowen et al., (New York: Appleton-Century-Crofts, 1967), p. 150.

[20]Lonnie E. Mitchell, "Nonprofessionals in Mental Health," in Charles Grosser et al., p. 93.

CHAPTER III

THE CONCEPT OF A THERAPEUTIC COMMUNITY IN DESIGNING A TRAINING PROGRAM FOR PARAPROFESSIONALS

In the proprietary homes selected for this study, a hierarchical model of organizational structure existed. The methods for administering programs and problem-solving was basically authoritarian and paternalistic. The relationships among administrator, staff and resident deviated from the models and behavior appropriate for such a setting. It was observed that within the proprietary home setting, staff had prescribed roles as custodians. The residents in these homes received no understanding or sensitivity in the care provided. Most residents spent their days sitting around the day room. At any one time, approximately fifty residents could be seen sitting around. The home administrators offered no program or direct action to alter or improve the social environment.

The consequences for residents and staff in the proprietary home settings are negative. The organization of services offers no framework for helping staff to understand the tasks they must perform. Staff has not been exposed to an orientation which provides a knowledge base for dealing with the problems they face daily. The only services

provided for the residents are routinely centered around room and board and medication.

To be effective, most agencies servicing this population employ staff with specific knowledge and skills for treating the mentally ill. In these proprietary homes, the paraprofessional is not skilled or linked with a professional staff as is the practice in the Board of Education, Mental Hospitals and medical settings. Therefore, staff have limited opportunities to observe treatment roles performed and the behaviors expected for optimal care for the residents. As will be discussed in Chapter IV, the only in-service training provided involved sporadic training by the Queens Adult Home staff.

Given this background and the limitations of the organization, it is important to introduce a training model sufficiently comprehensive to meet the needs of staff, the organization, and the training objectives. A key strategy is the selection of a training intervention that had the potential for addressing the entire organizational structure. Setting is also a critical factor.

Max Siporin has this to say about the ecology of the setting:

> The 'setting' in which the helping process is carried out is ecological space, or habitat, a place in which service is provided. Little consideration has been given to the important influences upon the dynamics of service of agency behavior settings, work place, buildings, or service facilities, and of client dwellings and neighborhoods, in which social workers see and work with clients. However, increasing attention is being given to the general ecological environment and to the processes

> through which life spaces and places influence interaction and behavior. The ecological environment provides form and structure, boundaries and symbolic meanings, norms and pathways for certain expected behavior and interpersonal relationships. Either the settings, and how they are used, nurture, shape and reinforce, and sustain desired behavior, or they prescribe or extinguish undesired behavior.[1]

Many of the services and programs once provided by institutions are now programmed through the community. However, traditional methods for rendering services and programs are limited due to lack of skilled professional manpower and adequate support systems. The conditions created by this institutional change has caused planners, providers, politicians, communities and consumers to review the present delivery of care for the former mental patient.

In response to the increasing demand for more quality mental health services, particular emphasis has shifted to up-grading the skill and role of the paraprofessional. This group represents the largest manpower category within the mental health service network. They also reflect the broadest range in background, education, skill, and knowledge base. A significant percentage are employed to supervise and care for ex-mental patients in the community.

Robert Reiff issues the following warning:

> There is no question that the use of these nonprofessionals opens up a great reservoir of manpower for mental health activities as well. But, unless this manpower is used effectively they can become nothing more than wardens and nursemaids tending the mentally ill who are waiting for the professional to serve them. They can also become a garbage heap where the professional dumps the patient he feels he can do nothing for. And, finally, the nonprofessional can become the menial who performs all the 'dirty work' that the professional resents and wishes he

> could get rid of so that he could have more time to do the same old things. Used this way, the nonprofessional will reinforce all the tendencies in institutionalized mental health practice that mitigate against change.[2]

Grosser et al supports the principle of utilizing paraprofessionals in such settings. "The substantial merit of using nonprofessionals in the mental health field has been established. Most professionals concede that noncertified, less trained personnel can meet manpower needs, bridge gaps with the clients, and provide service organizations with skills congenial to client population."[3]

An outcome of the Fort Meade Aide Role Project, a mental health study, showed that increased decision-making and interaction by the paraprofessional could alter performance. Emerging patterns indicate that the paraprofessional's use is being considered very seriously in upgrading the programs and services in other delivery systems as well. Alan Gartner and Frank Riessman feel that increasingly agencies will bear the responsibility of up-grading the role of the paraprofessional. They indicate that under the present political and social climate, "paraprofessionals are being socialized by the agencies, professionals, institutions, and colleges with which they are associated and by the training they are receiving."[4]

The New Careers Training Laboratory, Center for Advanced Study in Education, Graduate School and University Center, City University of New York, has completed several national studies on the utilization of paraprofessionals.

Two of their projects, "The Utilization and Training of Paraprofessionals in Special Education: Results of a Survey of State Directors of Special Education and Descriptions of Training Programs" and "Task Analysis for Paraprofessionals Working with Severly/Profoundly Handicapped Children and Mainstream Classrooms and Career Ladders and Lattices for Paraprofessionals in Special Education" indicate that clearly defined job descriptions have not been worked out for the paraprofessional. The former study showed that all paraprofessionals in special education could be more effective if training programs were available.

Salvador Minuchin adds this observation:

> Obviously the mental health field's system of credentialization will have to be reviewed and modified to accommodate these paraprofessionals. This will also force us to review the training of those currently credentialed. The contributions of professionals will not be nullified. But the training of all mental health workers, those who are currently credentialed as well as those who are not, will have to become much more differentiated and solution-oriented, so that we can make minimal and specific interventions which will be maximally helpful to our clients.
>
> Changing the social institutions which impinge harmfully upon our clients will remain one of the legitimate tasks of both paraprofessional and professional mental health workers. And confrontation will remain one of the techniques useful for jolting those institutions in the direction of change.[5]

Studies have indicated that untrained paraprofessionals are more responsive to training resources which combine didactic material and a job related experience. To demonstrate an integration of these approaches, the training sessions were designed to motivate staff to use the work

experience as a framework for a social organization. In addition, the amount and kind of content appropriate to the training of paraprofessionals will vary with the goals of a particular agency. Two of the defined objectives mandated for residents in proprietary homes are described below:

> (1) Supervision shall mean guidance of an individual resident as he carries out activities of daily living and social activities, including but not limited to reminding a resident to maintain his medication schedule as directed by his physician, reminding him of important activities to be carried out, assisting him in keeping appointments and being aware of his general whereabouts even though he may travel independently about the community.
>
> (2) Encouragement to participate with staff assistance and support as needed, in social, recreational, vocational and religious activities within the community and facility.[6]

The concept of a therapeutic community provided some guiding principles and ideas for designing a training program for staff working in an Adult Proprietary Home. The therapeutic community taught as a modality considers the total "social structure" and employs the principle of continuous feedback. According to Maxwell Jones:

> The social structure of a therapetuic community is characteristically different from the more traditional hospital. The term implies that the whole community of staff and patients is involved, at least partly, in treatment and administration. The extent to which this is practicable or desirable will depend on many variables, including the attitude of the leader and the other staff, type of patients being treated, and the sanctions afforded by higher authority. The emphasis on free communication in and between both staff and patient groups and on permissive attitudes that encourage free expression of feeling imply a democratic, egalitarian, rather than a traditional, hierarchical social organization.[7]

In 1961, Alfred W. Clark and Neville T. Yeomans initiated a study to demonstrate the effectiveness of a therapeutic community. The study completed ten years later, outlined important theory and practice considerations in maximizing the elements of a therapeutic community.

> A change in organization is necessary to establish a community in which the impact is therapeutic; the concept of a therapeutic community requires, therefore, that the ward becomes the locus of treatment in which the interaction of all participants, including patients and staff of all ranks, are deliberately used to effect change in patients. The following features characterize the specially devised social organization. The authority hierarchy is flattened, and control comes to be exercised by the community as a whole rather than by staff. Treatment is no longer the preserve of a few specialists; it is the responsibility of all members of the community. Thoroughgoing self-government is encouraged, and communication becomes more open than is usual in the mental hospital. In addition, a microcosm of the wider community is created, with representatives of both sexes (single and married), and of all age groups and social classes.[8]

The objectives of a therapeutic community demand the cooperation of the total organization. The processes not only require cooperation but a firm commitment and respect for the therapeutic principles involved. The strategy of the training program accepted the limitations of the hierarchial arrangements within the proprietary home. It was believed that as a result of this training, future in-service programs would be viewed as furthering the concepts of a therapeutic community.

Selecting training strategies for improving the delivery of services to the residents in a proprietary home setting was seen as the ultimate goal. The paraprofessional staff provided the linkage for a better delivery system within a

proprietary home setting.

Selection of Learning Needs

As an important provider of mental health services, at Kingsboro Psychiatric Center, the writer was consistently aware of the need for training staff in proprietary home settings to which patients were released. This project afforded the opportunity to meet a major unmet need. On repeated visits to these homes, the acute need was obvious.

Many share the belief that these homes should operate under conditions which enhance the psychological capacities of the residents. The paraprofessionals working in these homes are important in achieving such goals. A staff training design which would improve the skills, knowledge, and attitudes would result in more humane treatment of the residents living in these homes.

Clifford F. Melick and Charles O. Eysaman, research scientists for the State Office of Mental Hygiene, initiated a study in the Fall of 1976 covering 1,999 former patients placed in private proprietary homes. The patients represented in the study were residing in 26 proprietary homes in the New York City area.

The survey outlines the consequences of placing large numbers of former mental patients in private proprietary homes. Melick and Eysamen[9] found that forty-five percent of the residents (former mental patients) were in need of rehabilitative care instead of the maintenance care that is being received. This category of resident demonstrated more

dysfunction due to psychological problems than other residents. These behavior problems were characterized as disorientation, suspiciousness, verbal abusiveness, memory deficits, a need to wander, and depressions. They felt that under present conditions, adult proprietary homes cannot provide the level of care required by these residents.

This study represents a beginning attempt by the State Office of Mental Hygiene to evaluate and identify the level cf care provided to residents who were referred from state facilities. However, the trend is to avoid hospitalization at all costs and to maintain the mentally ill in the community. The Report of the President's Commission on Mental Health was issued on April 27, 1978 and stressed a continuation of mental health services in the community.

Prior to the implementation of this project, an exploratory study was undertaken the examine the level of service with regard to the care of the ex-mental patients in proprietary homes. On visits to the various homes in Brooklyn and Queens, it was recognized that the climate of these homes were not suitable for dealing with former mental patients. Further, it was observed that the staff had no understanding of their duties and responsibilities which might improve patient care.

The proprietary home is servicing a population formerly "treated" in state hospitals. It becomes crucial that such organizations become equipped to provide a level of service that maximized the psychological functioning of individuals

in their care.

All of the training material selected for this program was focused on the broad area of interpersonal behavior. Major themes are described below:

(1) Ways of helping residents to communicate

(2) Ways of helping residents to acquire skills in activities of daily living

(3) Ways of helping residents to develop ideas and express them in an acceptable manner to others

(4) Ways of perceiving the proprietary home setting as a therapeutic community enabling both staff and residents to engage in group dynamics and problem solutions

In Maxwell Jones' recent book, Maturation of the Therapeutic Community, he addresses the extensive responsibilities of the paraprofessional in the application of this concept.

> The reality of this fear may be reinforced by the fact that their supervisors are themselves not trained in social psychiatry and may apply a value system to their area of responsibility that is at variance with the developing culture in the unit. It may be that a long-term plan involving training seminars with supervisors will be a necessary adjunct to the effective functioning of the unit if the situation is to be rendered therapeutic. At the same time, it may appear that the anxiety of the aides stems in part from their personality difficulties attributable to their relatively inadequate education and lack of sophistication, which hampers them in their role relationship with the more highly trained personnel. They may deal with this by denial and rationalization, blaming the frequency of community meetings and lack of discipline for the unsatisfactory state of affairs. A situation of this kind is not infrequent and the mere gain in insight on the part of an aide may not be in itself enough. It may take a long period of education and support to tide them over the transition from their previous image of structured, simplified role to that of a therapeutic one.[10]

A practical principle underpinning the training of staff in this program is that the paraprofessional should be informed and oriented in principles of the therapeutic community framework. This acquisition of knowledge will result in the recognition that certain attitudes and behavior are required in carrying out the tasks of a therapeutic community. The staff will be asked to take an active part in defining a therapeutic community.

In providing an operational description of the therapeutic community, the processes of group dynamics and continuous communication were emphasized. Didactic exercises consisting of simulated situations helped staff examine role models appropriate for a therapeutic community. Some of these simulated situations include identifying individuals who make up a therapeutic community.

The Patient

The resident is always the primary focus of a therapeutic community. It was important that staff understand that a majority of the residents in the proprietary home was diagnosed schizophrenic. Certain treatment approaches have been developed for enhancing the improvement or stabilization of schizophrenic patients. Flinn et al relate that an overall approach should be one of flexibility.

> Qualities required of a therapist include honesty and openness, sensitivity to the nuances of the interpersonal relationship, awareness of his or her own feelings, ability to tolerate the anxiety engendered by the patient's hostile projections, and a relative freedom from omnipotent or narcissistic

> needs in relation to the patient. In addition, the therapist needs to understand certain common characteristics of schizophrenic patients which cause their relationships to be so potentially threatening, longings for closeness and understanding, inconflict with fears of being influenced, swallowed up, or controlled, feelings of marked dependency and neediness pulling against hateful feelings of jealousy and envy, and fear of their own rage and destructiveness. Whether or not these characteristics are primary or are the psychological consequences of an underlying disorder of perception and cognition, optimum pychotherapeutic management of the schizophrenic patient requires a therapist who is skilled in this interpersonal dimension.[11]

The Staff

A demonstration to the staff that they have ultimate responsibility for the direction of assigned tasks. Dramatic illustrations were used to show the varying roles performed by staff. This technique allowed the group to connect with their own particular setting.

A Team Approach

The personal growth of the resident may be enhanced if the team approach is used in planning, decision-making, and treatment goals. A listing of situations by which the team method would be utilized was described to the staff. Richard Almond sees the therapeutic community possessing two aspects: (1) the processes experienced by the individual who comes to the group as a sufferer and is inducted into membership; (2) the processes that sustain the group itself and create the atmosphere in which the individual process may occur.[12]

One scheme of helping the staff to learn was assignments in which the staff observed a resident's negative behavior

and attempted to imitate the model's solution. The observed behavior was brought to the training session, and the desired approach was discussed. The following are four of the staff's illustrations:

(1) "I have been watching a few of the patients in their reaction...one more than the others... Sometimes he is very friendly and then again nothing. Sometimes he goes around with me while I am cleaning and talk, talk, talk."

