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Education for
Community Psychiatry

Formulated by the
Committee on Medical Education

Group for the Advancement of Psychiatry

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This report is the fifth in a series of Reports and Symposiums that will comprise Volume VI. For a list of other GAP publications on topics related to the subject of this report, please see page 536.
STATEMENT OF PURPOSE

The Group for the Advancement of Psychiatry has a membership of approximately 185 psychiatrists, organized in the form of a number of working committees that direct their efforts toward the study of various aspects of psychiatry and toward the application of this knowledge to the fields of mental health and human relations.

Collaboration with specialists in other disciplines has been and is one of GAP's working principles. Since the formation of GAP in 1946 its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisages a continuing program of work according to the following aims:

1. To collect and appraise significant data in the field of psychiatry, mental health, and human relations;
2. To re-evaluate old concepts and to develop and test new ones;
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations.

GAP is an independent group and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

Education for Community Psychiatric was formulated by the Committee on Medical Education.*

* The Committee wishes to express its indebtedness to Leo W. Simmons, Ph.D., Department of Sociology and Anthropology, Western Reserve University, who served as Consultant on this report. While it was being formulated, two GAP Fellows worked with the Committee: Abraham Twerdik, M.D., Department of Psychiatry, University of Pittsburgh Medical School; and B. Gerald Dabbs, M.D., The University of Texas Southwestern Medical School. Paul Haun, M.D., was a member of the Committee during the time of formulation of the report.
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INTRODUCTION

A major impetus to the development of community psychiatry was provided by the Community Mental Health Centers Act of 1963. This Act of Congress makes it necessary to review psychiatric residency training programs to determine whether they are providing adequately trained personnel to staff community psychiatry centers and to carry out the various programs that the Act envisages.

First we have to clarify what community psychiatry entails before we study training for community psychiatry. The exciting developments in this field have led the Committee on Medical Education of GAP to examine the meaning and educational implications of community psychiatry. The committee has also gathered information about some of the developing patterns of training in this area and has formulated comments about the issues involved.

CURRENT FORMULATION

Community psychiatry is an evolving aspect of psychiatry in which the psychiatrist accepts responsibility within a population or functional unit for the promotion and establishment of programs of promotion of mental health, prevention, early case finding, and treatment. Community psychiatry accomplishes these goals through public education, as well as program conceptualization and operation. A primary tool of functioning is the mental health consultation that may be directly patient-centered, indirectly patient-centered, agency-centered, or program-centered. The focus is on advising and educating professionals who are in contact with clients or potential patients and/or who are influential in determining policy in various organizations. The source of the request, the administrative authority, the source of payment, and the implementation of the recommendation continue to reside with the organization.

Community psychiatry has been conceived of as a new medical specialty, an emerging subspecialty of psychiatry, or as an integral part of all effective psychiatric practice. As community psychiatry develops, it is likely to come to mean all three of these as interpreted and applied by the individual practitioner.

Community Psychiatry in Action

Functioning community psychiatrists were studied by the committee as guides in estimating the goal of the educational experience. College or industrial psychiatrists may be used as examples of community psychiatrists; their evolving roles illustrate the necessary change in points of view. For example, when a psychiatrist
first joins an industrial organization or accepts responsibility for the mental health of students, he is asked to diagnose and treat or to refer individuals who request such help or whose behavior has aroused concern. This orientation is identical to that existing in the usual clinic. As he becomes increasingly familiar with the physical and social environmental forces impinging on his patient, the psychiatrist includes this knowledge in his diagnostic appraisal and treatment plan. Common social elements affecting patients in this circumscribed environment come to his attention, enabling him to discover and promote means of modifying these elements to benefit increasingly larger segments of the group.

The psychiatrist's interest is drawn to factors beyond the problem of an individual patient. He may become interested in personnel not referred to him, involving such organizational problems as low productivity, absenteeism, and any obvious aberrant behavior traceable to personality or situational disorders. As his relationship with administrative personnel becomes closer, the psychiatrist may be asked to help with problems of selection and placement. The psychiatrist now is making judgments about relatively healthy persons and is affecting the organization through his screening techniques. The next step could potentially be psychiatric involvement in matters of policy. By then the psychiatrist's functioning has been expanded far beyond the traditional clinical model.

The psychiatrist is then less occupied in seeing individual patients and begins to make judgments about who else can deal best with particular problems in particular individuals. This complex indirect method offers individual and group consultation to those who deal directly with the person that is currently in crisis or is showing some signs of disorder. When successful, such consultations also help the individual to manage similar situations more ably in the future or at least to recognize when he is over his head. The psychiatrist is now involved in the emotional well-being of organizations or population units. The nature of his functioning will be partially determined by the implicit and explicit needs of the specific community he serves, whether police
<table>
<thead>
<tr>
<th>Body of Knowledge or Theory</th>
<th>Bread Geish</th>
<th>Closest to Patient</th>
<th>Degree of Responsibility for Patient</th>
<th>Type of Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual biologic or psychologic diagnosis and treatment of individuals or small groups (Biochemical or Neurophysiological) (Psychoanalysis) (Group Dynamics)</td>
<td>Treatment of Mental Illness</td>
<td>Close</td>
<td>Primary</td>
<td>Diagnostic and Interpretive</td>
</tr>
<tr>
<td>Program Research and Evaluation</td>
<td>Reduction of Prevalence and Incidence of Mental Disorder</td>
<td>Intermediate</td>
<td>Secondary</td>
<td>Correlative, Supportive in language of committee</td>
</tr>
<tr>
<td>Ecologic, Epidemiologic, Social System (Social Psychiatry)</td>
<td>Positive Mental Health</td>
<td>Far</td>
<td></td>
<td>Language of Organization or population</td>
</tr>
</tbody>
</table>

department, school, rural county, a circumscribed area of a large city, and so on. Such consultation may be centered on the individual patient, the functioning of the organization, or the establishment of new services. Usually the consultation is conducted for the agency or organization in the language of the consultant.

Many psychiatrists already spend a portion of their time in such consultation activity. Major commitment to private practice or to the offering of traditional services in a public setting is frequently combined with functioning as a community psychiatrist consultant.

As a community planner or organizer, the community psychiatrist is responsible for suggesting and partially implementing social and psychiatric services for a geographic, population, organizational, or functional unit. He may get help from the disciplines of sociology, ecology, and epidemiology, as well as from the traditional medical disciplines. Examples of this type of functioning are state commissioners of mental health and planners with the federal, state, or local government.

**Modes of Community Psychiatry Activity**

In attempting to examine the relationships between traditional clinical practice and community psychiatry, the committee found it helpful to prepare the accompanying chart, "The Differentiation of Community Psychiatry" (Fig. 1), and to define certain nodal points of practice. The nodal points chosen were clinical practitioner, the community psychiatry consultant, and the community psychiatry planner or organizer. Each mode of activity was compared with regard to the following characteristics: (1) activity, (2) to whom directed, (3) body of knowledge or theory, (4) broad goals, (5) closeness to patients, (6) degree of responsibility for individual patient, and (7) type of communication.

