

1-1-1975

The application of task and role analysis to define the salient elements of mental health technology.

Marga Simon Coler

University of Massachusetts Amherst

Follow this and additional works at: https://scholarworks.umass.edu/dissertations_1

Recommended Citation

Coler, Marga Simon, "The application of task and role analysis to define the salient elements of mental health technology." (1975).
Doctoral Dissertations 1896 - February 2014. 2938.
https://scholarworks.umass.edu/dissertations_1/2938

This Open Access Dissertation is brought to you for free and open access by ScholarWorks@UMass Amherst. It has been accepted for inclusion in Doctoral Dissertations 1896 - February 2014 by an authorized administrator of ScholarWorks@UMass Amherst. For more information, please contact scholarworks@library.umass.edu.

UMASS/AMHERST



312066013544033

2421
27

THE APPLICATION OF TASK AND ROLE ANALYSIS TO DEFINE
THE SALIENT ELEMENTS OF MENTAL HEALTH TECHNOLOGY

A Dissertation Presented

BY

MARGA S. COLER

Submitted to the Graduate School of the
University of Massachusetts
In Partial Fulfillment of the Requirements
For the Degree of

DOCTOR OF EDUCATION

April

1975

Higher Education

This project was partially supported
by a Stipend from the
United States Public Health Service

(c) Marga Simon Coler 1975
All Rights Reserved

THE APPLICATION OF TASK AND ROLE ANALYSIS TO DEFINE
THE SALIENT ELEMENTS OF MENTAL HEALTH TECHNOLOGY

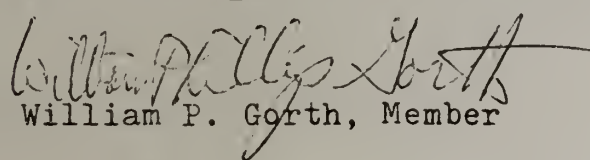
A Dissertation

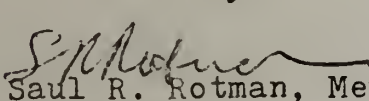
By

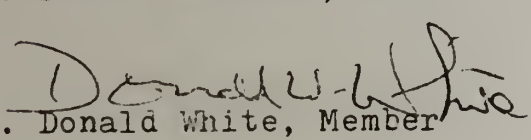
Marga S. Coler

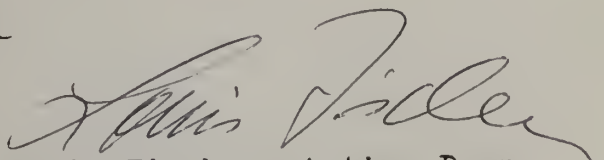
Approved as to style and content by:


Dr. William Lauroesch, Chairperson


Dr. William P. Gorth, Member


Dr. Saul R. Rotman, Member


Dr. Donald White, Member


Louis Fischer, Acting Dean
School of Education

April 1975

DEDICATION

This work is dedicated to

Helmuth Josef Simon, M. D.

"Langsam kommt man auch zum Ziel"

ACKNOWLEDGEMENTS

To claim sole credit for the culmination of a lifetime goal would be unjust. And so, to those persons who have passed in and out of my life's boundaries to shed a piece of themselves toward my professional growth, I give thanks. You will go unnamed, for you were many. Then, there are those with whom I more intimately shared my joys and frustrations; you, who were the elements of interaction in my support system:

Family Support

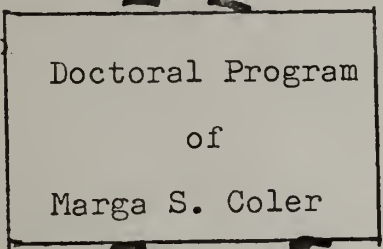
System

G. O. B., security
Andrew, my mainstay
Alyn, the grapher
Reginald, my facilitator
Ronald, philosopher
Anthony, patience
Nani, the stabilizer
Mus, health and welfare

Educational Support

System

WILLIAM LAUROESCH,
my mentor
William Gorth, my "analyst"
Saul Rotman, my liaison



Catalytic System

Nancy Casey
Norma Jean Anderson
Earl Seidman
Pat Sakery

Production System

Diane Beddia, multi-resource person
Frank Mirabello, computer programmer
Denise May
Robert Tracy
William Thibault } A.V.