(2) "She will explode laughing for no reason for a minute, then look at you and call you an S.O.B... look at herself in a mirror and also laugh...will stare for long periods of time...sleep wherever she find a place to lay down...do not care for her looks...she is in her own little world."

(3) "In the middle of an activity she will turn her chair completely around and will say that this is what 'they' want her to do. She has the belief that she has the power to will what she calls quick money."

(4) "Is just like a child, he does little things like turning off the dryer...you turn on, he turn off again, he take everything and hide it."

OBJECTIVES

Some intended objectives of the training program include the following:

(1) To enable the staff to be more sensitive and empathetic torward residents

(2) To provide the staff with an orientation to mental illness

(3) To increase the level of understanding among the staff, especially concerning residential care

(4) To stimulate and encourage independence among the staff

(5) To encourage the staff to act as role-models for the resident population

(6) To insure a climate for a participatory democracy

(7) To establish linkages for a new service with the concept of therapeutic community

(8) To insure that the staff will learn the basic elements for the creation of a therapeutic community.

Theoretical Formulation

Social learning theory supports the practice principles involved in carrying out this training project. It takes into consideration the diverse and varied backgrounds of the staff and residents. It allows staff to perceive a corrective action for themselves and the residents in a non-threatening environment. The staff is given the opportunity to continuously experiment in reaching desirable behavior.

Ernest L. Hilgard and Gordon M. Bower note that social learning theory as advanced by Bandura, Miller and Dollard, et al, tries to provide a balance of cognitive psychology with the principles of behavior modification.

> And in contrast to the learning by doing emphasis, social learning theory holds that a large amount of human learning is done vicariously, through observing another person making the skilled responses (or reading about it or viewing pictures of it) and then by trying to imitate the responses of the model. By this means, the observer can often learn and some time later perform novel responses without ever having made them before or having been reinforced for them (since they never occurred before).[13]

Investigators have demonstrated that modeling is effective as a process for teaching and shaping behavior. In training sessions the trainer frequently redefined the expected role of group members in the helping process. The learners were shown by use of audio-visual aids how the

various group members are utilized in a therapeutic community.

In the training program developed, scriptographic booklets related to each training module were given to the staff trainee at each session. One such booklet entitled, "What Everyone Should Know About Mental Health: described in words and pictures the methods used to treat mental illness, who can help with mental problems, and common patterns of mental illness. This combination or readings and visualizations was used to facilitate the learner's understanding of key topics in the program.

The cultural and educational background for a majority of the paraprofessionals in the training program was considered in efforts to demonstrate communication. In addition, the custodial quality of the proprietary home setting did not encourage an application of therapeutic communication. The work of Corydon, Goffman and Reusch provided conceptualizations useful to the writer. In Improving Therapeutic Communication by D. Corydon et al, steps for teaching effective communication are outlined. The authors believe that individuals who help others should understand the dynamics of emphatic communication. This lack of communication between staff and residents was one of the features Goffman described in Asylums.

Jurgen Ruesch wrote:

> Therapeutic communication differs from ordinary communication in that the therapist's gratification does not derive from the pleasure of communication with the patient but from the satisfaction inherent in earning a living and in the practicing of his skills. Therefore, when the patient has become capable of communicating successfully and the human network in which he operates shows

> signs of corrective feedback, the patient can be trusted to solve his own difficulties.[14]

In providing motivation this trainer concentrated on three distinct areas: (1) techniques in presenting the training materials, (2) the presentation of the specific content, and (3) the leadership of the trainer in actively demonstrating the role behaviors in real and hypothetical situations.

In many of the sessions, the trainer enacted the provocative behavior of a particular resident as described by a trainee. Discussion followed to develop the appropriate responses. The instructional process utilized this type of "role rehearsing" as a method for helping the learner to actualize the expected roles for problem solution of a therapeutic member. In a therapeutic community there are accepted role expectations which must be translated into certain behaviors if objectives of this model are to have meaning. Use of the model requires that all roles are altered in some ways to promote a harmonious social structure. In this respect modeling was helpful in a consistent reinforcement of role change:

> The efficiency of modeling approaches will be largely determined by what is being enacted. If change agents mainly encouraged clients to perform their customary ineffectual forms of behavior to reconstruct past relationship experiences, and to revivify the emotional reactions engendered by their inadequacies, then these methods are unlikely to fare any better than interpretive interview approaches that similarly accentuate the negatives. On the other hand, treatment approaches that employ modeling procedures to establish effective models of behavior often lack an adequate transfer training program in

> which clients are provided with opportunities to test their newly acquired skills under conditions likely to produce rewarding consequences. If change agents themselves portray requisite interpersonal competencies and arrange optimal conditions for their clients to learn and to practice more effective means of coping with potential problems, then this type of approach is almost certain to prove successful.[15]

The nature of the personnel working in proprietary homes made modeling an expedient and effective technique for learning. It allowed the trainer to establish a framework in the initial sessions for identifying the roles to be learned. Decisions on what should be the expected behavior and attitude helped participants to think about new skills and competences they might develop.

The New Careers Training Laboratory found that modeling was effective in establishing rapport among group members. The use of modeling provided a non-threatening atmosphere and the participants were free to demonstrate their own behavior and attitudes. A study carried out by Richard Sanders and Robert Smith at Philadelphia State Hospital in 1957 showed that staff training involving modeling resulted in an improved level of patient care.

M. Daniel Smith reported that modeling as a teaching strategy allowed for some long term benefits. He noted that imitation permits the trainee to demonstrate relevant or irrelevant behavior at later stages. He stated that "modeling is an important and basic approach to bringing about a behavior in a student, and learning, and therefore a way of motivating someone to learn. It provides an exemplar for

the behavior of the student."[16]

Another advantage of using this approach to training is the application of multiple role-playing. In presenting the personnel of a therapeutic community all of the participant trainees were able to simultaneously enact behaviors in an entire therapeutic community. For instance, various individuals were assigned the roles of resident, psychiatrist, social worker, nurse, aide and administrator.

In summary, the techniques of learning developed for this program attempted to change the behavior of staff by involvement as individuals and as group members. Each staff member had the opportunity to participate actively.

Footnotes

[1]Max Siporin, Introduction To Social Work Practice (New York: The Macmillan Co., 1975), p. 177.

[2]Robert Reiff, "Mental Health Manpower and Institutional Change," in Perspectives in Community Mental Health, eds. Arthur J. Bindman and Allen D. Spiegel (Aldine Publishing Co., Chicago: 1973), p. 5.

[3]Charles Grosser et al, Nonprofessionals in the Human Services (San Francisco: Jossey-Bass, Inc., Publisher, 1969), p. 5.

[4]Alan Gartner and Frank Riessman, "The Paraprofessional Movement in Perspective," Personnel and Guidance Journal 53 (December 1974): 256.

[5]Salvador Minuchin, "The Paraprofessional and the Use of Confrontation in the Mental Health Field,". American Journal of Orthopsychiatry 39 (October 1969): 729.

[6]New York State Department of Social Service, Division of Adult Residential Care, Draft Regulations for Residential Care Facilities for Adults, 5 July 1978, pp. 35-36.

[7]Maxwell Jones, Maturation of the Therapeutic Community, An Organic Approach to Health and Mental Health (New York: Human Science Press, 1976), p.87.

[8]Alfred W. Clark and Neville T. Yeomans, Fraser House, Theory, Practice and Evaluation of a Therapeutic Community (New York: Springer Publishing, 1969), pp. 3-4.

[9]Clifford F. Melick and Charles O. Eysaman, "A Study of Former Mental Patients Placed in Private Proprietary Homes," Hospital and Community Psychiatry 29 (September 1978): 589.

[10]Jones, Maturation of the Therapeutic Community, An Organic Approach to Health and Mental Health, pp. 96-97.

[11]Done E. Flinn, P. R. A. May and Louis Jolyon, Integrating the Treatment Approaches to the Schizophrenic Syndrome (New York: Grune and Stratton, Inc., 1976), pp. 274-275.

[12]Richard Almond, The Healing Community (New York: Jason Arson, 1974), p. 298.

[13]Ernest R. Hilgard and Gordon H. Bower, Theories of Learning (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1975), p. 600.

[14]Jurgen Ruesch, Therapeutic Communication (New York: W. W. Norton and Sons, 1961), p. 467.

[15]Albert Bandura, Principles of Behavior Modification (New York: Holt, Rinehart and Winston, Inc., 1969), p. 164.

[16]Daniel M. Smith, Theoretical Foundations of Learning and Teaching (Waltham, Massachusetts: Xerox College Publishing, 1971), p. 209.

CHAPTER IV

DESIGN OF TRAINING PROGRAM

Agency Overview

Private proprietary homes for adults are located throughout the State of New York. As of March 1978 there were 523 such facilities operating under profit and non-profit auspices. Prior to December 1964, these homes were supervised and approved by the county departments' of social services. In July of 1971, supervision of these facilities became the sole responsibility of the New York State Board of Social Welfare. In October 1977, this responsibility was shifted to the State Department of Social Services.[1]

Initially, as defined by the Board of Social Welfare, these homes were to be "operated for the purpose of providing suitable care therein, for compensation and profit, to two or more adults unrelated to the proprietor who, though not requiring medical or nursing care, are in such condition by reason of their age, infirmities or disabilities as to require, in addition to lodging and board, the services of attendants to assure their safety and comfort and to enable them to be bathed, dressed, fed or to move about."[2]

Three major changes have affected the original purpose of proprietary homes. Large state hospitals, as part of

their decentralization program, have utilized these homes as placement resources. As a result, many of these homes were filled with former mental patients. The public has become more accepting of community care for mental patients since the passage of the Community Mental Health Act of 1963. Finally, the proprietary home industry has become a strong political lobby in the State of New York.

The concentration of former patients in these homes created conditions which drew the attention of community groups and politicians alike. They reported incidents of resident abuse, deficiencies in food and clothing, poor hygiene, and inadequate staffing. The news media and television began to describe the inhumane treatment and conditions that existed for ex-mental patients in these homes. Their findings described further the deplorable conditions experienced by former mental patients in proprietary homes. They identified repeated instances of illegal dispensation of tranquilizers, gang visits by doctors, violent residents attacking other residents, and inadequate supervision.

As far back as 1975 steps were being taken to alleviate the problems which resulted from the policies of deinstitutionalization. An agreement was signed between the Department of Mental Hygiene, the State Board of Social Welfare and the State Department of Social Services, to offer mutual support to the discharged patient in a proprietary home setting. Sections of the agreement outlined specific standards for former mental patients, the need for higher

staffing and training.

The intent of the tripartite agreement was met with many inter-organizational conflicts. Mainly, the agreement did not provide for funding or the manpower to carry out the principles of the agreement, In fact, the last clause of the agreement noted that it shall not remain effective beyond April 1976, "unless each party evaluates its experience under the agreements' and notifies the other parties of its intent to continue the terms of the agreement, or to negotiate amendments to the terms of the agreement, on or before February 1, 1976."[3]

The above agreement prompted few improvements in the level of services, care and treatment of former mental patients residing in proprietary homes. In September of 1976, the Governor of the State of New York signed an Executive Order directing an independent survey of all proprietary homes in the state. The scope of the survey would inquire into the administration, management, control, operation, supervision, funding and quality of the adult home industry.

An interim report of conditions in proprietary homes was issued in March 1977 by Deputy Attorney General Charles J. Hynes. The range of abuses experienced by residents was more extensive than previously expected. Three of his findings were as follows:

> (1) Services received by residents of many adult homes do not conform to the requirements of the state and local laws governing the facilities. In a number of facilities, the living conditions offend basic decency and endanger the well-being of residents.

(2) The placement of large numbers of discharged patients from psychiatric centers into adult homes has not been generally accompanied by the provision of suitable rehabilitative and aftercare services.

(3) The use of adult homes as residences for large numbers of discharged patients of psychiatric facilities seems to be substantially and adversely altering the environment and character of the affected facilities.[4]

In the New York City Metropolitan area, there are 4,858 former mental patients residing in proprietary homes for adults. Nearly half of the members of this population are housed in homes located in Far Rockaway, Queens. This community reflects the racial, social and economic composition of the city. Once a resort community, its population could increase by the thousands during the summer months. However, the impact of changing social trends resulted in a loss of business to the resort hotels and many became rooming houses. Eventually, many of these hotels became known as proprietary homes.[5]

The residences for the most part are now old structures but some have been renovated. For many, the basic design includes interlocking single and double rooms with a bed, closet, bureau and bathroom. In many instances, the bathroom is shared. All residents have as a central meeting place a large day room where a television runs constantly during the day. Insufficient space is set aside for socialization activity, occupational therapy and sheltered workshop activity.

A ruling by the Office of Mental Hygiene requires that state hospitals discharging mental patients to proprietary homes provide aftercare services. The Creedmoor Psychiatric Center staffs the Queens Adult Home Program to provide aftercare services to the twelve proprietary homes in Far Rockaway. It should be noted that the Queens Adult Homes Program has no jurisdiction over proprietary homes.

The Queens Adult Home Program, staffed by personnel from Creedmoor Psychiatric Center, provides the aftercare services for 1,900 former mental patients in the borough of Queens. Approximately twelve proprietary homes are located in the Far Rockaway section of Queens. Each home averages about 120 residents. According to the director, this program is able to provide only crisis intervention. Because of limited manpower, one state worker is provided to each home once weekly to deal with problems encountered by the discharged mental patient.

As a provider of mental health services at Kingsboro Psychiatric Center, the writer had the opportunity to visit many of the homes in question. Many of the conditions outlined in Attorney General Hynes' report were observed by the writer first hand. It was from this experience that a strategy for a training program in proprietary homes was developed.

Initial steps for a formal in-service training intervention was coordinated with the Queens Adult Home Program. Following several meetings with personnel from this staff,

the feasibility of a training program was agreed upon.

The linkages of the Queens Adult Home Program facilitated a meeting of proprietary home administrators. Following a series of meetings and discussions with the administrators and the Queens Adult Home staff, several facts became evident. The recent investigations had caused some administrators to think differently about the resident population in their homes. In one of its first rulings, the Department of Social Services indicated that it will not place patients in grossly deficient homes. The Office of Mental Hygiene was evaluating the suitability, given the resources, of finding alternative placements for former mental patients. In addition, the investigation by Deputy Attorney General Hynes would continue.

As described in Chapter I, the organizational structure of the adult proprietary homes showed that nonprofessionals were the largest manpower category. They have always been the major group of service providers in adult proprietary homes. However, the admission of former mental patients to these facilities posed numerous problems for this category of staff. Tasks usually handled by trained psychiatric personnel confront the nonprofessional in the proprietary home.