The chart is designed to help the reader understand the goals of the educational process. Although the principal effort of most psychiatrists is clinical practice, this portion of the chart is abbreviated, for our purpose is best served by focus on the interface
between traditional clinical practice and community psychiatric practice. It should be emphasized that there is considerable fluidity between these various nodal points of practice. \textit{Individual shifts from one activity to another may occur within a single day or even a given contract.}

The committee strongly believes that psychiatric skills develop best beginning at the top of Figure 1, evolving gradually toward the bottom of the chart. Other approaches to training are being studied in certain training programs.\textsuperscript{3} At the current level of knowledge, we are convinced that while psychiatrists may fulfill many roles in community health activities, intimate, extensive, and intensive knowledge of the operation of the individual human being is primary. This develops best from experience as a doctor who has assumed clinical responsibility for individual patients. (This is elaborated below under “Curriculum Changes.”)

\textbf{Social Psychiatry}

Some clarification about the term \textit{social psychiatry}, as distinguished from \textit{community psychiatry}, is in order. Social psychiatry generally refers to that branch of psychiatry which is concerned with broad social factors that influence major segments of society in the direction of mental health and mental illness. At the present state of data gathering in this field, there are essentially no practitioners of social psychiatry as such. Those individuals currently working in the field of social psychiatry are devoting themselves primarily to investigation and development of theory. In contrast, community psychiatry means practical applications of theory at the various levels described in the chart.

\textbf{Impact of the Community Psychiatry Movement on General Psychiatric Residency Programs}

The introduction of material about community psychiatry into a three-year residency training program leads to a number of issues. These relate to the program director, the teaching faculty, multidisciplinary teaching, and changes in curriculum.

\textbf{Issues Involving the Program Director}

The teaching-learning changes implicit in the concept of community psychiatry requires self-assessment by the Program Director. This “new” movement is a challenge to his sense of professional identity and skills, as well as to his effectiveness as a model for his residents. He may find himself inadequately motivated or equipped to teach his students a new professional role and unfamiliar content. The ability to meet the challenge of a new teaching effort varies with the personality of the educator and his years of experience in psychiatry and teaching.

If he feels unwilling or unable to prepare himself suitably, he should delegate this teaching to others—ideally, to colleagues who have special interest and experience in community psychiatry.

As this committee emphasized in a previous report, the \textbf{Pre-Clinical Teaching of Psychiatry},\textsuperscript{4} it is difficult to translate intellectual concepts into functional operation. For example, the community psychiatry teacher must come to grips with what Srole\textsuperscript{5} described as the culture-bound difficulty of an observer perceiving the individual and his environment simultaneously.

Using a variety of community resources for the patient’s benefit in a well-organized treatment plan requires some changes in the
psychiatrist's functions, attitudes, and role perception. Let us consider the example of the private practitioner of psychiatry who has regarded himself as the sole treatment resource for his patients. He would be less adept at working with members of various professional disciplines and with nonprofessional personnel than the hospital psychiatrist who has been accustomed to using the total resources of the hospital community for his patients' benefit.

Teaching community psychiatry will obligate the psychiatric educator to devise field assignments for his trainees outside the psychiatric ward or hospital or outpatient clinic. Field experience in community institutions, such as schools, police departments, courts, industries, social agencies, and churches, poses new administrative problems for the psychiatric program and its director. He will need adeptness in public relations, communication, and collaboration in order successfully to share educational responsibilities with nonmedical agencies. Such potential new training resources depend primarily on the availability of local community agencies and their willingness to accept the intrusion of psychiatric students and their supervisors into their work arenas and inner sanctums. In order to accomplish this, the psychiatric teacher may have to relinquish some, but not all, supervisory and technical teaching to persons outside his own training institution.

In adding the teaching of community psychiatry to his training program, the program director will have to review his entire teaching program and reassess his goals. The persistently gnawing question "training for what?" is unavoidable. He must search through a morass of conflicting and overlapping terms and concepts in order to find practical formulations and objectives that somehow make sense to him. He may even reconsider his selection procedures for applicants to his training program. For example, if in the past he has based his selection of residents on criteria emphasizing skills in one-to-one relationships, does he now broaden his criteria of acceptable residents to include those who are interested in dealing with groups and the larger community?

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**Issues Involving the Teaching Faculty**

The program director, attempting to influence his psychiatric colleagues in their appreciation of community psychiatry, will encounter obstacles and resistances. Community psychiatry may be perceived more as a "demand" from outside than as an evolution within the field of psychiatry.

Community psychiatry seems to challenge the psychodynamic frame of reference in that it places emphasis on environmental stresses in causing behavioral difficulties and maladjustments. Thus, treatment methods are aimed at effecting adaptation rather than intrapsychic reorganization. Social adaptation, however, may have far-reaching personality ramifications in some instances and be superficial in others. "Deep" and "superficial," "external" and "internal" are oversimplifications of complicated frames of references and may lead to name-calling without real substance to the accusations.

Community psychiatry seems to say that change is easy to evoke while psychoanalytic theory points to how difficult it is to effect changes. However, this is only a seeming contradiction. The changes are not the same in the two instances. There is a place and need for both kinds of change—those that come out of social action and those that come out of individual psychological exploration.

Some faculty members may feel there is a choice between clinical, psychoanalytic psychiatry versus community psychiatry. In the committee's opinion, this should not be an either/or argument. Dynamic psychiatry is not being replaced—it is being enriched. The enrichment would derive from the awareness of the constant interplay between the intrapsychic and the external stresses. This would further lead to an increased ability to make practical use of the community and its resources.

A problem in this orientation is that the focus is on the patient as a member of a group or groups and that the psychiatrist's position may seem diminished. This is particularly evident when he must rely upon nonmedical people to modify and broaden his role as a mental health practitioner.
The program director may have established a community psychiatry training program. If the faculty fails to appreciate its worth, however, instruction in community psychiatry quickly becomes segregated from the main training goals. It will be incumbent upon the program director to find techniques for involving his colleagues, such as devising meetings and other procedures for clarifying their thinking, formulating definitions, establishing guidelines, and delineating roles to be assumed and taught.

An obstacle that frequently confronts the psychiatric faculty is lack of responsiveness by the residents when new concepts and practices are introduced. Thus, they may interpret community psychiatry as "second-rate" psychiatry when they compare it with the widely esteemed exploration of intrapsychic phenomena. Psychiatric residents may insist that they are already fully committed to other tasks and responsibilities. During their first year of training, they are primarily concerned with their own personal development. They tend to resist encroachment upon the intimacy of the doctor-patient relationship.