THANK YOU

The Application of Task and Role Analysis to Define
The Salient Elements of Mental Health Technology
(April, 1975)

Marga S. Coler, B. S., Cornell University
M. S., Syracuse University

Directed by: Dr. William Lauroesch

The purpose of this study has been to isolate the tasks and roles which typify a population of practicing mental health technicians (MHTs) in Massachusetts. The research was undertaken to add refinements to the pioneer efforts to date. Descriptive research unique to the middle level profession has come from two major sources: 1) The Southern Regional Education Board, and 2) The Center for Human Services Research at Johns Hopkins University.

Because of the paucity of quantitative data regarding the identity of the new profession, the objective of this research became the isolation of the tasks and roles performed by practicing MHTs to inform the areas of curriculum development, credentialing, and career mobility.

The practicing MHTs in Massachusetts were identified and visited at the place of employment where they were requested to complete an MHT Task Assessment. This instrument, a revision of the Inventory of Job Functions (IJF) constructed by Golann and Magoon (1963) to assess a similar group of workers, consisted of 171 tasks divided into nine

role groups. The number of tasks per group varied (range, 10 to 63).

Seven tasks representing two role groups were identified as typifying MHTs. Nine tasks, in three role groups were earmarked as being non representative of the population. Role groups were also examined by agency categories in which MHTs found employment. Unique agency role group characteristics were cited as potential sources for inter and intra agency mobility studies.

The approximate amount of time spent in role performance, heretofore unexplored, changed somewhat the role profile reported by earlier investigators using the IJF. Role Group VII, "Direct client services, helping," showed the most representation; whereas Role Group II, "Maintaining," gained visibility as having the second largest time commitment. Role Group II had heretofore not been identified.

On the basis of the discrepancy of the role group rank changes because of the newly introduced time factor, the recommendation was made to refine and investigate the area before any conclusions regarding role groups were made.

The isolated tasks identifying the behavioral components of the MHTs have the potential of forming an identity base which would provide the requisite data for reassessment of curriculum, credentialing, and career mobility for the new profession.

These data provided the basis for three major conclusions:

1. The utilization of the MHT Task Assessment was instrumental in the identification of the seven tasks characterizing the MHTs in Massachusetts.
2. The median percent of time spent by the MHTs in role groups across all tasks is generally in agreement with the findings of two previous studies.
3. Time is a dependent variable in the increasingly complex task and role analysis of the MHTs.

The need for further investigation in the new profession remains urgent. Refinements are required to accommodate the constraints of geographic limitations, time ranges, and human error in self evaluation imposed by the methodology of this research.

Finally, the standardization of the title of the practitioners is recommended as a preliminary step in defining the boundaries of curriculum, credentialing, and career mobility.

TABLE OF CONTENTS

	Page
COPYRIGHT.....	ii
APPROVAL.....	iii
ACKNOWLEDGEMENTS.....	v
ABSTRACT.....	vi
TABLE OF CONTENTS.....	ix
LIST OF TABLES.....	xi
LIST OF FIGURES.....	xii
 CHAPTERS	
I. INTRODUCTION.....	1
Introduction to the Problem.....	1
Statement of the Problem.....	4
Definition of Terms.....	5
Delimitations.....	12
Basic Assumptions.....	12
Significance of the Study.....	14
II. REVIEW OF LITERATURE.....	19
Paraprofessionals in Mental Health.....	19
The Role of Higher Education in the Preparation of the Workers.....	23
Defining Job Roles for Mental Health Technicians.....	31
III. RESEARCH METHODOLOGY.....	39
Procedure for Collecting Data.....	43
Procedure for Analyzing Data.....	57
IV. INTERPRETATION OF FINDINGS.....	63
MHT Survey Analysis.....	63
MHT Task and Role Analysis.....	67

Table of Contents (Continued)

	Page
V. SUMMARY, CONCLUSIONS, AND IMPLICATIONS....	89
Summary.....	89
Conclusions.....	93
Recommendations.....	97
Implications.....	108
 APPENDICES	
A. Data Collecting Instruments.....	111
1. Survey Questionnaire.....	112
2. MHT Task Assessment.....	115
a. With task frequency compilations	
b. Identification by Role Groups (R.G.s were not identified in instrument administered to study population	
B. Related Correspondence.....	129
C. MHT Survey Computer Program.....	144
REFERENCES.....	155