The planning of a training strategy revealed no evidence of in-service education for staff in adult proprietary homes. The New York State Board of Social Welfare required that all levels of staff receive in-service education or continuing

education on a regular basis. Despite the social and political climate for proprietary homes, this objective was not being achieved. All of the administrators interviewed indicated time and financial limitations for this deficiency.

A number of studies have indicated that intervention on all levels is essential if conditions in adult proprietary homes are to be altered. The discussion below describes intervention at one level: the design of a training program for nonprofessionals in adult homes. The selection of this category of staff for training was the least threatening to home administrators. In addition, these staff members were the major providers of services in the lives of 1,900 former mental patients.

Training Objectives

The immediate training objectives of the training program were to provide paraprofessionals working in adult proprietary homes with: (1) increased knowledge about mental illness; (2) information on the attitude and behavior of individuals helping the mentally ill; (3) demonstration and development of a group-support system for problem-solving and organizational change.

The existing conditions for residents who live in proprietary homes, both socially and physically, do not ensure an atmosphere for self-respect and dignity. The paraprofessional staff working in these homes represents a

key link in achieving this goal. A training program utilizing the concepts and practices of a therapeutic community could alter this condition.

In addressing the program objectives, all training activities were centered around the social structure of a therapeutic community. This methodology allowed for an integration of the therapeutic community concepts and opportunities to learn through a direct application in their work situation.

Within the context of this approach, the trainee is better able to grasp the socio-psychological characteristics a therapeutic community. In addition, it allows the trainee to view, "both clients and the organization as purposeful and open systems with analogous functional components."[6]

Particular emphasis was placed on the following learning themes"

(A) Helping the trainee to understand that a positive environment can exert a therapeutic effect on the resident population

(B) Demonstrating to the trainee that factual knowledge will help provide new methods and skills for helping the mentally ill

(C) Engaging in problem-solving within the organization results in common benefits for both resident and staff

(D) Having positive attitudes towards the mentally ill can influence improvement of residents

(E) Enhancing the social repertoires of the residents is instrumental in developing self-respect and dignity for the residents

Description of Training Program

The training program consisted of once a week, two-hour class sessions, occurring between October 25, 1977 and January 8, 1978. The program extended over a ten week period. The training involved a variety of independent units: lectures, role-playing, audio-visual exercises, graphic illustrations, a field trip, and a portfolio of information on mental illness and group dynamics.

This study represented a pioneering effort for both setting and personnel. It was important to consider probable obstacles and unexpected issues which could affect the program. To reinforce the willingness and cooperation of home administrators, they were involved in both the planning and implementation of the training program. The possibility that administrators would not release personnel was always a potential threat. The Queens Adult Home Program staff constantly demonstrated the appropriateness of the program to staff and administrators.

In July 1977 a meeting was held with six administrators to establish guidelines in order to assure completion of the project. During this meeting, negotiations concerning time, place, etc., were tentatively agreed upon. During the life of the program, similar meetings were held.

There was a concern as to whether the participants' reading and writing skills would be sufficient for them to manage the curriculum. During the first session participants were asked to write out some definitions and to turn

them in following the session. This exercise helped the trainer not only to evaluate competence but make many observations. How was the staff dressed? Who did they sit near? Who talked during the session? Throughout this exercise the trainer offered assistance and moved about. A majority of the staff attempted and completed definitions.

Participants rotated the responsibility of arriving early to prepare for the training session. This involved opening the meeting place, arranging for coffee, distributing transportation money, and helping to pass out information during the training.

A month before the program was to begin, information was sent to twelve proprietary home administrators. It was stressed that such a program had the potential for increasing the skilled care of residents in their home. Included were registration forms which announced the program itself. They included the following information:

<u>Who Should Attend</u>

The training program is useful to all aides, service workers, porters, administrative aides, and kitchen personnel employed in adult homes located in Rockaway, Queens

<u>Class Schedule</u>

Training sessions will be held each Tuesday beginning October 18, 1977 and ending December 20, 1977 (It actually started October 25th and ended January 8). Each class will meet once a week for one and one-half hours. (This time was extended by thirty minutes to include the group-support exercises).

Transportation

All enrollees will be reimbursed for public transportation from place of employment to the training site.

Field Trip

One field trip will be arranged.

Tuition

There is no tuition fee.

The obtaining of a small grant from the Brookdale Center on Aging at the Hunter College School of Social Work made a substantial contribution to the recruitment of participants. This grant allowed for weekly reimbursement of transportation, coffee for the participants during the training session, and the printing of certificates awarded each participant after the program ended. The grant also provided for the purchase of a cassette recorder used in the program.

To help manage the various time phases of the project, a flow chart was developed. The use of this device helped to categorize priorities for the project and helped the trainer to recognize problem areas and assess secondary effects of the program early. The flow chart included some of the following:

May - August 1977

(1) Coordinate approval of the project

(2) Request ongoing meetings with project committee

(3) Develop alternatives for training resources

(4) Obtain approval of training manual

(5) Coordinate the possibility of using students from York College as volunteers in the home

if this should prove necessary

(6) Continue negotiations with the Creedmoor Psychiatric Center, Kingsboro Psychiatric Center, and the Queens Adult Home

September - 1977

(1) Make checklist of all resources needed where developed

(2) Set tentative date for field trip and transportation

(3) Plan for recruitment

(4) Select participants

(5) Gain approval from project committee for implementation

The sharing of bench marks and target dates with program resources, i.e., personnel, agency administrators, and sponsoring agency, helped the project to maintain a high level of visibility. This technique had implications when the trainer was asked to meet with Albany legislators in October 1977 to discuss the need for training in adult proprietary homes.

Linkages

Negotiating with various agencies provided support for the program and cooperation from the administrators. Initially, there had been attempts to coordinate the intended training through the home administrators. An assessment of this situation indicated no sanctions for insuring the completion of the program. The linkages of the Queens Adult Home Program, Creedmoor Psychiatric Cenyer and the New York State Board of Social Welfare, provided a framework for

cooperation from the home administrators. Irwin M. Lasky, Senior Social Service Consultant for the New York State Board of Social Welfare, in a letter dated September 27, 1977, stated that administrators of adult proprietary homes are required to provide continuing education hours and in-service training for their staff.

The plan for implementing the training program received the support of the State Department of Social Services when it assumed supervision of adult homes in October 1977. Training was among its list of eleven priorities noted in "The Needs and Problems of Adult Home Residents in New York," published in February 1979. Elizabeth Dinehart, a director in the regional office, offered her assistance if major problems should develop.

Content of Course

The content for the training program included abstractions from a variety of studies, theories, and programs relating to a concept of a therapeutic community. The intent of the course was designed to provide participants with an orientation for a therapeutic community.

The areas of study are described below:

Topic: Introduction

(1) An overview of mental illness

(2) A description of key variables inherent in a therapeutic community based on Maxwell Jones' article, "Towards a clarification of a 'therapeutic community' concept

Topic: Communication

(1) A discussion of modes of verbal and

non-verbal interaction

(2) A definition of helping communication as described by Jurgen Ruesch in Therapeutic Communication

(3) The remedial effect of therapeutic communication

Topic: "Role-playing"
(1) A discussion of how to help participants to perceive their proper roles through this exercise

(2) A discussion of the behaviors acted out

Topic: The Social Organization
(1) An analysis based on the study of Alfred W. Clark and Neville T. Yeomans provides a framework of the social structure for a therapeutic community

(2) An evaluation of models of a therapeutic community as outlined by Richard Almond in The Healing Community

Clinical case studies from the guide Toward Therapeutic Care[7] as formulated by the Committee on Therapeutic Care Group for the Advancement of Psychiatry was used in helping staff to partialize the problems of an individual resident. Overwhelming behavior of a specific resident could be an obstacle to the helping process.

Some areas covered include the following:

(1) Withdrawal from the demanding patient

(2) Meeting the needs of the over-demanding patient

(3) Bribery used for acceptance

(4) Vulnerability to patient's perceptiveness

For technical subject matter, experts made the presentations. For instance, in session number 5 a registered nurse from the Queens Adult Home staff made the presentation on

psychotropic drugs. Many patients in adult homes are on medication and the majority of institutional personnel are familiar with neither medications or their effects.

The curriculum is more fully outlined in the Training Manual located in Appendix B. The content included in the training manual attempts to build for the participants an understanding of practice principles inherent in a concept of a therapeutic community.

Group-Support Exercise

The parameters of the social structure in proprietary homes did not provide avenues for free communication, interaction among staff and support in presenting problems. As stated previously, the organizational structure of the proprietary homes was the traditional hierarchical model. Based on the trainer's observations, and the investigative reports, there was no meaningful system for nonprofessionals to contribute to the achievement of agency's goals. Generally most of the participants would handle problems individually with the administrator or the resident involved. They had no formal methods for sharing mutual concerns.

Eugene Litwak and Henry Meyer note that "if the bureaucratic organization and external primary group are too isolated from each other, they are likely to interfere with each other and reduce the contribution of one or the other in achieving a social goal."[8]

The use of the group-support exercise provided the participants with an orientation on the maintenance functions

of a group. To provide a focus for this exercise, the participants were asked to write down existing problems they would like to consider.

In all, participants listed a total of eighty-six problems. These problems were organized by the trainer into twenty-five categories, and seven were selected by the group for possible task functions.

The Problem Solving Assignments

Input
(1) The group does not have materials to complete assigned work tasks in the adult home.

Job Satisfaction
(2) The group is not clear on job expectations. For example:

> "My boss expected me to clean out the people room and throw out clothes. But I couldn't because the people get mad and violent."

Interpersonal Relationship
(3) The group examines how to influence the negative behavior of a co-worker

Management of Resident
(4) The group analyzed steps and actions involved in getting the psychiatrist to evaluate a difficult resident

Task Requirement
(5) The group was not clear on steps and actions to take in an emergency.

The sessions of the group-support exercise were tape recorded to facilitate a better understanding to the participants' orientation to problem solving.

Teaching methods were selected which would encourage group participation. Some of these techniques were as follows:

(1) Participants shared responses on homework assignments

(2) They were asked to describe themselves to the group in a helping situation

(3) Role-playing sequences were enacted during the session

(4) The trainer, as model, enacted appropriate responses, behaviors and attitudes

(5) A visit to an inpatient psychiatric ward was planned

Research Design

The research hypothesis tested in this project was that the proposed training would increase the participants' knowledge of mental illness and change their attitudes positively. Based on the research hypothesis that the training would increase the participants' knowledge of mental illness and change their attitudes positively, a statistical null hypothesis was constructed. Using ideas suggested by Moursund (1973) and Rynon and Haber (1976), the statistical null hypothesis was constructed to correspond to the research hypothesis. The null hypothesis, according to Moursund, "includes all of the possibilities not covered by the research hypothesis; if it can be shown to be untrue, or unlikely, then the research hypothesis is supported."[9]

H_1: Training increased participants' knowledge and changed attitudes in a positive direction.

H_o: Training had no effect or actually decreased participants' knowledge and changed attitudes negatively.

The one-group pre-test, post-test design was used for

measuring variables before and after training. All of the participants were given the test before the program and after the program was terminated. Novia Carter and Brian Wharf note possible sources of errors which can occur in this type of design. They state that "among the possible sources of error which do not necessarily allow crediting changes which occur to the program is when the before measure itself constitutes a stimulus to change. This is often difficult to prove. Further, in the field of social inquiry, the fact that a particular piece of research (the program) is under way may instigate changes which had not been planned before the inquiry began."[10]

To minimize the effects of extraneous variables; such factors as climate, site, maturation, instrument decay, and mortality were considered in the design. The problems within the proprietary home system were publicly known. Any intervention, however well intended, was viewed with suspicion by most administrators. Therefore, the variables of site and climate were carefully considered during the program. It was important to be aware of the power of the administrators and the negative effects they could produce for the program.

The participants in the training program were volunteers or self-selected. Carol H. Weiss comments on the limitations of a self-selected sample. She notes that "people who choose to enter a program are likely to be different from those who do not, and the prior differences (in interest,

aspiration, values, initiative) make post-program comparisons between served and unserved groups risky."[11]

The time-frame for the program took into consideration that a participant could drop out at any time by choice and that administrative action in a proprietary home could cause a participant to drop out at any time. A range of incentives were provided to maintain the program at a high level of attractiveness to the participants. Every effort was maintained to respect the mutually agreed upon scheduling with the administrators.

Instruments

The demographic questionnaire was used as a means of evaluating the effects of such input variables as age, education, work experience, race and sex on the program. Essentially, the demographic questionnaire was constructed to illustrate the range of the participant's knowledge, experience and motivation.

The sex of the participants was not included on the demographic questionnaire. The trainer felt that gender played an important and significant role; therefore, the participants were asked to include gender.

Items on the demographic questionnaire were developed to yield information in the following areas:

(1) Job satisfaction

(2) Personal attributes

(3) Skills

(4) Previous employment

(5) Perception

(6) Length of time in present job

(7) Educational status

(8) Previous in-service training courses

The questionnaire was constructed in an attempt to collect basic data without overwhelming the participants. As discussed earlier it was a basic assumption that the participants had minimal skills in the three R's.

Examples of items on the demographic questionnaire included the following:

(9) Do you describe yourself as an excellent, fair, poor employee? (circle one)

(11) Write briefly your definition of mental illness

(12) Do you have a special skill? Please identify (example: Play the guitar, piano, etc.)

(14) Do you think you could benefit from training? ____yes____no.

Attitude Scale

The attitude scale hoped to measure the direction change of participants' attitudes in the categories of authoritarianism, benevolence, mental hygiene, social restrictiveness, and interpersonal etiology before and after the training. This instrument as developed by Cohen and Struening (1959) consists of 51 items on the above categories.

In the space provided, the participants had to check

among six choices their opinions about mental illness.

Example: If parents loved their children more, there would be less mental illness.

(1) Strongly agree_____
(2) Agree_____
(3) Not sure but probably agree_____
(4) Not sure but probably disagree_____
(5) Disagree_____
(6) Strongly disagree_____

If the participants receive low scores in the authoritarian category, they would be considered more positive. Should participants score high on benevolence and mental hygiene, the directions would indicate a more positive attitude. A high score on the social restrictiveness category would represent a negative direction. On the interpersonal etiology category, a high score would represent a positive movement.

Achievement Test

This test was designed to evaluate the participants' basic knowledge in the area of mental illness. The test was constructed from the content of the training course, as well as other factual information in the field of mental health.

Prior to the initiation of the study, all of the items represented on the instrument were reviewed by a panel of six experts. It was general agreement, that for the purpose of this study, face validity was achieved.

The instrument consisted of twenty-five true-false questions and covered both theory and practice. The test alternated theory and practice questions. The theory questions were odd numbers, and the practice questions were the

even numbers.