**Issues Involving Multidisciplinary Teaching**

The training program director may have to organize or expand a multidisciplinary faculty. Srole suggests that the authoritative psychiatric teacher can no longer operate alone. As community psychiatry educator, he must be supplemented by the equal-status, multidisciplinary teaching team. Rosenbaum and Zwerling have described the problems confronting the psychiatrist in attempting to integrate his teaching activities with those of the social scientist who approaches the task from quite a different frame of reference, such as social systems theory. This is quite different from the approach of the biologist, physiologist, biochemist, or even psychologist who speaks a much more understandable language for the psychiatrist. Then comes the task—with all its status complications—of the relationship between the biological and the social scientists, not to mention the feelings of each toward the psychiatrists.

The attainment of a productive multidisciplinary team requires complex alterations in the composition of the teaching staff. The experience of actually having practiced community psychiatry is a great advantage. Since such an organization requires good communication among the disciplines involved, implicit differing frames of reference must be made explicit. For example, the psychiatrist should cultivate an understanding of the anthropological point of view, while the sociologist should become acquainted with the clinical point of view. The issue of who teaches what is very complicated. There could be some very convincing arguments for having each member of a discipline teach some aspects of another discipline. Thus a psychiatrist often is readily understood by other psychiatrists when he is talking about group dynamics or sociology from his own vantage point.

The most unfortunate occurrence is that which we described in multidisciplinary teaching in courses to the medical students in the behavioral sciences. There occurs a fragmentation of a number of viewpoints with no cohesive force pulling these views together. This is less likely to occur in dealing with actual situations and consultations than in a seminar discussion about theoretical issues.

The development of a multidisciplinary effort in a behavioral science framework within a psychiatric department could lead to further separation of psychiatry from general medicine. The psychiatric educator who imports nonmedical staff has the added burden of making his ambitious community psychiatry-oriented attitudes acceptable to his medical and surgical colleagues. In some general hospitals, the clinical psychologist and the psychiatric social worker are barely tolerated now. When a psychiatrist adds a sociologist, a social psychologist, a cultural anthropologist, a statistician, and an epidemiologist to his department, the medical staff feels threatened as though by an invasion of strangers. As we noted previously, a psychiatric department may come to resemble a small self-sufficient academic group.

Knowing where and how to get the additional personnel essential to an effective community psychiatry effort poses a practical
problem. Bernard has pointed to the advantage of locating a community psychiatry training program in a university medical center because of the "richness and diversity of its faculty, laboratories, and other resources, and because it provides access to variegated student body and community psychiatry consumer groups." Many psychiatric residency programs, however, are not situated in university medical centers with these "rich resources" readily at hand. This lack is a handicap in presenting an up-to-date curriculum. However, residents could be sent to one or more affiliated special facilities for brief visits as observers or for longer assignments as participants.

Issues Involving Curriculum Changes

In considering the addition to the curriculum of training in community psychiatry, the psychiatric educator must identify the special knowledge and skills necessary for effective community work and then decide how and when to add them to his program without threatening the existing quality of training or the professional development of the residents as clinical psychiatrists. Although extensive direct experience in community psychiatry is crucial for the training of fourth- and fifth-year residents as specialists in the field, the amount of practical experience needed to present a point of view about community psychiatry in the three-year residency poses a moot question.

One obvious problem concerns the decision as to how much emphasis to continue placing on the one-to-one doctor-patient model in the training experience. In our opinion, it is impossible for the psychiatric trainee to learn about people without extensive and intensive one-to-one doctor-patient interaction—regardless of the resident's future plans. Some authors emphasize the difference between standard clinical training and teaching the new subspecialty of community psychiatry. They stress that social and community psychiatrist must be concerned about cultural, social, and familial factors and their etiological relationships to mental illness and mental health. The extreme of this position is that the psychiatrist should treat the community, not the individual patient. This committee concurs with the majority of writers who emphasize that this is no either/or problem: "Clinical insights are as important to the methods and techniques of mental health services for non-psychiatric agencies and professions as they are to the services offered directly to patients." Community psychiatry is considered as supplementary to the psychiatrist's core skill, his one-to-one clinical approach.

The doctor-patient model contributes further to the goals of community psychiatry by teaching the resident to use those aspects of the one-to-one relationship that are relevant to consultation in different settings.

The chart on page 496 of this report may be used as a general guide for the development of the psychiatric resident with an interest in community psychiatry. He should master the knowledge, attitudes, and skills represented at the top of the chart (clinical practitioner) before attempting specialized work as a consultant or, later, as organizer and planner.

An essential part of the community psychiatry educational program in the regular three-year residency is the presentation of data about community agencies and institutions. The psychiatrist who intends to work in the public schools needs to know something about educational processes, learning theories, the functions of special classes, and even the curricula of teachers' colleges. The psychiatrist who is going to be a consultant to legal and penal agencies should become familiar with the adversary method of trial procedure, the operations of a police juvenile bureau, techniques of probation and parole, and the philosophy of corrections. For similar reasons, the curriculum may include material on industrial organization, labor-management relations, and the mental health of executives. In another program the curriculum might include material about the administrative hierarchy of a religious sect, the multiple-pastor church, the clergyman as pastoral counselor, and theological attitudes toward anxiety, sin, and guilt.

Practical work in more than one setting is desirable in order that the student may learn to apply the experience he gains from
one aspect of the community to another. Such multiple experiences will help him derive general principles of community psychiatry.

Teaching students how to teach, particularly how to teach nonmedical people, should be emphasized. The psychiatric consultant should be an articulate instructor, capable of clearly transmitting psychiatric knowledge and insights in an organized presentation that is free of jargon.

A special task that the psychiatrist increasingly faces is the evaluation of "normal" people. For example, psychiatrists are often requested to evaluate applicants for the Peace Corps or other candidates for overseas assignments, inductees for the military service, medical students, and trainees for police departments.

This committee recommends the introduction of community psychiatry concepts to the psychiatric resident during the three-year program. Curriculum changes or additions appropriate to the training of second- or third-year residents are uncertain and have scarcely been commented on in the literature. Though there is much room for experimentation, it must be more than just an intellectual presentation of material in a lecture course or seminar if it is to have maximum effectiveness. The resident needs opportunities to identify himself "with a faculty which is actively engaged in the practical application of community psychiatry concepts to patient care in the ordinary clinical settings in which the resident customarily works." The objective is to bring about more "community psychiatry mindedness." This is analogous to endorsing "research mindedness" as a training goal. Not all residents become researchers; nor should all aspire to become community psychiatrists. However, all should be aware of both fields.

A study of current training practices in community psychiatry reveals a variety of methods used in different residency programs. These methods vary with the goals of the program, its location and available training facilities. They differ with respect to timing, type, and extent of the educational experience; supervisory processes; and the content of didactic seminars. The existence of changing patterns of training within particular centers suggests that training is still evolving. The following examples present a summary of representative programs throughout the country.