Examples of Theory Questions:

(1) Teaching residents to participate in decision-making promotes growth of the individual.

(3) When a resident is acting out, (yelling, cursing, pacing) one can be most helpful by trying to understand that a resident is trying to give a message.

(5) Activity provides an opportunity for residents to express their feelings with support of others.

(11) The use of medication is not very significant in the treatment of mental illness.

Examples of Practice Questions:

(2) All persons with mental illness have to be placed in a mental hospital.

(6) Do the majority of the mentally ill residents like to be alone and idle?

(10) Major goals of a well-run home are to provide an excellent environment for the residents, therapy, and structures which encourage them to remain.

(18) When necessary, scapegoating (several staff or patients ganging up against another patient) is good to keep the patient in line.

Group Support

The method utilized in evaluating group support was based on Robert F. Bales, "A Set of Categories of Small Group Interaction." The aim of the Bales technique was a rating of behavior that takes place in the group. In this project, the analysis was done by listening to verbal responses from the recorded group sessions.

Each tape was analyzed to determine whether the participants were acting independently or as part of the group

process. Eight classifications were developed to record the group's action toward solution of the problems previously outlined.

The eight categories included in the rating were as follows:

(1) Showing solidarity
(2) Indicating perception
(3) Demonstrating an understanding
(4) Showing conflict
(5) Making decisions
(6) Creating tension
(7) Asking for help
(8) Asking for suggestions

The trainer served as rater of this exercise guided by the Bales theoretical model. The verbal interaction of the group was rated by giving a plus (+) if they moved toward a solution and a negative (-) if no approach was made.

Follow-Up Study

A questionnaire adopted from the "Advocacy Project, National Council for Homemaker Home Health Aid Services, Inc.," was used to evaluate the project three months after it ended. It was expected that such a follow-up would provide some long term effects of the program.

The participants were asked to think back over the three months since the training ended and reflect on the following questions:

(1) How did the training program stimulate me to acquire more information about my job?

(2) Does the adult home administrator respect the training that I have received in the Helping Skills Program?

(3) Have I developed some skills in working with

residents?

(4) Have I gained new knowledge which has been useful to me?

Field Visit

One of the highlights of the program was a field trip to a therapeutic ward at Kingsboro Psychiatric Center. The participants were given an orientation on the linkages of state hospitals to other agencies in the community, staff relationships and patient care. The tour, which lasted for approximately four hours, afforded most of the participants an opportunity to see a state hospital for the first time. In addition, the field trip allowed each participant to confront his own social stereotypes and prejudices about the mentally ill.

This program design was formulated to include training material that required active participation by the trainee's at all times. The combination of didactic material and group support helped the program achieve this goal.

The collaborative planning demonstrated in this design, which included substantial discussion of participants' perceived needs, was a major attempt to avoid fragmentation and to maximize the potential for participants to learn theory and generic practice principles for those working with the mentally ill.

Footnotes

[1]Irwin M. Lasky, personal letter.

[2]New York State Department of Social Welfare, Principles and Rules for Domiciliary Care Facilities for Adults and Guide to Interpretation of the Rules, 1972, p.6.

[3]Tripartite Agreement among the New York State Department of Social Services, the New York State Department of Mental Hygiene, and the New York State Board of Social Welfare, 1975, p. 12.

[4]New York State Attorney General's Office, Private Proprietary Homes for Adults, by Charles J. Hynes, A Second Investigative Report Issued Pursuant to Executive Law, Section 63 (8), 1977, p. 8.

[5]Anne Wyden and William L. Werner, "Community Psychiatry Stepchildren and their Rehabilitation," November 1976. This article can be reviewed at the Office of Mental Hygiene, Two World Trade Center, New York, New York.

[6]Rosemary C. Sarri and Yeheskel Hasenfedl, The Management of Human Services, (New York: Columbia University Press, 1978), p. 187.

[7]The Committee on Therapeutic Care Group for the Advancement of Psychiatry, Toward Therapeutic Care: A Guide for Those Who Work With the Mentally Ill (New York: Springer Publishing Company, 1970), pp. 489-503.

[8]Eugene Litwak and Henry J. Meyer, "A Balance Theory of Coordination Between Bureaucratic Organizations and Community Primary Groups," Administrative Science Quarterly 2 (June 1966): 37.

[9]Janet P. Moursund, Evaluation: An Introduction to Research Design (Monterey, California: Brooks/Cole Publishing, 1973), p. 100.

[10]Novia Carter and Brian Wharf, Evaluating Social Development Programs (Ottawa, Canada: The Canadian Council on Social Development, 1973), p. 116.

[11]Carol H. Weiss, Evaluation Research (Englewood Cliffs, New Jersey: Prentice-Hall Inc., 1972), p. 70.

CHAPTER V

ANALYSIS OF DATA

Four measures were used to yield information about the effects of the training program: an achievement test, attitude test, audio-tapes of support group meetings, and follow-up questionnaire. The instruments for the achievement and attitude tests were given at the beginning of the training period and at the end of the training period. The testing situation occurred with all of the participants together. Careful steps were taken to provide specific directions and to clarify questions about the instruments. During the planning phase, environmental considerations were weighed, and every effort was taken to accommodate the participants with ample space and quietness. It was assumed that changes in the before and after scores would be due to the training intervention.

The effects of the group support exercise were analyzed by the trainer. Since an independent judge was not used, the danger of bias must be considered in the analysis of the group support exercise. Anne Anastasi cites three common tendencies that can influence outcomes:

> (1) The potential for the individual rater to be influenced by a single favorable or unfavorable trait, which colors his judgment of the individual's other traits.

(2) The possibility of placing persons in the middle of the scale and to avoid extreme positions.

(3) The assigning of more favorable ratings and thereby, making the ratings less discriminative.[1]

All of the participants were involved in the five week group support exercises. Problems were selected from five categories for the participants. As discussed in Chapter IV, the cassette tape recorder was used to record the verbal interaction of the group. Depending upon the direction of problem solution, the group was rated a plus (+) or a minus (-).

To obtain some impressions of the longitudinal effects of the training program, a follow-up study was administered three months after the training program ended. The questionnaire was given to all fourteen participants who started and completed the program. The data collected by use of this instrument allows an interpretation of lasting changes in knowledge and attitude. In addition, this data demonstrated the impact of the group support exercise upon the participants.

Based on the research hypothesis that the training would increase the participants' knowledge of mental illness and change their attitudes positively, a statistical null hypothesis was constructed. The research and null hypothesis are stated as follows:

H_1: Training increased participants' knowledge and changed attitudes in a positive direction.

H_o: Training had no effect or actually decreased participants' knowledge and changed attitudes

negatively.

The Participants

Both before and after the training, the participants were asked to comment on certain statements which would provide additional dimensions of knowledge, organizational dynamics, and individuality of each participant.

The program initially enrolled twenty-one participants for the training. Seven of the trainees withdrew because of personal problems and difficulties on the job obtaining a release to attend the sessions. None of the seven participants who dropped out indicated their decision was based on the training program itself.

The participants in the program included fourteen staff members from three proprietary homes for adults in Rockaway, Queens. Of those who completed the training program, thirteen were female and only one was male. The one male participant was a thirty-nine year old Puerto Rican who completed the tenth grade and had been employed in the Hi-Li Home during the past two years. When asked what his adult home needed most, he stated: "better relationship between the residents and staff."

The female participants' ages ranged from twenty-one to fifty-eight. In this group, six were married, one separated, and six were single. Educationally, the breakdown was as follows: three had completed two years of college; five had completed high school; and five did not complete high school. The racial composition was almost evenly distributed with

six blacks and seven whites.

Only four of the participants listed prior formal in-service training courses. The prior training included courses on the treatment of mental illness conducted by Dr. Peggy Heller of the Queens Adult Home staff. Much of the training related to crisis intervention. For instance, if a resident escaped or attempted suicide, usually a representative from the Queens Adult Home staff would conduct a follow-up session with the participants where the incident occurred.

The participants were asked to list previous work experience, and the responses included employment at McDonald's, factory work, baby nursing, housekeeping, nurse's aide work, bankteller work, sales work and laundry work. Two of the female participants listed related mental health experience, one had worked at Long Island Jewish Hospital as an occupational therapist, and the other at Creedmoor Psychiatric Center as a mental health therapy aide.

Determining whether the participants had a special skill or talent was seen as important information in promoting the concept of a therapeutic community. It was found that three of the trainees indicated a special skill in art and music.

Through informal discussion, it was noted that all of the participants belonged to union local 1115. However, none of the participants thought their union provided assistance in improving the level of performance or work

environment. They believed that the union was in collusion with administration.

All participants were asked to provide a subjective rating of themselves as employees in the adult home prior to training. Choosing from three categories of excellent, fair, and poor. Seven participants rated themselves as excellent, six indicated fair, and one no response.

One question on the demographic questionnaire asked the participants to write briefly their definition of mental illness. This question generated a response from all participants except two. Generally the group felt that mental illness was characterized by behavior problems occurring suddenly.

For example: The participant who completed high school and worked at McDonald's thought that mental illness was defined as "people who really can't help their actions, also need care and understanding from outsiders and residents." The answer provided by the participant who only completed the tenth grade and had experience at Creedmoor Psychiatric Center stated, "a person who is unable to function on their own and have problems getting along with others." The lone male participant defined mental illness as "a split personality and lack of contact with reality." One of the participants who completed two years of college indicated that "mental illness is a term given to a series of illnesses where a person's behavior does not fit into the 'normal' standard set by society."

The information from the demographic questionnaire indicates two things: (1) that a standard of education or prior work experience was not a requirement for employment in proprietary homes; (2) that a majority of the participants had some notion of mental illness. Further, it can be concluded that the staff members who completed the program were interested in self-improvement and opportunities the training might represent.

Gaines in Knowledge

Achievement tests were administered to the participants before and after the training to determine how much had been learned. Table I shows the results of the pre-test and post-test. As demonstrated by the table, all participants scored in the high range (close to the maximum of 25) on both tests. In spite of the high scores, the results of the t-test indicate there was statistically significant improvement from before to after training, ($t=1.8$, $p>.15$, one-tailed test.)

TABLE I

SCORES OF FOURTEEN SUBJECTS ON TRAINING ACHIEVEMENT TEST SCORES BEFORE AND AFTER TRAINING

Subject	Before	After
1	22	22
2	24	23
3	20	22
4	13	20
5	25	23
6	24	21
7	21	22
8	22	23
9	22	24
10	21	24
11	19	23
12	19	21
13	23	22
14	23	25

We find that the participants showed minimal difficulty in obtaining the correct responses to items 6, 10, 13 and 14. These statements included the following:

(6) Do the majority of the mentally ill residents like to be alone and idle?

(10) A major goal of a well-run home is to provide an excellent environment for the residents, therapy and encouragement to remain.

(13) The best environment for the mentally ill is in a country surrounding.

(14) With some residents, taking a stern and forceful approach may have desirable therapeutic results.

On the pre-test, eight participants who obtained the correct response to (6) and (9) answered it correctly on the post-test. For (10), nine scored correctly on the pre-test and eleven on the post-test. The participants were correct less often on the post-test than on the pre-test for (13), nine before and eight after. The results for (14) showed similar results, eleven on the before and eight after.

The mean achievement scores by education, age, and length of time on job were computed for all participants. The data reported in Table 2 (mean achievement scores by education) shows that the participants who completed 7th-9th grade level in school achieved the greatest gain.

TABLE 2

MEAN ACHIEVEMENT SCORES BY EDUCATION

Years Completed	Number of Subjects	Pre-test Scores	Post-test Scores
7-9	2	17	21
10-12	9	22	22
13-15	3	22	24

Comparison of mean achievement scores by age and length of time employed on the present job were reflected in Tables 3 and 4, respectively. In Table 3, each age category showed a difference after the training except 40 - 49. In looking at Table 4, we find that all groups of participants increased their scores after the training.

TABLE 3

MEAN ACHIEVEMENT SCORES BY AGE

Age	Number of Subjects	Pre-test Scores	Post-test Scores
20-29	4	21	22
30-39	4	21	23
40-49	4	22	22
50-59	2	22	23

TABLE 4

MEAN ACHIEVEMENT SCORES BY TIME ON PRESENT JOB

Time on Job	Number of Subjects	Pre-test Scores	Post-test Scores
Less than 1 Yr	5	21	22
1 Yr. but less than 3	7	22	23
3 Yrs. or More	2	22	23

Change In Attitude

The participants were measured on the factors of authoritarianism, benevolence, mental hygiene, social restrictiveness and interpersonal etiology. As discussed in Chapter IV, if the participants receive low scores in the authoritarian category, they would be considered more positive. Should participants score high on benelovence and mental hygiene, the direction would indicate a more positive attitude. A high score on the social restrictiveness category would represent a negative direction. On the interpersonal etiology category, a high score would represent a positive movement.

The t-test for correlated samples, as described in Runyon and Haber (1976), was used to determine whethere there is a statistically significant difference between the before and after scores.

The t-test involved letting μ_D be the population mean, $\bar{D}$ be the sample mean, s_D the standard deviation of the difference, and N the number of participants or sample size; then the formula used in this analysis is:

$$H_0: \mu_D \leq 0 \qquad t = \frac{(\bar{D} - \mu_D)}{s_D/\sqrt{n}}$$

$$H_1: \mu_D > 0$$

Tables A-1 through A-5 represents scores obtained in each of the above categories before and after training.

Scores on the authoritarian category (Table A1) showed that nine of the participants had a less authoritarian attitude after the training than before training. Four

showed a more authoritarian attitude. This indicates an overall movement towards a less authoritarian attitude. Applying the t-test to the authoritarian scores, the difference is significant:

($t = -1.95$, $p > .05$ one tailed test).

Referring to Table A2, we find that eleven of the participants demonstrated gains on the benevolence factor after training. Two of the participants were less benevolent. One participant showed no movement. Applying the t-test to this factor, the difference is significant ($t = 1.89$, $P > .05$, one tailed test).

The scores for the mental hygiene factor (Table A3) show that only five of the participants scored in a positive direction. Seven of the participants scored in the low range after training. This would suggest that most of the participants' attitudes were more negative on this factor after the training.

Applying the t-test to this factor, we find there is no significant difference on the before and after training ($t = -0.73$, $p > .10$, one tailed test).

On the social restrictiveness factor (Table A4), seven of the participants moved in a positive direction on this factor. Six of the participants demonstrated a more negative direction in social restrictiveness after the training. Again the difference is not significant when the t-test is applied ($t = -0.99$, $p > .10$, one-tailed test).