**Programs Teaching Community Psychiatry During the General Psychiatric Residency Program**

The usual program of this type is designed to increase the resident's awareness of the field and to train community-minded general psychiatrists. Most programs include three major elements: (1) The resident is given the experience of relating to a variety of community health, education, and welfare agencies as an observer, participant, or consultant. These experiences may be part-time, extending over months or years, or full-time in a block rotation for several months; (2) individual or small group supervision of this experience; and (3) didactic seminars. These experiences are either preceded or accompanied by training in current psychiatric theory and practice. Hospital consultation, interdisciplinary collaboration, ward administration, and patient ecology often provide important basic skills that can be transferred with modification to settings outside the hospital.
Training sites include courts and correctional institutions, schools, social agencies, recreation centers, vocational and rehabilitation clinics, homes for the aged, and public health facilities. The opportunity to spend limited amounts of time in observing several settings and a more intensive experience in one setting provides both breadth and depth.

The resident’s response depends more on the attitudes of leadership within the department, the quality of supervision, and the availability of models for identification, than on his own motivation.

Seminars in community psychiatry during the basic residency are usually of two types. Experience-oriented seminars characterized by group sharing and group supervision of experiences in the field offer the opportunity to extend perspectives and increase understanding of the similarities and differences between settings. Subject-oriented seminars introduce the resident to public health concepts and practices, the epidemiology of mental illness, community organization, and related social science theory. Such seminars are taught in different programs at first-, second-, and/or third-year levels.

Still another training technique, which has occasionally been used, is the special workshop devoted to community psychiatry. Here the resident, usually during a period of one or two weeks, gets an intensive experience in observation and in introduction to the body of knowledge and theory that is the basis for community psychiatry practice.

Other programs offer an opportunity for a full-year elective in community psychiatry in the third year of residency training. This experience is on the borderline between the programs described above and the more specialized postresidency experiences described below.

Programs Offering Postresidency Training in Community Psychiatry

These programs accept trainees for a one- or two-year period at the third-, fourth-, or fifth-year level. They frequently include all elements previously described but are most intensive and extensive. Field placements usually involve at least one extended contact in which the trainee becomes an important element in the functioning of the agency or institution. The multiple functions of the mental health consultant are emphasized, as well as planning and organizational functions of the community mental health specialist. Research is usually encouraged and may be required. Supervision is on an individual and a small-group basis.

Didactic courses include such topics as statistics, ecology, epidemiology, public health theory, social science theory, the psychology of small groups, principles of administration, community organization, government, financing, the law, research methodology, and communication techniques. These training programs not only prepare the individual for roles involving work in and consultation with community facilities, but also provide the background for roles involving policy development and the organization of services for population units, geographically or organizationally.
CONCLUSIONS

1. Community Psychiatry is an important facet of psychiatry that is making an impact through a number of professional, social, and political channels.
2. Community Psychiatry is an extension of clinical psychiatry and is complementary and supplementary to it.
3. Community Psychiatry implies an attitude and an orientation that enriches clinical practice.
4. Community Psychiatry is becoming an integral part of general psychiatry, as have such other areas of specialization as child psychiatry, psychosomatic medicine, and applied psychoanalysis.
5. Psychiatric educators should include training in Community Psychiatry in the basic three-year curriculum of the psychiatric resident.
6. The traditional core skills of clinical psychiatry are an indispensable foundation for training in Community Psychiatry.
7. The amount and kind of Community Psychiatry content and experience included within the three years of residency training should be differentiated from the specialized curricula and subsequent years of training required for the community psychiatry subspecialist.
8. All residency programs cannot and should not be tailored to the same mold. The teaching method will vary according to the primary objectives of the program and the specific characteristics of both the hospital and the community.
9. A respected faculty member with a primary interest in Community Psychiatry should serve as a model for the trainee and foster Community Psychiatry in a training program.

REFERENCES

BIBLIOGRAPHY

Training


General

Following is a selected group of references. This list is not all-inclusive but will permit the interested reader to explore further into the subjects from bibliographies contained in the references cited.

In order to make this report as current as possible, the committee asked representative institutions for descriptions of their programs in Community Psychiatry as of January, 1966. This compendium by no means includes all institutions doing such training but is representative according to our information of what is going on in the United States at the present time.

The program descriptions were submitted by program directors and were not evaluated by the committee. They are reproduced here with only minor alterations. We are well aware that many centers have programs in Community Psychiatry that are not contained in this Appendix; inclusion in this compendium is in no way an endorsement of these programs. The principle that guided us in choosing the following programs for description was simply that the committee members had some direct or indirect contact with these programs.

**Name of Training Program:** Albert Einstein College of Medicine
Division of Social and Community Psychiatry
Department of Psychiatry

**Program Director:** Israel Zwerling, M.D., Ph.D.

**Address of Program Director:** 2327 Eiebe Avenue
Bronx, New York 10461

**Objectives of training program:**
(a) To provide training in basic skills (family treatment, group process, and mental health consultation) essential to community psychiatric practices, and to provide an orientation to social determinants of illness and to the use of community resources in treatment and rehabilitation, for all psychiatric residents; (b) To train specialists in social and community psychiatry.

1. A six-month seminar (weekly 2-hour meetings) on Family Process and Family Diagnosis.
2. A six-month seminar (weekly 2-hour meetings) on Group Process and the Therapeutic Community.
3. A two-month seminar (weekly 1½ hour meetings; part of a didactic sequence in General Psychiatry) on Social Psychiatry (readings on cultural value orientation, social class, ethnic, national and community determinants of behavior, and on the social role of a psychiatrist).

**B. Second year (15 residents)**
1. One morning a week, all year, on Brief Therapy (clinical work in the Community Walk-In Clinic; conference weekly on case presentations on crisis theory and on the use of community resources in diagnosis and treatment).
2. Clinic assignments include outpatient supervised experience with Family Therapy and Group Therapy.

**C. Third year (15 residents)**
A four-month, half-time (25 hours per week) rotation, required for all residents (except the chief resident), in the Division of Social and Community Psychiatry, including:
1. Mental Health Consultant Service: a weekly didactic seminar (1½ hours) on mental health consultation and community organization, plus one half-day per week of supervised clinical work as consultants to a community agency (Family Court, Public Health Nurse, Visiting Nurse Association, Local Officer, Clergy, or Welfare Department Supervisors projects).
2. Supervised Brief Family Therapy assignments.
3. Supervised Brief Group Therapy assignments.

**II. Social Psychiatry Fellowship Program (3 to 5 Fellows)**
(for one or two years, at 4th-year and 5th-year levels)
Three Fellows are appointed each year, selected from a growing number of applicants. Each Fellow's program is individually tailored to fit his special interest—in school mental health work, rehabilitation, epidemiology, family and group process. However, each Fellow's program includes some time assigned to:
1. Didactic sequence on Social Psychiatry, Communications Theory, Epidemiology, and Research Design.
2. The Day Hospital, and treatment of psychotic patients concurrently with individual, family, and group therapies.
3. Advanced Family Treatment Seminar.
5. Research—each Fellow must be accepted into one of the ongoing Division projects, or design a small project of his own.

**Name of Training Program:** Boston State Hospital  
**Program Director:** Milton Greenblatt, M.D.  
**Address of Program Director:** 591 Morton Street  
Boston, Massachusetts 02124

*(1) Objectives of training program: There are two training programs—the basic three-year and the advanced two-year programs. The objectives of the basic training period are to provide first-, second-, and third-year residents with introductory supervised experience and education in community psychiatry. This required training occurs within the context of a comprehensive residency education, including extensive, analytically-oriented study of individual patients. The Advanced Program for interested fourth- and fifth-year students offers intensive, full-time education toward psychiatric leadership of community-focused services and programs.*

*(2) Brief outline of program (including where appropriate, duration, course content, place of experience): The advanced resident may be assigned to develop and lead treatment programs within the hospital, such as brief-treatment units (Emergency Screening Service), rehabilitation of the chronically ill, day and night care, halfway house, and foster family care unit. He receives intensive education in techniques of home-visit treatment of patients and their families (Home Treatment Service). He learns about the treatment and rehabilitation of drug addiction through work in the hospital 10-bed inpatient unit. In relation to all the community-oriented services, advanced residents also obtain additional training in intensive psychotherapy, group therapy, and conjoint family therapy. Another important aspect of the advanced program is training in psychiatric consultation and education with diverse professional caregiving groups, e.g., general practitioners, physicians in general hospitals, clergy, public health nurses, as well as ancillary personnel within Boston State Hospital. Affiliated training is available in such areas as mental retardation and delinquency. Interested residents may have an apprenticeship in mental health planning with the state Department of Mental Health. All trainees are encouraged to participate in the research activities of the hospital that are open to them for study, collaboration, or individually-guided project work. Intensive social psychiatry seminar work is required of all trainees, thus affording theoretical instruction in community-social psychiatry and development of an integrated framework of sociological concepts. Guest experts in community psychiatry frequently participate in the program as lecturers, seminar leaders, and consultants. First-, second-, and third-year residents rotate through community-type services, such as Home Treatment, Day Hospital, Outpatient Clinic, and Emergency Screening Unit. They also attend formal didactic seminars that discuss "classic" studies in social and community psychiatry.*

*(3) Special or Unique Features: None*  
*(4) Number and level of trainees: Basic Residency Program: 33 trainees; Advanced Residency Program: 2 trainees.*  
*(5) Degree awarded if any: None.*

**Name of Training Program:** Center for Training in Community Psychiatry and Mental Health Administration  
**Program Director:** Portia Bell Hume, M.D.  
**Address of Program Director:** 2509 Milvia Street Berkeley, California 94704

*(1) Objectives of Training Program: (a) To formulate principles, methods, and criteria for the practice and teaching of Community Psychiatry and Mental Health Administration; (b) To offer advanced, sub-specialty training to psychiatric and parapsychiatric clinicians and administrators; (c) To supplement 3-year psychiatric residencies elsewhere with selected courses at the Center; (d) To promote affiliations with field-work placements that provide adequate, psychiatric supervision of trainees and that bring into practice the skills being taught; (e) To offer affiliations and consultation to psychiatric residency training programs and to professional schools.*

*(2) Brief outline of program (including where appropriate, duration, course content, place of experience): Four courses are offered in each of three sequences, that is, three courses are given each "quarter" of three months' duration; thus, 12 courses are taught each year via subject-seminars, reading seminars, tutorial sessions, and supervised practice in the field. The research sequence includes Descriptive Studies in Community Psychiatry, Biostatistical Research in Community Psychiatry, the Epidemiology of Psychiatric Disorders, and Program Evaluation in Community Psychiatry. The preventive services sequence includes Community Resources in the Practice of Comprehensive Clinical Psychiatry, The Structure and Functions of Nonpsychiatric Community Resources; Mental Health Education for Nonpsychiatric Agencies and Professions, for Planning and Legislative Organizations, and for the General Public; and Men-
nal Health Consultation for Nonpsychiatric Agencies and Professions. The administration sequence includes Community Psychiatry and the Law, Community Organization for Mental Health, Principles of Organization and Staff Development in Mental Health Programs, and Administration of Community Mental Health Programs. Each course involves a trainee in eight to 11 hours of work per week, except for the courses in the Summer quarter, which are full-time.

(3) Special or unique features: Not only is the faculty multidisciplinary but also four professions are taught together: psychiatrists (including psychiatric residents and fellows at the fourth- or fifth-year levels), psychiatric social workers at the post-Master's level, clinical psychologists at the post-Doctoral level, and public health-psychiatric nurses at the post-Master's level. Field work is in psychiatrically directed programs providing community-based, preventive services to nonpsychiatric agencies and professions, good supervision, research, and administrative experience. Part-time, as well as full-time, training is offered, making possible the completion of the curriculum by taking one course at a time over a three-year period, or in one year full-time.

(4) Number and level of trainees: In calendar 1965 there were 205 individual trainees, i.e., 88 psychiatrists (including 34 residents and 3 fellows), 69 psychiatric social workers, 30 clinical psychologists (including 2 post-Doctoral Fellows), 12 public health-psychiatric nurses, and 6 other (biostatisticians or administrators from the Department of Mental Hygiene admitted to selected courses for special reasons).

(5) Degree awarded if any: Full-time Fellows may supplement their training with required courses at the School of Public Health, University of California at Berkeley, if an M.P.H. degree is desired. The Center issues a certificate upon completion of its curriculum.

Name of Training Program: Columbia University
Training programs in Community and Social Psychiatry of the Division of Community Psychiatry of the Department of Psychiatry and the School of Public Health and Administrative Medicine

Program Director: Viola W. Bernard, M.D.
Address of Program Director: 630 West 168th Street
New York, New York 10032

(1) Objectives of training program: (a) To provide education in the techniques, concepts, and data of Community and Social Psychiatry in programs for training specialists in this field; (b) To supplement clinical train-

ing of the general psychiatric resident in the Department of Psychiatry; (c) To integrate mental health teaching into the curriculum of the M.P.H. and M.S. degree candidates in the School of Public Health and Administrative Medicine.