The responses of the interpersonal etiology factor

(Table A5) revealed that seven of the participants moved in a negative direction after the training. Five of the participants moved in a positive direction after the training. Two of the participants showed no change. In this case, a majority of the participants expressed a more negative attitude toward interpersonal etiology after training. Results of the t-test show no significant difference ($t=-1.05$, $p>.10$, one tailed test).

Mean scores on the five attitude factors were compared with the variables of age, education, and length of time on job.

Length of Time on Job, Tables 5-9

The data in Tables 5, 6, and 8 show that participants who had worked on the job one year but less than three years indicated an overall movement on the authoritarian, benevolence, and social restrictiveness factors after training. As indicated by Table 7, participants in all categories showed a more negative movement after training on the mental hygiene factor. Referring to Table 9 we find that the participants who had been on the job less than one year showed movement on the interpersonal etiology factor after training.

TABLE 5

MEAN AUTHORITARIANISM VERSUS LENGTH OF TIME ON JOB

Number of Subjects	Time on Present Job In Mental Health	Before	After
5	Less Than 1 Yr.	29	29
7	1 Yr. But Less Than 3 Yrs.	31	25
2	3 Yrs. or More	32	31

TABLE 6

MEAN BENEVOLENCE VERSUS LENGTH OF TIME ON JOB

Number of Subjects	Time on Present Job In Mental Health	Before	After
5	Less Than 1 Yr.	42	51
7	1 Yr. But Less Than 3 Yrs.	47	50
2	3 Yrs. or More	52	49

TABLE 7

MEAN MENTAL HYGIENE VERSUS LENGTH OF TIME ON JOB

Number of Subjects	Time on Present Job In Mental Health	Before	After
5	Less Than 1 Yr.	31	30
7	1 Yr. But Less Than 3 Yrs.	29	28
2	3 Yrs. or More	32	31

TABLE 8

MEAN SOCIAL RESTRICTIVENESS VERSUS LENGTH OF TIME ON JOB

Number of Subjects	Time on Present Job In Mental Health	Before	After
5	Less Than 1 Yr.	22	22
7	1 Yr. But Less Than 3 Yrs.	25	23
2	3 Yrs. or More	22	22

TABLE 9

MEAN INTERPERSONAL ETIOLOGY VERSUS LENGTH OF TIME ON JOB

Number of Subjects	Time on Present Job In Mental Health	Before	After
5	Less Than 1 Yr.	16	17
7	1 Yr. But Less Than 3 Yrs.	16	15
2	3 Yrs. or More	26	14

Age

From the data presented in Tables 10-14, we find that the young group showed the greatest change on the variable of age. The age group between ages twenty to twenty-nine scored an increase on the authoritarianism, benevolence, and social restrictiveness factors after the training. The group between the ages of thirty to thirty-nine showed similar results, scoring an increase on the benevolence, social restrictiveness, and interpersonal etiology factors after the training. The other groups demonstrated a rather mixed picture.

TABLE 10

MEAN AUTHORITARIANISM VERSUS AGE

Number of Subjects	Age	Before	After
4	20-29	31	24
4	30-39	25	27
4	40-49	35	29
2	50-59	32	31

TABLE 11

MEAN BENEVOLENCE VERSUS AGE

Number of Subjects	Age	Before	After
4	20-29	42	52
4	30-39	44	48
4	40-49	49	51
2	50-59	52	49

TABLE 12

MEAN MENTAL HYGIENE VERSUS AGE

Number of Subjects	Age	Before	After
4	20-29	31	30
4	30-39	25	25
4	40-49	34	31
2	50-59	32	31

TABLE 13

MEAN SOCIAL RESTRICTIVENESS VERSUS AGE

Number of Subjects	Age	Before	After
4	20-29	27	21
4	30-39	21	20
4	40-49	25	27
2	50-59	22	22

TABLE 14

MEAN INTERPERSONAL ETIOLOGY VERSUS AGE

Number of Subjects	Age	Before	After
4	20-29	15	13
4	30-39	13	16
4	40-49	19	19
2	50-59	26	14

Education

According to Tables 15-19, the groups who completed the 7-9 grade level of education showed a difference on the authoritarianism, mental hygiene, social restrictiveness, and interpersonal etiology factors after the training. The participants who completed the 13-15 grade level of education improved on the benevolence, mental hygiene, and social restrictiveness factors after the training. The group in the 10-12 grade level of education demonstrated the least change after the training. Scores for the education variable showed an overall improvement by a majority of the participants. The young group demonstrated the most impact on this variable.

TABLE 15

MEAN AUTHORITARIAN VERSUS EDUCATION

Number of Subjects	Education	Before	After
2	7-9	37	29
9	10-12	30	27
3	13-15	26	29

TABLE 16

MEAN BENEVOLENCE VERSUS EDUCATION

Number of Subjects	Education	Before	After
2	7-9	34	49
9	10-12	48	50
3	13-15	48	51

TABLE 17

MEAN MENTAL HYGIENE VERSUS EDUCATION

Number of Subjects	Education	Before	After
2	7-9	30	31
9	10-12	31	28
3	13-15	28	30

TABLE 18

MEAN SOCIAL RESTRICTIVENESS VERSUS EDUCATION

Number of Subjects	Education	Before	After
2	7-9	30	27
9	10-12	21	23
3	13-15	21	18

TABLE 19

MEAN INTERPERSONAL ETIOLOGY VERSUS EDUCATION

Number of Subjects	Education	Before	After
2	7-9	16	19
9	10-12	17	15
3	13-15	17	15

A comparison of the mean scores on the five attitude factors indicate that the participants after the training were less authoritarian and more benevolent than before training. The participants experienced the greatest difficulty with the items on the mental hygiene factor. The participants in the 7-9 grade level of education, who had worked on the job one year but less than three years, demonstrated the greatest movement. The picture represented by the scores on the achievement test and attitude test indicate a relatively independent relationship. Once conclusion is that participants could do well on the achievement test and yet show negative attitudes.

Evaluation of Group Support

The responses by the participants on the taped support group exercise demonstrated a beginning orientation by the participants in learning techniques of group process as a tool for problem solving within organizations. The problem

solving group was a new experience for many of the participants. It was necessary in the beginning sessions to deal with the participants' anxiety, and lack of trust of each other; it was also vital for them to gain self-confidence in verbalizing their feelings on the problems that were discussed. The trainer gave particular stress to stimulating verbal interaction among the participants. A major limitation was the constraint of the time in maximizing many of the variables associated with group techniques. Five sessions were completed utilizing the use of group support as a method of problem-solving within the organization. Problems were selected from five categories and the group was assigned a plus (+) if they moved in the direction of a problem solution, and a minus (-) if no approach to a problem solution was made. As outlined in Chapter IV, the classification of responses was based on Bales' "A Set of Categories for The Analysis of Small Group Interaction."

TABLE 20

DIRECTION OF GROUP IN PROBLEM-SOLVING EXERCISE

Tape #1	Tape #2	Tape #3	Tape #4	Tape #5	Direction of Interaction
+	+	+	-	+	Shows Solidarity
+	+	-	-	+	Perception
+	+	+	+	+	Demonstrate an understanding
+	-	+	+	+	Show Conflict
-	-	+	-	+	Decision Made
+	+	+	+	+	Tension Created
+	+	+	+	+	Ask for Help
-	-	+	+	-	Ask for Suggestion

An analysis of Table 20 indicates that the participants were able to grasp a general understanding of all problems presented. The frequency of disagreement was viewed as positive, and the tension this created demonstrated the group's effort in solving the presenting problem. In all instances, the group would ask for help when they were not sure of the limits of their input. The participants' cohesiveness was identified in a majority of the taped-exercises. They were only able to arrive at a decision on Tapes #3 and #4. In general, this five-week period of group support exercise taught the participants' a beginning orientation to

using group support as a tool in carrying out their responsibilities. Further, it helped the participants to conceive themselves as important and powerful linkages within the work setting (organization).

Follow-Up Questionnaire:

All fourteen participants returned to take the follow-up questionnaire. The responses show that a majority of the participants looked upon the training experience as favorable. The staff completing the program was asked to answer nine yes-no statements relating to the training, the organization, and group-support.

A total of twelve of the participants felt better about working in the adult home, while two didn't. Seven of the participants stated they had met as a group since the training program ended to discuss problems and ideas. Only eight felt that the adult home administrator recognized the training they had received. Thirteen of the participants indicated they had been motivated to seek further information on mental health as a result of the training. When asked if they had participated in in-service training since the program ended, twelve answered no.

An attempt was made through the follow-up questionnaire to obtain some impression of long term career goals. The participants were asked if they considered furthering their education as a result of the training program. One answered as follows: "Because we have realized that we can give and do the best for other epople...this experience has

been useful to me not only on my job but outside too." Two other participants offered these comments: "I will attend programs" and "It's very interesting because you can help others...It's very rewarding too, you feel useful."

In the follow-up study, participants were asked to rate their satisfaction with the training program itself. The participants could check whether they were quite satisfied, fairly well-satisfied, satisfied but not enthusiastically, somewhat dissatisfied, and quite dissatisfied. Seven of the individuals felt fairly well-satisfied, five quite satisfied, and one satisfied but not enthusiastically and one no response.

In general, the data shows that there was improvement by the participants after the training program ended. It provides some baseline information on a category of paraprofessionals working in the mental health field. It appears that most of the staff working in these proprietary homes were female between the ages of twenty-one and fifty-eight. A majority of the paraprofessionals were married and over half had a high school education.

This training intervention was conducted in a very sensitive political climate. Therefore, the method of selecting the sample must be considered a limitation in the program design. The program, however, does demonstrate that a training model based on a therapeutic community may be utilized in proprietary homes. Give the time, such a program could deal with some of the boarder issues outlined in this

project.

The participants were pleased with the training program as presented. However, the limited time planned for the program did not allow for the maximum development of the potential for learning in the group-support exercise. In future programs this component of training should be allocated a larger unit of time.

Footnotes

[1]Anne Anastasi, *Psychological Testing*, (New York: The Macmillan Company, 1968), pp. 420-21.

CHAPTER VI

SUMMARY AND CONCLUSION

This project describes the development of a training program for fourteen paraprofessionals who were the major providers of care for residents living in adult proprietary homes. The majority of residents living in these facilities were former mental patients. The presence of former mental patients in adult proprietary homes was relevant to the intended design of this program and its objectives.

One result of decentralization programs by state hospitals was the relocation of huge numbers of discharged chronic patients to these facilities. Their placement created conditions which drew attention to the provisions of care and treatment. In many proprietary homes there were reports of resident abuse, overmedication, improper dress, bizarre behavior, and inhumane treatment.

It is important to point out that this project was not an attempt to examine mental health policy or service delivery. Moreover, the project was not concerned with altering the basic organization of the mental health system or proprietary home industry. However, it would be impossible to plan adequately for this training program without addressing some issues of need, power, conflict, and structure in

the mental health system. This study deals with providing training to paraprofessionals who were the major providers of care to former mental patients in adult proprietary homes.

A training program was designed with the purpose of achieving the following objectives: (1) to increase knowledge and skill, (2) to provide information on the attitude and behavior of those working with the mentally ill, and (3) to orient participants to the use of group support in problem solving within the organization.

A training curriculum was formulated on the principles and practices of a therapeutic community framework. By utilizing this approach, the participants were exposed to a range of techniques and methods unique to the social organization model. The social structure of a therapeutic community implies that the whole community of staff and patients is involved in treatment and administration.

It was expected that by introducing participants to a training content with rule-learning, problem-solving, and structure, they could better manage and influence the lives of residents.

A combination of teaching methods was used which included both experiential and didactic approaches emphasized role, behaviors, and attitudes appropriate to a helping community. Within this context, trial and error was not viewed as failure but learning. The intent was to have as much participation on a voluntary basis from the participants as possible. It was through communicating situations

associated with the job setting that the most response was stimulated. For many of the participants, the training program offered a consistent method to test their own job knowledge and experiences.

The problem-solving component as an objective was intended to help participants think of solving organization and resident problems by a group approach. The methodology included a taping of each problem discussion group and stressed the need for group interaction. The participants were encouraged to examine problems and seek a group solution. The inclusion of this training objective enhanced the experimentation of the program.

Such incentives as coffee, transportation expenses, a field trip, and issuance of certificates of course completion were effective. The incentives facilitated the program operation and also stimulated a greater commitment by participants to remain in the program.

The participants included thirteen females and one male. They ranged in age from twenty-one to fifty-eight years old. None of the staff had completed college. The highest level of schooling was two years of college by two participants. Five had completed high school and five had not. All of the participants worked in proprietary homes in Far Rockaway, Queens.

The fourteen participants spent a total of ten weeks in the training program. The program occurred between October 1977 and January 1978. To the writer's knowledge, this was the first formal training offered to staff in adult

proprietary homes.

The own-control design was used in evaluating changes in knowledge and attitudes in the training program. All of the participants were measured on these variables before the program started and after the program ended. In view of the limitations of this design, steps were instituted to minimize the consequences of intervening variables. Peter H. Rossi notes that, even though one is able to compare changes by measurement, all such changes cannot be attributed to the effect of the program.[1]

A statistical null hypothesis was constructed to analyze the changes in the before and after test on the variables of knowledge and attitude. It was hypothesized that no improvement would occur after training. The student t-test for correlated samples was used to determine the before and after difference. The computed t-value was as follows:

$$t = \left(\frac{\bar{D} - M_D}{S_D / \sqrt{n}}\right)$$

In the interpretation of the results, one must consider five factors which weigh upon any definitive conclusions about outcomes: (1) All of the participants were self-selected; therefore, any generalizations to the larger population are limited. (2) Prior work history of all participants was menial. (3) All participants were volunteers. (4) The small size of the sample must be taken into consideration. (5) In relationship to knowledge of mental illness, the experienced and inexperienced showed no significant difference.

The responses on the knowledge test showed that participants scored on the high spectrum on the before and after test. The two participants who completed 7-9 years of education showed the most improvement on the post test. A comparison of mean scores by education, age, and length of time on job supports the inferential relationship of education and achievement.

In spite of their limited exposure to previous in-service training programs, the participants evidenced a greater knowledge of mental illness than had been expected. Only four of the participants reported prior in-service training relating to mental illness. Two other participants had indicated work experience in a mental health setting.

It was common practice in the training to reinforce helping knowledge brought to the program. The participants were encouraged to seek opportunities to use their skills in the work setting. Particular emphasis was given to methods and techniques for working with chronically mentally ill residents. Once given the framework of practice, many of the participants volunteered to act as role models for the program.

The attitude test consisted of evaluating the subjects on five factors: (1) authoritarianism, (2) benevolence, (3) mental hygiene, (4) social restrictiveness, and (5) interpersonal etiology. Each of these factors defined a particular group of items relating to attitudes about mental illness.