(2) Brief outline of program (including where appropriate, duration, course content, place of experience): Under (1) (a) five programs are in operation: (a) combined psychiatric residency and degree training in Community Psychiatry over a four-year period; (b) combined general psychiatry, child psychiatry residency, and degree training for Community Psychiatry over a five-year period (trainees can be accepted for the above two programs with advanced standing); (c) post-residency degree traineeship in Community Psychiatry over a one-year period; (d) mid-career degree programs 12-21 months; (e) special student—non-degree programs (full- or part-time, one year). The Community and Social Psychiatry trainee program consists of the following elements: (1) Core Curriculum—courses and seminars on the following subjects: Legal Aspects of Psychiatry, Psychiatric Hospital Administration, Special Areas and Development in Community Psychiatry, Interrelationships of Psychiatry with Allied Professions and Consultancy, Tools of Communication for Psychiatrists, a Seminar by Visiting Psychiatrists, Social Dynamics of Ward Management, Contributions in Social Psychiatry, Reading Seminar in Social Psychiatry, Principles of Administrative Psychiatry, Case Studies and Administrative Psychiatry, Governmental Processes and the Community, and Epidemiology of Mental Disorders. (2) Selected courses from the School of Public Health and Administrative Medicine and other departments of the University covering topics such as Biostatistics and Survey Research Methods. (3) Weekly field trips during the academic year to a wide variety of community and institutional agencies and services—rural and urban—medical and nonmedical. (4) Supervised field placements chosen from settings that emphasize prevention, rehabilitation, and community planning; organization and coordination of psychiatric and other mental health facilities: psychiatric care in general hospitals, public mental hospitals, and specialized psychiatric hospitals. Patterns of professional collaboration, consultation and education in relation to health educational, correctional, legislative and welfare personnel, techniques of research methodology and program evaluation.

(3) Special or unique features: (a) Curricula that are worked out individually, depending on trainee needs and objectives; (b) The resources of the Department of Psychiatry, The School of Public Health and Administrative Medicine, and other departments of the University, as well as selected community organizations and services, are available for individual program construction; (c) In the programs of combined residency and com-
psychiatric activities. He will be comfortable in moving to activities outside of the usual physician-patient relationship. This base of training or bias must be built into the total program. Our trainees will be in a favorable position to evaluate and accept changing responsibilities of the psychiatric practitioner.

(3) Special or unique features: Community visits of first-year residents centered around planning for selected inpatients.

Name of Training Program: Harvard Medical School
Educational Program in Community Mental Health of The Laboratory of Community Psychiatry
Department of Psychiatry
Gerald Caplan, M.D.
Address of Program Director: 58 Fenwood Road
Boston, Massachusetts 02115

(1) Objectives of training program: To train specialists in community mental health administration, education, planning, and research.

(2) Brief outline of program (including where appropriate, duration, course content, place of experience): The full-time educational program of the Laboratory of Community Psychiatry, Department of Psychiatry, Harvard Medical School, is geared to the needs and interests of the community mental health specialist. During the academic year from late September to early June, the student spends about one-half time in lectures and seminars given by the multidisciplinary staff of the Laboratory with the remainder of his time throughout the year spent in supervised field instruction and participation in community mental health research and practice. In addition, the student is a participant observer in the sessions of the Visiting Faculty Seminar in Community Psychiatry. At the end of the academic year students may elect a placement of two to three months in an ongoing community program as an internship experience. This is intended to complement the field training carried out during the year. The course content of the lectures and seminars covers such areas as research methodology, fundamentals of administration and planning, community dynamics, contributions of social science to community mental health consultation theory, group processes, legal aspects of community mental health, visual communication in professional education, and principles of preventive psychiatry. Field instruction in community mental health research and practice includes consultation practice, field visits related to seminars, a mental health research project, and placement in community agencies. Fellowships, which include stipend and tuition, are available from the Na-
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National Institute of Mental Health. Fellowships are also available through funds provided by the Grant Foundation, Inc., of New York.

(3) Special or unique features: The methods and techniques of consultee-centered consultation are taught under supervision. Each student has an individually planned program of supervised field instruction in community mental health research and practice, with opportunities to develop skills in community participation and social action with emphasis on understanding community processes.

(4) Number and level of trainees: 10-18. Multidisciplinary: Psychiatrists who have completed three years of approved residency. Psychologists with at least three years of postdoctoral experience. Social Workers with at least five years of community and supervisory experience. Nurses with a master's degree and supervisory experience in the public mental health field.

(5) Degree awarded if any: Certificate in Community Mental Health by the Courses for Graduates, Harvard Medical School.

Name of Training Program: Johns Hopkins University
Public Health-Mental Health
Department of Mental Hygiene

Program Director: Paul Lenkau, M.D.

Address of Program Director: Johns Hopkins University
School of Hygiene and Public Health
615 North Wolfe Street
Baltimore, Maryland 21205

(1) Objectives of training program: The program consists of a year of intensive training, approximately one-quarter of which is in bio-statistics, epidemiology, biological bases of the prevention of disease, environmental hygiene, and public health administration. Mental hygiene courses relate to personality development and environmental forces that influence health, and the opportunities to adjust these in healthful directions through action at individual, group, or community levels. Other courses study community practice in dealing with mental health problems, ranging from educational practice to those of state hospital systems. Seminars throughout the year deal with both theoretical and practical issues of mental health program administration and research topics. Students receive the M.P.H. degree after one academic year but are usually required to enlarge their experience through working in operating programs or through multiple observation during the rest of the year.

(2) Brief outline of program (including where appropriate, duration, course content, place of experience): Qualified psychiatrists, psychologists, nurses, and social workers are accepted in the program and work together throughout the year, along with the physicians, nurses, engineers, and other health scientists specializing in other programs in the School. Specialists in mental hygiene make up 10 per cent to 15 per cent of the class of approximately 70 students. Candidates for research degrees at the master's or doctoral level are accepted. Such candidates take two or three years to complete course work, a research project, and a thesis based on the research.

Name of Training Program: Langley Porter Neuropsychiatric Institute
Langley Porter Community Mental Health Training Program

Program Director: M. Robert Harris, M.D.

Address of Program Director: 401 Parnassus Avenue
San Francisco, California 94122

(1) Objectives of training program: This program offers two separate levels of training, namely, basic and advanced training. The Basic Training Program has as its goals the introduction and orientation to the community mental health field on an elective basis of third-year psychiatric residents, postdoctoral psychology fellows, second-year school of social welfare students, graduate students from the school of criminology, and medical students, all of whom are participating in training programs at Langley Porter and the Department of Psychiatry, University of California School of Medicine. The Advanced Training Program is offered to psychiatrists and clinical psychologists who wish to undertake postgraduate, specialty training in the field over a one- or two-year period.

(2) Brief outline of program (including where appropriate, duration, course content, place of experience): Basic Training Program: Generally offered as a six-month, half-time or full-time experience beginning in July and January. Training includes seminars, supervised field experiences, staff supervision, reading and reports. Students are introduced to network of community services, social and mental health problems, and practice skills of mental health professional including mental health consultation. Advanced Training Program: Full-time specialty training, covering one or two years, beginning in July of each year. Seminar instruction includes: (a) Methods and Practices Seminar in Community Mental Health Field, 1½ hours weekly; (b) Principles and Theory in Community Mental Health Field, 1½ hours weekly; (c) Discussion of Field Experience, 1½ weekly. Through a variety of field, agency, and program assignments, participants under supervision are expected to acquire knowledge of and expertise in mental health consultation, community organization, program planning and administration, committee membership and group dynamics, community research, and program evaluation. Each advanced
fellow undertakes an intensive study, both didactic and applied, of a particular problem or issue relevant to the community mental health field. Staff supervision, required reading, and reports are also major features of the program.

(3) Special or unique features: (a) Multidiscipline staff includes teaching participation from psychiatrists, social worker, psychologists, sociologists, anthropologists, and mental health nurse consultant; (b) Involvement of program includes over 50 different agencies and programs, facilitating the design of quite varied programs for participants; (c) Opportunity to "shadow" a number of community mental health specialists in their practice roles; (d) Opportunity for observation of and participation in rapidly expanding community mental health service programs in San Francisco and Bay Area.

(4) Number and level of trainees: Basic Program: Number of students varies. In each six-month period, there are generally four third-year psychiatric residents, or eight in academic year. Each academic year generally finds two predoctoral psychology fellows, one or two social work students, two criminology students, and two or more medical students participating. Advanced Program: Opportunity for four fourth- or fifth-year training appointments for psychiatrists at established National Institute of Mental Health stipend levels. In addition, there are opportunities for specialty training for clinical psychologists funded by postdoctoral support from sources independent of program.

(5) Degree awarded if any: None. (Certificate designating period of training awarded).

Name of Training Program: Johns Hopkins Hospital
Maryland Training Program in Community Psychiatry

Program Director: Howard M. Kern, M.D.
Address of Program Director: 208 Phipps Clinic
Johns Hopkins Hospital
Baltimore, Maryland 21205

(1) Objectives of training program: To expose senior psychiatric residents to a work situation in which they become aware of some of the issues confronting workers in the field of community mental health. Among these are the limits of the one-to-one doctor-patient relationship, the question as to who should be "running the show"; the problems of state hospital-community relationships and adequate provision for continuity of patient care; the series of attitudes best described as the public health approach; the meaning of consultation; the work being done by others in the field; the creative aspects of administration; the necessity for clear and meaningful communication; and the limits of the traditional team approach. Most important of all, the trainees are faced with the magnitude of the community's mental health needs, and are forced to realize that the traditional methods of psychiatric treatment are insufficient to meet these needs.

(2) Brief outline of program (including where appropriate, duration, course content, place of experience): One day a week for at least a year, 20 third-year psychiatric residents from seven training institutions in Maryland work in 14 county health departments. Each health department is staffed by a health officer and public health nurses, and a clinical psychologist and, in a few instances, a social worker attend on a one day a week basis. The trainees' work experience in the counties is supplemented by the following activities at "home base": individual sessions with the training program director and his assistants, weekly mental hygiene seminars, monthly small group meetings with training program consultants who represent various disciplines, and a monthly meeting of all trainees and consultants for discussion and comparison of activities. In addition, the program director and staff make occasional visits to the counties. The staff's relationship with the trainees is consultative as well as supervisory, and the trainees are encouraged to develop initiative and a healthy appetite for experimentation, skill in leadership as well as in consultation, and respect for the skills of others. In the counties the trainees divide their time fairly equally between direct treatment services and consultation to the mental health clinic and health department staffs, general practitioners, educators, the clergy, and social and judicial personnel.

(3) Special or unique features: (1) No senior psychiatrist present in the work situation, i.e., in the county health departments; (2) A work experience program, with little didactic material.

(4) Number and level of trainees: Twenty at present. All are in their third year of psychiatric residency, or are more advanced.

(5) Degree awarded if any: None.

Name of Training Program: Massachusetts General Hospital
Training in Community Mental Health for Psychiatrists

Program Director: Robert L. Bragg, M.D.
Address of Program Director: 112 Charles Street
Boston, Massachusetts 02114

(1) Objectives of training program: The objective of the program is to try to produce a psychiatrist who has integrated knowledge and techniques from the seven training areas emphasized (see (2), below) so that he can function effectively as a clinician-practitioner-administrator.
(2) Brief outline of program (including where appropriate, duration, course content, place of experience): This program, Training in Community Mental Health for Psychiatrists, is a one-year or two-year program for psychiatrists in the third, fourth and/or fifth year of residency training. It is one of four psychiatric career programs offered by the Psychiatric Service of the Massachusetts General Hospital, Boston. Seven areas for training are emphasized: (1) Community Processes, (2) Epidemiology, (3) Crisis Intervention, (4) Mental Health Constitution, (5) Group Dynamics, (6) Research Training in Community Mental Health and (7) Communication and Education. In addition to these some emphasis is placed on Administration and Child Development. The training in these areas is accomplished through the fellow’s participation in and attendance at didactic exercises associated with each of the training areas. These in turn are complemented by practical experiences in the various units of the Psychiatric Service of the Massachusetts General Hospital and associated field stations, of which the Human Relations Service of Wellesley, Inc., is the major one.
(3) Special or unique features: The ratio between didactic and practical experiences is about 40/60. This provides an opportunity for the Fellow to spend a great deal of his time in practical experiences. The Training in Community Mental Health is available to psychologists and social workers as well.
(4) Number and level of trainees: Three, i.e. fourth year of residency training; 2, fifth year of residency training.
(5) Degree awarded if any: None.

Name of Training Program: Menninger Foundation
Department of Preventive Psychiatry
Post-Residency Fellowship in Community Psychiatry

Program Director: Herbert C. Mollin, M.D.
Address of Program Director: Box 829
Topeka, Kansas 66601

(1) Objectives of training program: Development of community psychiatrists with special skills as (a) mental health consultants; (b) administrators of community mental health centers and programs; (c) investigators of psychosocial phenomena related to mental health and illness.
(2) Brief outline of program (including where appropriate, duration, course content, place of experience): This is a two-year program for psychiatrists who have completed three years of approved residency training. The program is administered by the Department of Preventive Psychiatry, Menninger Foundation. Division Assignment: Each Fellow will be assigned to one of the five divisions of the department: Law and Psychiatry, Religion and Psychiatry, School Mental Health, Industrial Mental Health, Psychosocial Research. He will be required to spend time in at least two of the divisions during his tenure and, at his election, may spend six months each in four divisions. He will participate, under supervision, in the ongoing work of each division, and will receive field placements in schools, industries, juvenile courts, multiple pastors churches, college campuses, OEO programs as indicated. Field Trips: Field trips on a twice-monthly basis will acquaint the Fellow in some detail with the many community agencies handling distressed people. Didactic Program: Seminars provided for the fellows will include a reading group in the basic literature of community and social psychiatry; substantive areas of community psychiatry (anyone intending to work in the public schools, for example, needs to learn about the educational process, learning theory, the rationale of special classes, and even the curriculum of teachers' colleges); the consultant to legal and mental agencies should be informed about the adversary method of trial procedure, the operations of a police juvenile bureau, techniques of probation and parole, and the philosophy of corrections; techniques of community practice including family and group dynamics, the consultation process, interprofessional collaboration, communications' theory, community organization processes, research design, epidemiology of mental disorders. Visiting Teachers: Selected experts will be invited to supplement the contributions of the permanent faculty, particularly in the areas of administration, public health psychiatry, and social science. Research: Each Fellow will be required to pursue an investigative project and write a paper summarizing his experience; during each year of training, Fellows will visit community psychiatry programs throughout the country and attend conferences and meetings potentially contributory to their education.
(3) Special or unique features: This program emphasizes (1) the role of the mental health consultant, i.e., the psychiatrist functioning in non-medical agencies with non-patients; (2) planning for and administration of mental health programs in centers and communities; (3) the substantive content of community psychiatry activities.
(4) Number and level of trainees: Four trainees in the fourth year; four in the fifth year.
(5) Degree awarded if any: None.