The students' t-test was used to compute whether the participants moved in a more positive direction before and after the training.

On the authoritarianism factor, nine of the participants moved in a positive direction. An examination of the benevolence factor showed that eleven of the participants improved after training. The social restrictiveness factor indicated a change in seven subjects, and six of the participants moved in a more negative direction after the training. The scores on the mental hygiene factor showed no significant difference. On this factor, seven of the subjects were more negative after the training.

In applying the one-tailed test to the five attitude factors, participants showed the greatest change on the benevolence and authoritarianism factors. The scores on the other factors were just about evenly divided between positive and negative.

In summary, participants demonstrated a more positive attitude on the factors of authoritarianism and benevolence; while in the factors of mental hygiene, social restrictiveness, and interpersonal etiology, the direction of change in attitude was roughly divided between positive and negative. It may be inferred that participants could perform more emphathetically and less custodially.

The mean scores on the attitude factors were compared to the variables of age, education, and length of time on job. These scores were computed for each of the five

factors. In comparing these results, subjects who had worked on the job less than three years moved to a high range on authoritarian, benevolence, and social restrictiveness. The subjects within the age group of twenty to thirty-nine scored an increase on the same three factors after the training. Similar results were also shown for the thirty to thirty-nine age group. In terms of education, subjects who completed the 10th-12th grade level of education demonstrated the least change after the training.

The distribution of mean scores on the attitude factors suggests that an attempt to measure feelings or beliefs can be useful. All four categories showed a mixed picture. This would indicate that all staff working with the mentally ill might benefit from this kind of training.

For the purpose of this study, the measure was used to make an initial assessment on the attitude of this training group. This type of information can be helpful in determining the preconceived notions about individuals working with the mentally ill.

The group support component was not easily integrated into the program. Initially anxiety was manifested by both the participants and trainer. For many of the participants, communicating feelings and being recorded on tape was a new and threatening experience. The trainer's anxiety was focused on his limited experience in this type of training process.

Essentially, the participants shared written and verbal

problems they were experiencing in the work setting. Seven of their problems were selected and structured for the participants to solve in the group support exercise. The broad categories included: input, job satisfaction, interpersonal relationships, management of residents, and task requirements. Because of time limitations, the group dealt with only five problems.

Care was taken so that participants did not use this aspect of training as "gripe" sessions. The dynamics of group interaction, decision-making, mutual support, and communication were highlighted for the participants.

The outcome of the group support exercise revealed that participants had grasped the use of group as a method for problem solving. Responses from the taped exercises were rated against Bale's "A Set of Categories for the Analysis of Small Group Interaction." If the category of responses moved toward a solution, it was rated positive. The participants showed a positive movement toward problem solution in all categories.

Among the many avenues stimulated by the group support exercise was a feeling that creative alternatives exist. At the end, the participants felt a need for this phase of training to be a longer period. It seems evident that the use of a support group is an appropriate unit of training for staff in proprietary home settings.

Three months after the program ended a follow-up questionnaire was administered. This measure attempted to

explore the extent participants had implemented aspects of the program. A typical question was, "Have you met as a group?" All fourteen participants returned to participate in the follow-up study.

The responses demonstrated that training did have some lasting impact. Seven of the participants indicated some participation in a group activity. Thirteen of the respondents tried to seek further information about mental illness.

Esprit de corps was at a high level during all phases of the training program. This was demonstrated by regular attendance, arriving early, and staying behind for extended discussions. At the conclusion of the program, the participants planned a party which was held at the home of a participant and attended by all who completed the program. On that occasion, the trainer presented certificates of course completion to each participant. The trainer was pleasantly surprised to receive a gift as a token of their appreciation.

The results of this study bring into focus a particular category of paraprofessionals in the mental health field. Subjects who participated in this program reflected many of the characteristics attributed to paraprofessionals in related settings. They were lacking in formal education and had no special training for employment. An identifiable difference was the absence of organizational resources to enhance job performance and role expectation.

The nature of the organization (adult homes) was seriously considered in the application of a training model for this study. The selection of training events which minimized organizational conflict was deemed desirable. The flexibility of the therapeutic community model allows social learning on all levels. Therefore, the point of training intervention could begin from a variety of strategies. In the design of this study, paraprofessionals were used to introduce the concepts of the therapeutic community to their places of employment.

In the training, participants were able to learn the composition of those individuals who are important to the achievement of the goals of a therapeutic community. It was clearly spelled out to the participants that the success of a therapeutic community depends upon team work and the concept of community. For instance, most therapeutic communities have as participants, a physician, social worker, nurse, patients, psychologist, aides, and recreation therapist. Since all proprietary homes do not employ such staff on a regular basis, the implementation for some of the therapeutic community principles and practices was limited. It should also be noted that, teaching methods used to help the participants understand the dynamics of working in a therapeutic community came from a variety of sources. The imitative approach of modeling as advanced by Bandura was used extensively.

Even though adequate training resources were provided,

the training site placed limits on sample size and scope of the training program. It would have been desirable to include a larger sample of paraprofessionals working in adult proprietary homes. The involvement of administrators and other adult home personnel could broaden the base for training and for the achievement of long term goals.

The utilization of paraprofessionals in adult proprietary homes is a recent development. This study is an opening wedge which provides an opportunity, in a beginning way, to learn more about this group of personnel. The staff working in these homes is confronted by the stress of working with former mental patients daily. They are not prepared for this population by either training or experience. Adult home operators have not developed strategies for responding to the legitimate needs of this group of employees. Steps to provide these linkages of support could provide the provision of knowledge, the modification of attitudes, and the use of support groups in training, as demonstrated by this study, and would be appropriate for staff of adult homes. Such training would help deal with the issues of job satisfaction, the sense of self-worth, and ultimately improved care and treatment of the residents.

Additional information on this target group of workers should be gathered. More should be known about their problems, needs, and limitations. Subsequent studies might utilize a sample size which permits results to be generalized.

Adult home administrators and those associated with their sanction must become more concerned for the paraprofessionals working in these settings. They must become concerned with how organizations impinges upon their performance. The participants in this study indicated a lack of recognition for problems they experience on the job, a share in decision-making and training needs. They felt no one was concerned with the stress and strain from their daily tasks.

This study clearly indicates that with appropriate training, this group can perform effectively. If the adult home alters its system of organization to include the needs of paraprofessionals, both will be able to articulate new priorities and values for the residents. One other impression suggest the linkages of management and union in developing means for improving conditions for this category of staff. This project also provides some baseline data on staff expectations.

Providers in both the public and private sectors must begin to address the issues of training and community care for the chronic ex-mental patient in adult proprietary homes. Both can best be served by collaborative planning on those issues that have prevented even sound and effective policies to be implemented.

As this study suggest, a lack of training and organizational issues present major limitations for staff in performing their tasks. To make effective use of personnel in

adult proprietary homes, the adult home industry must clarify its needs and priorities in terms of planning for full utilization of staff potential and optimal patient care. The participants in this study did response to a concept of team functioning, problem solving and the building of a therapeutic community.

Therefore, it is crucial for the adult home industry to develop a plan of action which includes educational programs to help staff become genuinely helpful. To provide alternatives within the organization to aid staff in dealing with stressful personal situations and the subtle changes of the chronic mental patient.

It is evident that adult proprietary homes have special needs. Unlike the traditional state hospitals, adult proprietary homes do not have the capability of shifting medical, educational, and financial resources. However, the outcomes of deinstitutionalization present many inadequacies in our present mental health delivery system. The adult home industry must assume the leadership in planning for a better system of care for the former mental patient in their care. This training program outlines approaches to meet many needs of these residents. In the end though, the adult home industry must bring to the attention of legislators, government officials, business leaders and consumer groups their need to provide full patient care and plan of action.

Shortly after the completion of this study, the

Department of Social Services, State of New York, officially indicated a need to further explore the training needs of administrators and staff working in adult proprietary homes. They hope to emphasize training and continuing education in the following areas: (1) The effects of various medications commonly taken by proprietary home residents; and (2) Social involvement and activity programming in adult proprietary homes.

The author's involvement with the use of paraprofessionals dates back to the development of the Ocean-Hill Brownsville Demonstration Project in the '60s. The use of paraprofessionals was supported by national policy. Roles, education, and functions were defined. The networks of services which were developed in the '60s included the planned use of paraprofessionals. In-service training was an effective tool in helping the paraprofessional meet the goals and objectives of the programs.

Major changes in the system of mental health care and the introduction of entrepreneurs as service providers has created massive shifts in services and personnel from the field of mental health to the field of social welfare. The participants described in this study represent an element of this transition. Professionals have an ethical responsibility to be sensitive and alert to such structural and organizational changes and their consequences. As previously indicated, this study was an effort to draw attention to the fragmentation and limitations of services created by an

upheaval in the system of care for the mentally ill.

Footnotes

[1]Peter H. Rossi and Walter Williams, _Evaluating Social Programs, Theory, Practice and Politics_ (New York: Seminar Press, 1972), p. 59.

Appendix A

Tables Relating to the Analysis of Data

TABLE A-1

Scores obtained on the Authoritarianism Factor of the Attitude Test Before and After Training

Subject	Before	After
1	35	27
2	32	23
3	18	19
4	38	30
5	32	31
6	28	17
7	36	27
8	17	18
9	29	34
10	25	33
11	38	37
12	37	33
13	34	34
14	25	19

TABLE A-2

Scores Obtained on the Benevolence Factor of the Attitude Test Before and After Training

Subject	Before	After
1	57	45
2	56	56
3	40	44
4	22	48
5	47	53
6	53	57
7	46	49
8	45	55
9	47	52
10	51	49
11	39	42
12	49	48
13	45	52
14	46	51

TABLE A-3

Scores Obtained on the Mental Hygiene Factor of the Attitude Test Before and After Training

Subject	Before	After
1	30	30
2	37	30
3	20	15
4	31	31
5	36	35
6	28	24
7	29	31
8	32	23
9	34	32
10	23	28
11	24	32
12	36	31
13	32	33
14	27	31

TABLE A-4

Scores Obtained on the Social Restrictiveness Factor of the Attitude Test Before and After Training

Subject	Before	After
1	24	22
2	29	21
3	18	16
4	36	29
5	26	18
6	19	20
7	24	25
8	13	15
9	20	21
10	17	17
11	35	30
12	27	30
13	19	31
14	25	16

TABLE A-5

Scores Obtained on the Interpersonal Etiology Factor of the Attitude Test Before and After Training.

Subject	Before	After
1	28	13
2	17	20
3	11	10
4	18	24
5	15	10
6	12	6
7	14	14
8	12	13
9	24	14
10	12	19
11	16	20
12	25	20
13	21	21
14	16	12

Appendix B

TRAINING MANUAL

Developed As An In-Service Training Tool For Paraprofessionals in Adult Proprietary Home

Training Manual

Module #I

Purpose:

An introduction of the participants to the training program

The nature of the training program is described to the participants:

A. Moral treatment of the mentally ill - Improving the care of the mentally ill in a proprietary home.

B. Increasing the skills of the participants - Techniques that will help the participants provide better care to the mentally ill.

C. Some topics to be considered:
   1. knowledge of mental illness
   2. The transitional setting
   3. Interpersonal relationships
   4. Communications
   5. Attitudes toward mental illness

Module #I

Outline

1. Each participant and the session leader will introduce themselves. The session leader will acknowledge all of the participants. Session leader will provide the participants with a time frame for the training session.

2. Have the participants complete the demographic questionnaire. Explain the importance of this instrument. Provide assistance as needed.

3. Hand out to participants a schedule of the training session. Explain the importance of attendance at each meeting.

4. Elicit from participants their experience in a therapeutic community. Ask for volunteers. Evaluate and discuss their point of view.

5. Pass out to the participants the hand out, "Towards Clarification of the 'therapeutic community' Concept" by Maxwell Jones, edited by Jean J. Rossi, Ph. D and William J. Filstead, Ph. D.

6. Provide the participants with an operational description of the therapeutic community. Based on the works of Karasu, et al describe the prevailing concept of a therapeutic community.

7. Each participant will bring to the next session a question about the therapeutic community based on the article by Maxwell Jones. The session leader will answer and discuss some of these questions at the next session.

8. Remind participants of the time and place for the next session. Our topic for the next session, Module #2.

See you next week!

References

1. Morgan, Arthur J., & Moreno, Judith W., The Practice of Mental Health Nursing: A Community Approach J. B. Lippincott Company, Philadelphia, Copyright 1973.

2. Clark, Alfred W., and Neville T. Yeomans, Fraser House, Theory, Practice and Evaluation of a Therapeutic Community, Springer Publishing Company, New York 1969.

3. Frank, Jerome, Persuasion and Healing, The John Hopkins University Press Maryland, 1961.

Module #I Aspects of lesson plan

I. The concept of a "helping " community arose partly from interpersonal psychiatry, partly from the historical tradition of moral treatment, and partly from experiences of British psychiatrists during World War II.

II. The initial enthusiasm for the "helping" community in Europe was followed by equally hopeful introductions in America.

III. The revival of the interest of milieu therapy and its implication for the "helping" community.

   A. Explain milieu therapy
   B. How it is related to the therapeutic community.

IV. The issues raised as to whether "helping" community is an idealogical model or practice model.

V. What are some positive characteristics of a "helping" community?

   A. Social interaction
   B. Problem solving
   C. Decision-making by resident
   D. Humanization
   E. Resident participation in activities of daily living
   F. Extention to other communities, i.e. immediate community, family, other agencies, etc.
   G. Team relationship

VI. The "helping" community can be a useful modality for improving the provision in most proprietary homes for enhancing the behavior of residents, improving communication, and the development of positive functional role models.

VII. What are some of the concluding limitations in utilizing the concept of a therapeutic community?

   A. Setting - Medical, etc.
   B. Rapid turnover
   C. Failure of adapting principles of helping community that apply to "your" setting, i.e. we have a population of residents who are mostly ex-mental patients with a psychiatric diagnosis of Schizophrenia.

What is this phenomenon that we call Schizophrenia?

Schizophrenia is the most prevalent of the psychotic disorders and probably the most feared psychiatric diagnosis. The four classic and primary symptoms of schizophrenia are known as the four A's:

1. Disturbances in association (loosened)
2. Affect (flattened)
3. Ambivalence
4. Autism (withdrawal from real world and preoccupation with idiosyncratic thoughts and fantasies)

VIII. The major question: The <u>values</u> of the institution and the staff, and how <u>they relate</u> to the residents in our care.

Can the Concepts and Principles of the "helping" community be the answer?

*Helping has been substituted for therapeutic.

<u>Synonyms for therapeutic</u>:

1. Help

2. Assistance

3. Corrective

4. Alternative

5. Relief

6. Aid

7. Cure

Training Manual

Module #2

Purpose:

To demonstrate to the participants how therapeutic (helping) communication differs from ordinary communication.

To define the various differences in helping communication and ordinary communication.

That participants will be able to distinguish helping communication from ordinary communication.

Outline

1. A definition of communication will be described to the participants. For emphasis the session leader will write the word COMMUNICATION on the blackboard.

2. Participants will be asked to describe examples of helping communication from ordinary communication.

3. The group leader will provide the participants with a descriptive guide to the communication process as an agent in mental healing.

4. The use of attitude in molding the behavior of the resident in the communication process. An example of resident vs. participants attitude in the communication process will be presented.

5. Thank each participant for their attention and participation. Distribute handout on communication.

References

1. Ruesch, Jurgen, M.D. Therapeutic Communication. W.W. Norton & Company, Inc., New York Copyright 1973. pp. 138-139.

2. Redl, F. and Wineman, D.: Controls From Within Glencoe: Free Press, 1952.

3. Ruesch, J.: The Schizophrenic Patient's Ways of Communication in Congress Report (1957) vol. 4. Zurich: 2nd International Congress for Psychiatry, 1959.

Module #2 Aspects of lesson plan

I. Communication is a universal function of man that is not tied to any particular place, time or context; and basically communication which produces a therapeutic effect in no way differs from what happens in ordinary exchanges.

II. Generally therapeutic communication involves more than just the therapist and the patient. A child can be therapeutic for the mother and a boss can be therapeutic for his employees; therapy is done all day long by many people who do not know that they act as therapist, and many people act as therapist without knowing it.

III. Therapeutic communication is remedial in that a person who has learned to relate effectively will be able to accept the inevitable while steering his existence in matters where he has some choice.

IV. Therapeutic communication thus presupposes the presence of several people, one of who must be wiser, more mature, and more skilled in communication than others; and if this more able person uses his skills to develop the communicative functions of the immature, young, or seriously disturbed individual, then he is engaging in therapeutic communication.

V. At times, this process is referred to as therapy; at other times as education; some call it counselling, others simply friendship.

VI. But regardless of the exchange, therapeutic becomes apparent when other person has a certain readiness to understand; to acknowledge, and to reply. This has been aptly referred to as the "therapeutic milieu."

VII. What is the aim of therapeutic communication?

a. Improve resident's behavior
b. Improve speech and language
c. To help the resident experience fully activities of daily living
d. To share experiences with others
e. Self-realization for the resident
f. Promote individuality
g. Induce the resident to seek more gratification
f. Develop confidence and trust

VIII. The vacuum phenomenon is characterized by the particular

feeling that the other person does not respond. One plainly gets the feeling that the other person is not there. It may be a blank stare, facial expression seems to be non-participating, their posture does not acknowledge, and they have nothing pertinent to contribute.

IX. Whenever the therapist encounters such characteristics as listed above in residents, several steps can be taken:

1. Acknowledge that the individual is in need of help
2. Prolonged and consistant contact will bring about some amelioration
3. Be observant
4. Comment on areas that are concrete to promote indication, i.e., menus, activities, visit, family, trips, etc.
5. Timely visits are important

X. Unfavorable attitudes of the patient toward his illness can be changed gradually, through responsiveness, into attitudes which will favor improvement. A sample of such attitudes may read as follows:

Attitude of the resident	Attitude of a therapist
This is an illness, for which I am not responsible	This is a way of adapting, but perhaps there are better ways.
I want to please you	What pleases me most is your functioning well.
You do not understand me	I listen, and I try to understand you.
Tell me what to do	We will discuss each problem as it arises.
I cannot say it	When you are ready, you will talk.
I want things to go my way	It takes a great deal of skill and thought to control people. You have a lot of learning to do.
I expect to improve	If you work hard at it, you will improve.

Attitude of the resident	Attitude of a therapist
You will cure me	If you work on your problems, you will understand yourself better.
If I get into trouble, you are to blame	If you get into trouble, you will bear the consequences.

The formation of this module is based primarily on the book, Therapeutic Communication by Jurges Ruesch, M.D.

Training Manual

Module #3

Purpose:

To introduce "Role Playing" to the participants.

To demonstrate the value of this teaching tool in helping the participants to view themselves and to look at the actions and behavior of others.

Provide the participants with an atmosphere which offers feedback and insight to particular individuals.

To help participants gain greater awarness of the resident's feelings and behavior.

To increase the opportunity of the participants to actively participate in the program.

Outline:

1. Provide the participants with information on the techniques of role playing and its relevance.
2. For emphasis and interest the group leader will act out an appropriate role-playing sequence, i.e. "a resident who is sleeping and needs to be awaken".
3. Request from the participants examples of some common problem situations they have experienced.
4. Organize the group to role-playing two of the most relevant examples.
5. Group leader and participants to discuss the session.
6. Have participants to list how the role-playing was helpful.
7. Pass out information for next class, "environment and the residents." Stress the importance of attendance and being on time.

References

1. Read, Donald A. and Simon, Sidney B. Humanistic Education Source Book Prentice-Hall, Inc., Englewood Cliffs, New Jersey. 1975 "Role Playing in the Classroom" by Mark Chester and Robert Fox, pp. 421-432.

2. Smith, Daniel M., Theoretical Foundations of Learning and Teaching, Xerox Publishing, Walthaman, Massachusetts, 1971.

Module #4

Purpose:

To discuss with the participants the social and emotional aspects of residential care.

To share with the participants components of residential care which can enhance the fulfillment of the residents physical, social and emotional needs.

Outline

1. Ask the participants to define a residential setting.
2. Go over with the participants their feelings about a residential setting.
3. See what expectations the participants have about residential care.
4. Go over with the participants certain principles that underlie residential care.

<u>SOME TOPICS TO BE CONSIDERED</u>:

A. The sense of self is almost always threatened by drastic changes in life style, location, and through the loss of independence.

B. No matter how welcoming strangers may be, the person who newly enters into situations where others have been before him, tends to feel lonely, isolated, often unwanted and generally endangered.

C. Part of a sense of one self emanates from and is illustrated by the uniqueness of one's clothing. Most persons feel that, within certain limits, they are different from others. Having one's own clothing, caring for them, wearing them in one's own way, underlines that one is somebody.

D. Difference is a matter of right: Equal treatment confirms it.

E. The emphasis on institutional efficiency at the expense of individual dignity also contributes to one of the most distressing aspects of institutional living: The loss of sense of "self". In exchange for having his physical needs met, the resident often must surrender his psychological sense of self. In exchange for the security of a closed communal life, the resident may lose touch with the outside world and his sense of belonging to it.

References

This session is based on a project conducted by the National Institute of Mental Health, 1971. The title of the publication, "It can't be home..."

Training Manual

Module #5

Purpose

To review highlights of training sessions to date.

Provide the participants with the expectations for the next two sessions.

Give the participants an opportunity to ask questions.

Introduce the session on Psychotropic Drugs.

Outline

1. This session will be taught by Barbara Manning, R.N., Community Mental Health Nurse at Creedmoor Psychiatric Center, Queens, NY.

2. Two sessions will cover the important aspect of psychotropic drugs and their significance in the treatment of mental illness.

3. The instructor will cover such medication issues as follows:

   A. Practical Pharmacology of Psychotropic Drugs.

   B. Considerations the psychiatrist use in prescribing medication.

   C. The potential of Psychotropic Drugs.

   D. Helping residents towards the adaptive experience of drug therapy in a transitional setting.

References

DiMascio, A., and Shader, R.I. Clinical Handbook of Psychopharmacology. New York, Science House, 1970.

Greenblatt, E.J. and Shader, R.I. "The Clinical Choice of Sedative - Hypnotics." Annotated Internal Medicine, 1972.

Hollister, L.E. Clinical use of Psychoterapeutic Drugs Springifeld, Illinois: Thomas, 1973.

Shader, Richard, Manual of Psychiatric Therapeutics Boston, Massachusetts, 1975.

Training Manual

Module #8

Purpose

Introduce staff to field visit to Kingsboro Psychiatric Center, Brooklyn, New York or to Creedmoor Psychiatric Center, Queens, New York.

Have participants to evaluate their observations.

Conduct a question and answer period after the field visit.

Outline

1. Coordinate field visit.
2. Pass out evaluation form.
3. Direct participants to assigned ward to observe.
4. Follow-up: Discussion groups

Demographic Questionnaire

This instrument was constructed to gain certain information about the participants. For example, questions #1, #2, and #3 will yield information about the participants age, sex, and grade level. Other questions will provide some indication of perception, skill, knowledge, and self-esteem.

Questionnaire
Helping Skills: A Basic Training Program
For Staff In An Adult-Home

1. Name________________________ Address____________________

2. Date of Birth________________

3. Highest grade completed______

4. Marital status_______________

5. Length of time on present job____

6. Previous work experience________________________________

____

7. List courses taken in mental health____________________

____

8. In-service training courses attended__________________

____

9. Race______________________________

10. Do you describe yourself as an excellent, fair, poor employee? (circle one)

11. Do you think you could benefit from training?
Yes__________ No_________

12. Do you have a special skill? Please identify. (example, play the guitar, piano, etc.)

____

13. What does your adult home need most?

____

____

14. Write briefly your definition of mental illness._______

____

____

____

Instrument to Measure Attitude

This standarized instrument contains statements which can effectively measure attitudes toward mental illness. The scale which was developed by Cohen and Struening contains five factors: Authoritarianism, benevolence, mental hygiene, social restrictiveness, and interpersonal etiology.

The instrument was administered to seven mental health therapy aides at Kingsboro Psychiatric Center, Brooklyn, New York. They are comparable to the participants for the project. A follow-up discussion with the group found that they understood the test and had no problems following the directions.

The plan is to give this test before the program begins and to administer the test again once the program ends.

Please check ( ) in the space provided that choice which comes closest to saying how you feel about each statement. You can be sure that many people, including doctors, will agree with your choice. There are no right or wrong answers: we are interested only in your opinion. It is very important that you answer every item. Please do NOT sign your name.

1. Nervous breakdowns usually result when people work too hard.

   strongly agree_____ agree____ not sure but probably agree_____ not sure but probably disagree____
   disagree____ strongly disagree_____

2. Mental illness is an illness like any other.

   strongly agree_____ agree____ not sure but probably agree_____ not sure but probably disagree_____
   disagree____ strongly disagree_____

3. Most patients in mental hospitals are not dangerous.

   strongly agree_____ agree____ not sure but probably agree_____ not sure but probably disagree_____
   disagree____ strongly disagree_____

4. Although patients discharged from mental hospitals may seem all right, they should not be allowed to marry.

   strongly agree_____ agree____ not sure but probably agree_____ not sure but probably disagree_____
   disagree____ strongly disagree_____

5. If parents loved their children more, there would be less mental illness.

   strongly agree_____ agree____ not sure but probably agree_____ not sure but probably disagree_____
   disagree____ strongly disagree_____

6. It is easy to recognize someone who once had a serious mental illness.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

7. People who are mentally ill let their emotions control them: normal people think things out.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

8. People who were once patients in mental hospitals are no more dangerous than the average citizen.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

9. When a person has a problem or a worry, it is best not to think about it, but keep busy with more pleasant things.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree______

disagree_____ strongly disagree_____

10. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everyday life.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

11. There is something about mental patients that makes it easy to tell them from normal people.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

12. Even though patients in mental hospitals behave in funny ways, it is wrong to laugh at them.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

13. Most mental patients are willing to work.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

14. The small children of patients in mental hospitals should not be allowed to visit them.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

15. People who are successful in their work seldom become mentally ill.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

16. People would not become mentally ill if they avoided bad thoughts.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

17. Patients in mental hospitals are in many ways like children.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

18. More tax money should be spend in the care and treatment of people with severe mental illness.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree____

disagree_____ strongly disagree_____

19. A heart patient has just one thing wrong with him, while a mentally ill person is completely different from other patients.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree____

disagree_____ strongly disagree_____

20. Mental patients come from homes where the parents took little interest in their children.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree____

disagree_____ strongly disagree_____

21. People with mental illness should never be treated in the same hospital as peole with physical illness.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree____

disagree_____ strongly disagree_____

22. Anyone who tries hard to better himself deserves the respect of others.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree____

disagree_____ strongly disagree_____

23. If our hospitals had enough well trained doctors, nurses, and aides, many of the patients would get well enough to live outside the hospital.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree____

disagree_____ strongly disagree_____

24. A women would be foolish to marry a man who has had a severe mental illness, even though he seems fully recovered.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

25. If the children of mentally ill parents were raised by normal parents, they would probably become mentally ill.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

26. People who have been patients in a mental hospital will never be their old selves again.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

27. Many mental patients are capable of skilled labor, even though in some ways they are very disturbed mentally.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

28. Our mental hospitals seem more like prisons than like places where mental people can be cared for.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

29. Anyone who is in a hospital for a mental illness should not be allowed to vote.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

30. The mental illness of many people is caused by the separation or divorce of their parents during childhood.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____
disagree_____ strongly disagree_____

31. The best way to handle patients in mental hospitals is to keep them behind locked doors.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____
disagree_____ strongly disagree_____

32. To become a patient in a mental hospital is to become a failure in life.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____
disagree_____ strongly disagree_____

33. The patients of mental hospitals should be allowed more privacy.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____
disagree_____ strongly disagree_____

34. If a patient in a mental hospital attacks someone, he should be punished so he doesn't do it again.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____
disagree_____ strongly disagree_____

35. If the children of normal parents were raised by mentally ill parents, they would probably become mentally ill.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____
disagree_____ strongly disagree_____

36. Every mental hospital should be surrounded by a high fence and guards.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

37. The law should allow a woman to divorce her husband as soon as he has been confined in a mental hospital with a severe mental illness.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

38. People (both veterans and non-veterans) who are unable to work because of mental illness should receive money for living expenses.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

39. Mental illness is usually caused by some disease of the nervous system.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

40. Regardless of how you look at it, patients with severe mental illness are no longer really human.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

41. Most women who were once patients in a mental hospital could be trusted as baby sitters.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

42. Most patients in mental hospitals don't care how they look.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

43. College professors are more likely to become mentally ill than are business men.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

44. Many people who have never been patients in a mental hospital are more mentally ill than many hospitalized mental patients.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

45. Although some mental patients seem all right, it is dangerous to forget for a moment that they are mentally ill.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

46. Sometimes mental illness is punishment for bad deeds.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

47. Our mental hospitals should be organized in a way that makes the patient feel as mush as possible like he is living at home.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

48. One of the main causes of mental illness is a lack of moral strength or will power.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

49. There is little that can be done for patients in a mental hospital except to see that they are comfortable and well fed.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

50. Many mental patients would remain in the hospital until they were well, even if the doors were unlocked.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

51. All patients in mental hopsitals should be prevented from having children by a painless operation.

strongly agree_____ agree_____ not sure but probably agree_____ not sure but probably disagree_____

disagree_____ strongly disagree_____

Test About Mental Illness

This instrument was constructed from the content of the training course. It is designed to yield participant's knowledge in three basic areas: Methods, therapeutic interaction and information about mental illness. It has been reviewed by a panel of six experts in the field of mental health. They have made many suggestions and feel it is appropriate for the participants.