Name of Training Program: The Institute of the Pennsylvania Hospital
Community Psychiatry

Program Director: Perry Ottenberg, M.D.
Address of Program Director: 111 North 49th Street
Philadelphia, Pennsylvania
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(1) Objectives of training program: To supplement the basic clinical psychiatric residency training with academic and field experiences in community social agencies broadly defined, where psychiatrists can make valuable contributions in leadership or as members of the staff.

(2) Brief outline of program (including where appropriate, duration, course content, place of experience): A one- or two-year program in two parts:

Part A: A continuing seminar on all aspects of social problems; role definition of psychiatrists; problem areas of prejudice and discrimination in the community; community crises and disorganization due to a variety of causes; delinquency; urban renewal; foster child care and placement; hospitalization; administrative patterns of community mental health organization. Part B: Field placement in highly selected, well-supervised agencies in which the community psychiatry trainee will participate in whatever role seems to offer the most experience and usefulness to broaden his understanding and experience. This would include court agencies, adoption agencies, general hospitals, foster home placement agencies, halfway houses, Department of Welfare, schools, etc.

(3) Special or unique features: This program is devoted to the individual talents of the psychiatrists in order to help them find the community area aligned to their career aspirations.

(4) Number and level of trainees: Two trainees who have finished their basic psychiatric residency.

(5) Degree awarded if any: None.

Name of Training Program: University of Rochester School of Medicine and Dentistry
Division of Preventive Psychiatry
Department of Psychiatry
Training Program in Preventive and Community Psychiatry

Program Director: Elmer A. Gardner, M.D.
Address of Program Director: 260 Crittenden Boulevard
Rochester, New York 14690

(3) Special or unique features: In addition to what was mentioned above, the residents and the teaching staff have at their disposal a psychiatric case register that was initiated in January, 1960, encompassing all psychiatric service given to the population of Monroe County by both public and private sources. This register is used in teaching and in conducting follow-up studies in which the third-year residents participate. In follow-up analyses, they go to the patients' homes to study their functioning and residual pathology following a specified period, one to three years, after their discharge from psychiatric care. The residents also evaluate families in their homes with the Mental Health Team and carry those families
in therapy. The Team also operates as a catalyst to bring about better communication among the social and health agencies in this community.

(4) Number and level of training: (a) Second-year residents—12 in groups of three; (b) Third-year residents—3–6 (not less than three, nor more than six). Three residents during a six-month period; (c) one fourth-year fellow; (d) one fifth-year fellow.

(5) Degree awarded if any: None.

Name of Training Program: The University of Texas Southwestern Medical School Department of Psychiatry
Program Director: Robert L. Sublettefield, M.D.
Address of Program Director: 5323 Harry Hines Boulevard Dallas, Texas 75233

(1) Objectives of training program: To integrate community psychiatry training into general residency with special program for those more interested. Primary objective: to help the psychiatric practitioner develop a community approach.

(2) Brief outline of program (including where appropriate, duration, course content, place of experience): This two-year, postresidency program presently leading to an M.P.H. (a master's degree in Social Psychiatry from the UCLA Graduate Division has been applied for) involves 26 quarter hours of instruction from the Social and Community Psychiatry Division, 10 quarter hours from the School of Public Health, and 10 elective hours, including a thesis or a comprehensive examination. The courses taught by the Division of Social and Community Psychiatry are: The Social Sciences in Psychiatry; Social Psychiatry in Theory and Practice; Introduction to Community Structure; Concepts of Mental Health Consultation; Epidemiology of Mental Health; Social Class, Culture and Mental Health; and Administration in Community Psychiatry. The courses taught by the School of Public Health are: Biostatistics, Epidemiology, Environmental Health, and Public Health Administration.

(3) Special or unique features: (1) The Social and Community Psychiatry Fellows receive integrated training from both academic and practical experience. (2) The goals are two: (a) training in social psychiatry where the emphasis is placed upon basic research, theory building, and innovation validation; (b) training in community psychiatry where the emphasis is upon innovation, implementation, and administration for preventive psychiatry programs serving large populations. Concomitantly, interdisciplinary approaches to problems are stressed. Therefore, collaboration between social psychiatrists and community psychiatrists and other mental health specialists is a major concern during all aspects of training. (3) Currently, our Fellows are involved with a program providing information and communication between psychiatry and practical programs in the Watts-Compton area. This is being carried out by two social psychiatry Fellows and indigenous youth leaders from the Watts community.

(4) Number and level of training: 7 postresidency Fellows.

(5) Degree awarded if any: M.P.H.

Name of Training Program: University of California at Los Angeles Department of Psychiatry
Program Director: Frank Talman, M.D.
Address of Program Director: UCLA School of Medicine Department of Psychiatry
Los Angeles, California 90024

(1) Objectives of training program: The objectives of the postdoctoral program in Social and Community Psychiatry are to develop community mental health specialists who will possess skills in mental health program administration, techniques of consultation with non-professionals, preventive psychiatry for business and community agencies, research tech-
(1) Objectives of training program: (a) to develop practitioners in community psychiatry who will be especially interested in program development and evaluation; and (b) to train research workers who will bring to the field of mental health a coherent and consistent point of view on the relation between psychopathology and normal personality functioning, particularly in a social context.

(2) Brief outline of program (including where appropriate, duration, course content, place of experience): A two-year M.P.H. program, including the “core” curriculum in public health, and a mental health curriculum including the following courses. Introduction to social science concepts, epidemiology and control of mental illnesses, seminar in community psychiatry, seminar in social psychiatry, seminar in psychopathology and behavior, appropriate advanced courses in biostatistics and in the methodology of social research, and fieldwork and research application.

(3) Special or unique features: Course work is tailored to the needs of individual students, and courses are available by arrangement in other departments of the medical school and the university. Field work placements are designed to acquaint students with community health and welfare problems and with changing practices in the community organization of psychiatric services.

(4) Number and level of trainees: Not more than 6–8 students at any one time, including psychiatrists, social workers, psychologists, nurses, etc.

(5) Degree awarded if any: In addition to the M.P.H. degree, candidates are also considered for the Dr.P.H. and Ph.D. degree in the epidemiology of mental illness.
Acknowledgments

The program of the Group for the Advancement of Psychiatry, a non-profit tax exempt organization, is made possible largely through the voluntary contributions and efforts of its members. For their financial assistance during the past fiscal year, in helping it to fulfill its aims, GAP is grateful to the following foundations and organizations:

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