In addition, the test was given to seven staff members at the Kingsboro Psychiatric Center. The staff is comparable to the participants for the training program and was able to understand the directions for the test.

OPINIONS ABOUT MENTAL ILLNESS

Directions: Listed below are statements about the mentally ill. This is not a test. Please read carefully all statements and check only one of the responses noted. Circle True, if you think the statement is correct. Circle False, if you think the statement is in-correct.

1.	Teaching residents to participate in decision making promotes growth of the individual.	True	False
2.	All persons with mental illness have to be placed in a mental hospital.	True	False
3.	When a resident is acting out, (yelling, cursing, pacing) one can be most helpful by trying to understand that the resident is trying to give a message.	True	False
4.	Residents are kept in adult homes because they are dangerous to self and others.	True	False
5.	Activity provides an opportunity for residents to express their feelings with the support of others.	True	False
6.	The majority of mentally ill residents like to be alone and idle.	True	False
7.	Our attitude towards the mentally ill resident can be most effective in maintaining the therapeutic relationship.	True	False
8.	To be "therapeutic" is most commonly defined as to be "helping."	True	False
9.	One of the tasks in a helping community is to promote a team relationship.	True	False
10.	A major goal of a well run adult home is to provide an excellent environment for the residents, therapy, encouraging them to remain.	True	False

11. The use of medication is not very significant in the treatment of the mentally ill. <u>True</u> <u>False</u>

12. Society wants everyone to lead a normal life. <u>True</u> <u>False</u>

13. The best environment for the mentally ill is in a country surrounding. <u>True</u> <u>False</u>

14. With some residents, taking a stern and forceful approach may have desirable therapeutic results. <u>True</u> <u>False</u>

15. For the most part, all mental patients are alike. <u>True</u> <u>False</u>

16. Communiation is an important factor in developing a helping relationship. <u>True</u> <u>False</u>

17. Force must be applied to residents who do not take their medication. <u>True</u> <u>False</u>

18. When necessary, scapegoating (several staff or patients ganging up against another patient) is good to keep the patient in line. <u>True</u> <u>False</u>

19. Because of their condition, the mentally ill do not require the rights of normal people. <u>True</u> <u>False</u>

20. "Sex" is important in the lives of the mentally ill. <u>True</u> <u>False</u>

21. The licensing of adult homes helps to maintain standards for the mentally ill residents. <u>True</u> <u>False</u>

22. Ms. Jones was heard by a staff as saying "I want to kill myself." The staff should talk with Ms. Jones about this. <u>True</u> <u>False</u>

23. It is desirable for staff to be readily available to the residents. <u>True</u> <u>False</u>

24. Attitudes of staff have no relationship to the development of the helping community. True False

25. An appropriate goal of the adult home staff in a helping community is to set demands that will lead to the improvement of the resident. True False

Helping Skills Program

Queens Adult Homes

1. Thinking back over the time since you participated in the training program, which of the following do you feel are applicable in your case?

Check One ( )	Yes	No
A. Gained new knowledge which has been useful to you...		
B. Developed some skills in working with residents...		
C. Found helpful ideas, solutions through informed discussions with the group...		
D. Felt better working within the organization (Adult Home)...		
E. Can confront administration about problems, ideas, and frustrations after the training program...		
F. We have met as a group to discuss problems, ideas since the training program...		
G. The training program stimulated me to acquire more information about my job...		

Check One ( )	Yes	No
H. I have participated in another training program since the Helping Skills Program...		
I. The Adult Home Administrator respects the training that I received in the Helping Skills program...		

Please list any other comments:

____

____

____

2. In light of your experience since attending the training program, what topics would you recommend or suggest to be added or omitted?

   To be added ______________________________

   ____

   ____

   To be omitted ______________________________

   ____

   ____

3. Given your participation in the training program, how would you now rate your overall degree of satisfaction with the program as a whole.
   (check one)

   Quite satisfied.............. ________

   Fairly well satisfied......... ________

   Satisfied but not enthusiastically............. ________

   Somewhat dissatisfied........ ________

   Quite dissatisfied........... ________

4. Have you considered furthering your job as a result of the training program? ______yes ______no

   If yes, please comment:________________________________
   ____
   ____

Thank you

Field Visit Observation Form

Write your impressions of the field visit:

What did you think of the patients?

Identify problems you observed.

What would you change to improve the ward?

Circle one: The field visit was: Excellent

Good

Fair

Poor

SCRIPTOGRAPHIC BOOKLETS

The following Scriptographic Booklets will be given to each participant at various stages of the training program:

1. "What everyone should know about stress" - helps people understnad the causes of stress and ways to alleviate it.

2. "What everyone should know about mental illness" - explains some of the main causes, symptoms and treatments of mental illness.

3. "Your attitude and you" - explains what is an attitude and why it is so important.

4. "Who's Prejudiced?" - Is a commonsense analysis of human interaction. It stimulates better understanding among people.

These unique booklets offer a fresh approach to some basic problems we all face in dealing with the world around us. They are concerned with individuals and their relationship to themselves, to their families and to society.

These graphic, easy-to-read booklets are highly effective in the education and counseling programs.

CMB:lmb
10/3/77

East New York Mental Health Clinic

394 HENDRIX STREET ▫ BROOKLYN, NEW YORK 11207 ▫ (212) - 345-6302

Executive Director
JOHN E. WILLIAMS, CSW

Chairlady, Board of Directors
MRS. BARBARA C. HAIRSTON

Medical Director
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Deputy Director, Coordinator of Services
Richard J. Mason, M.A.

Adult Services, Division X
Kingsboro Psychiatric Center
681 Clarkson Ave., Ward 6
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Division Chief
Cleveland M. Black, CSW, acting

Team Leaders
Enid Cohen, R.N., B.S. - In-Patient Unit
Sue Harris, Ph. D. - Out-Patient Unit

Day Treatment Center
George R. Fleming, Jr., Ph. D. - Director

Supervisors of Treatment Services
Marie Arce, MSW
Edna F. Baxter, MSW - Intake Unit
Patricia A. Briggs, R.N. Nursing
Dorothy L. Moore, M.S.W. Training
Jan F. Selby, S.T.M., M.S.W.

Affiliated Psychiatrists
Joseph Herson, M.D.
Hong J. Kim, M.D.
James A. Mastrota, M.D.
Dorothy Saffron, M.D.
John C. Saunders, M.D.
Julia L. Schneider, M.D.

September 30, 1977

Administrator

The Queens Adult Home Program announces a Training Program For Staff In Adult Homes. This is an opportunity for staff in Adult Homes to develop skills and learn about Mental Health Care in a transitional setting. The program begins Tuesday, October 18, 1977 and ends Tuesday, December 20, 1977.

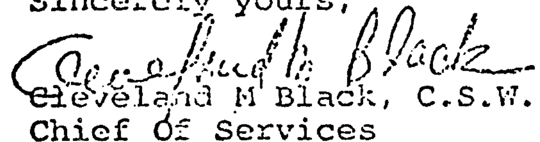
Enclosed you will find a brochure outlining the design of the program. The program is eligible for all Aides, Service Workers, Porters, Administrative Aides, and Kitchen Personnel employed in Adult Homes located in Rockaway, Queens.

We hope you will take this opportunity to share in an educational experience that will increase the skilled care for residents in your home.

Should you have further questions, please contact Cleveland M. Black, C.S.W. Telephone 735-1538, Monday - Friday, 9:00 - 5:00 P.M.

Hoping to see your staff representative in this training program.

Sincerely yours,



Cleveland M Black, C.S.W.
Chief Of Services

em/cb

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EXECUTIVE DIRECTOR

September 27, 1977

Mr. Cleveland M. Black
Kingsboro Psychiatric Center
681 Clarkson Avenue
Brooklyn, New York 11203

Dear Mr. Black:

In response to your letter of September 6, 1977 we are sending you a copy of the Board rules for adult homes, which contain the information about a number of the areas mentioned in your letter.

The operators of adult homes establish the monthly rates charged to their residents, and these vary according to whether the residents are private paying guests or recipients of Supplementary Security Income (SSI).

In regard to staff training in proprietary homes, the Board has a rule requirement regarding continuing education hours for administrators. Hopefully, they provide in-service training for their staff. The latter sometimes involves training provided by after-care staff from psychiatric centers and Board staff (nutritionists and field staff).

We do not have any literature available on the history of proprietary homes in New York State. These homes were supervised by the county departments of social services until December 31, 1964 and became subject to Board approval and supervision by the State Department of Social Services thereafter. In July 1971 supervision of these facilities became the sole responsibility of the Board of Social Welfare. In October, 1977 this responsibility will revert to the State Department of Social Services, which will amend the current rules to reflect the 1977 legislation regarding mandated personal allowance for residents, fines for non-compliance, residents rights, etc.

I trust that the above information will be helpful. Thank you for your interest in writing.

Sincerely yours,

Irwin M. Lasky
Sr. Social Services Consultant

IML/vab

Selected Bibliography

Albee, George W., and Wissim Denis, "Clinical Psychology," Hospital and Community Psychiatry 27 (July 1976): 496.

Almond, Richard. The Healing Community. New York: Jason Arson, 1974.

Anastasi, Anne. Psychological Testing. New York: The Macmillan Company, 1968.

Bandura, Albert. Principles of Behavior Modification. New York: Holt, Rinehart and Winston, Inc., 1969.

Bockoven, Sanbourne, J. Moral Treatment in Community Mental Health. New York: Springer Publishing Co., 1972.

Bunker, H.A. "The Mental Health Disciplines," Hospital and Community Psychiatry 27 (July 1976): 479-505.

Carter, Novia and Wharf, Brian. Evaluating Social Development Programs. Ottawa, Canada: The Canadian Council on Social Development, 1973.

Clark, Alfred W., and Yeomans, Neville T. Fraser House, Theory Practice and Evaluation of a Therapeutic Community. New York: Springer Publishing Co., 1969.

Ellsworth, Robert B. Nonprofessionals in Psychiatric Rehabilitation. New York: Appleton-Century-Crofts, 1968.

Encyclopedia of Social Work, 1971 ed. S.V. "Profession of Social Work: Aides," by Leonard Schneiderman.

Flinn, Don E.; May, P.R.A.; Jolyon, Louis. Integrating the Treatment Approaches to the Schizophrenic Syndrome. New York: Grune and Stratton, Inc., 1976.

Gartner, Alan and Riessman, Frank. "The Paraprofessional Movement in Perspective," Personnel and Guidance Journal 53 (December 1974): 256.

Goldberg, Gertrude S. "Nonprofessionals in Human Services, In Nonprofessionals in the Human Services, p. 26. Edited by Charles Grosser. San Francisco: Jossey-Bass, Inc., 1971.

Grob, Gerald N. Mental Institutions in America. New York: The Free Press, 1973.

Hardcastle, David. "The Indigenous Nonprofessional in the Social Service Bureaucracy: A Critical Examination," Social Work 16 (April 1971): 59.

Hilgard, Ernest R. and Bower, Gordon, H. Theories of Learning. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1975.

Karno, Marvin and Schwartz, Donald A. Community Mental Health: Reflections and Explorations. New York: Spectrum Publications, Inc., 1974.

Klein, William. "The Training of Human Service Aides," In Emergent Approaches to Mental Health Problems, p. 150. Edited by Emory L. Cowen. New York: Appleton-Century-Crofts, 1967.

Litwak, Eugene and Meyer, Henry J. "A Balance Theory of Coordination Between Bureaucratic Organizations and Community Primary Groups," Administrative Science Quarterly 2 (June 1966): 37.

Maxwell, Jones. Maturation of the Therapeutic Community, An Organic Approach to Health and Mental Health. New York: Human Science Press, 1976.

Melick, Clifford F., and Eysaman, Charles O. "A Study of Former Mental Patients Placed in Private Proprietary Homes," Hospital and Community Psychiatry 29 (September 1978): 589.

Minuchin, Salvador. "The Paraprofessional and the Use of Confrontation in the Mental Health Field," American Journal of Orthopsychiatry 39 (October 1969): 729.

Mitchell, Lonnie. "Nonprofessionals in Mental Health," In Nonprofessional in the Human Services, p. 93. Edited by Charles Grosser. San Francisco: Jossey-Bass, Inc., 1971.

Moursund, Janet P. Evaluation: An Introduction to Research Design. Monterey, California: Brooks/Cole Publishing, 1973.

New York State Department of Social Welfare. Principles and Rules for Domiciliary Care Facilities for Adults and Guide to Interpretation of the Rules, 1972.

New York State. State Attorney General's Office. Private Proprietary Homes For Adults. A Second Investigative Report Issued Pursuant to Executive Law, Section 63 (8) by Charles J. Hynes, 31 March 1979, p. 8.

Reiff, Robert. "Mental Health Manpower and Institutional Change," In Perspectives in Community Mental Health, p. 5. Edited by Arthur J. Bindman and Allen D. Spiegel. Chicago: Aldine Publishing Co., 1973.

Reissman, Frank. "Strategies and Suggestions for Training Nonprofessionals," Community Mental Health Journal 3 (Summer 1967): 105-106.

Rossi, Peter H. and Williams, Walter. Evaluating Social Programs, Theory, Practice and Politics. New York: Seminar Press, 1972.

Ruesch, Jurgen. Therapeutic Communication. New York: W.W. Norton and Sons, 1961.

Sarri, Rosemary C. and Hasenfeld, Veheskel. The Management of Human Services. New York: Columbia University Press, 1978.

Siporin, Max. Introduction to Social Work Practice. New York: The Macmillan Co., 1975.

Smith, Daniel M. Theoretical Foundations of Learning and Teaching. Waltman, Massachusetts: Xerox College Publishing, 1971.

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

The Committee on Therapeutic Care Group for Advancement of Psychiatry. Toward Therapeutic Care: A Guide for Those Who Work With the Mentally Ill. New York: Springer Publishing, 1970.

Weiss, Carol H. Evaluation Research. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1972.

Wilensky, Harold L. and Lebeaux, Charles N. Industrial Society and Social Welfare. New York: Russell Sage Foundation, 1958.