LIST OF TABLES

Table	Page
1. A Portion of the Prototype Mental Health Technician Task Questionnaire Used for Pilot Testing.....	50
2. Illustration of Method Used to Assess Relative Time Spent per Role Group by Mental Health Technicians (as determined by number of tasks per role group).....	62
3. A Profile of Graduates of Mental Health Technology Programs in Massachusetts (April, 1974).....	64
4. Tasks and Roles Performed by More than 90% of Mental Health Technicians.....	68
5. Tasks and Roles Performed by More than 94% of Mental Health Technicians.....	69
6. Tasks and Roles Performed by Less than 10% of Mental Health Technicians.....	71
7. Median Response Across all Tasks Within Each Role Group by Agencies.....	76
8. Median Indices of Typical Time Spent by Mental Health Technicians in Role Groups by Agencies (calculated from responses to individual tasks).....	80
9. A Comparison of Role Groups Representing the Median Percentage of Functions Performed.....	87

LIST OF FIGURES

Figure	Page
1. Median response by Mental Health Technicians across all tasks within each Role Group (responses to time categories 1-4 representing approximate time spent per week)...	73
2.(a-g) Median response by Mental Health Technicians across all tasks within each Role Group by Agencies (categories 1-4 representing approximate time spent per week).....	77
3. Median index of Mental Health Technicians total time spent per Role Group (calcu- lated from responses to individual tasks).....	79
4.(a-g) Median index of Mental Health Technicians total time spent per Role Group by Agencies.....	82

C H A P T E R I

INTRODUCTION

Introduction to the Problem

Mental health technology had its inception less than a decade ago when a two-year experimental program at Purdue University graduated its first class of the paraprofessionals. Presently, there are approximately 200 such programs (McPheeters, NEBHE address, October, 1973), mostly located in community colleges. The growth of this new occupation nurtured by Federal funds and visions of educators parallels that of other allied health sciences, responding to a societal need for quickly trained workers to alleviate the professional manpower shortage.

As is often the case with new occupations, this hastily conceived paraprofession is fragmented and ill-defined. The price for such a flux has often been justified by states of open-mindedness, dedicated pursuit, intellectual curiosity, social responsiveness, and willingness to explore. These unique characteristics are the very ones which are frequently lost when professions become entrenched in society. As indicated by Young et al. (unpublished), the majority of mental health technicians are being utilized in occupa-

tions for which they were trained. Yet, there has been no discrete identity for these people. It has been postulated (Cowen et al, 1967, p. 90) that the lag has, in part been due to the interprofessional rivalry existing in mental health systems. The authors corroborate this premise by citing that the professional caregivers in the already nebulous area of mental health are victims of their pre-formed cognitive and connative ideologies, deeply rooted by years of graduate school (p. 439). Henry, Simms, and Spray, (1971) have also mentioned such competition in a study of how persons of diversified disciplines have climbed the ladder to The Fifth Profession (psychotherapist). Each, however, can quickly revert to the comfort of a particular profession with a set of standards (or, in the jargon of mental health, an identity) in the face of challenge.

Mental health technology, to date, has nothing to fall back on but conceptual models. The graduates from two-year programs have been hired as assistants to all professions and are frequently labeled as such (e.g., social work case aide, psychology aide, psychiatric technician). The new profession of mental health technology lacks specific standards and is quite powerless to alter the pattern in a culture dependent on lobbying forces.

Harold McPheeters (personal communication,

1/15/1974) of the Southern Regional Education Board (SREB), a leading advocate for this group of workers, argues in favor of maintaining the status quo. He stated that the lack of certifying standards encourages mobility. Although it is true that credentialing may impede progress, it does serve the function of giving recognition to a specified group of practitioners. It is indeed the rare professional proponent of the new paraprofession who does not have his own association to lean on in time of need. Mental health technicians now have no such system to support their upward mobility. They must rely completely on the benevolence of their mentors.

If the mental health technicians are to be utilized effectively as generalists in the evolving area of community mental health, their functions must be identifiable and subject to evaluation (Pennel, 1971, p. 11). If there is to be horizontal and vertical mobility for these workers, there must be standards (Hatch, 1973, p. 16).

There is, to date, no valid role concept for the thousands of practitioners in a nebulous field dominated by an array of well established professional isolates. There has been no descriptive information about what MHTs do to inform the development of curriculum, to give

guidance to the establishment of performance criteria, and to make determinations about how the group might interface with other career patterns. What there is, has been based on non validated inferences.

Statement of the Problem

The purpose of this study has been to identify the professional roles and functions common to practicing mental health technology graduates. The results of this descriptive study are intended to inform the backbone areas of the profession: 1) curriculum development, 2) credentialing, and 3) career mobility.

Curricula can now be reviewed to determine if colleges are teaching the skills and subject matter related to their occupations. In the area of credentialing, commonalities can be identified to provide a base for accountability. Finally, accessibility across similar job categories and on to higher jobs on a career ladder will be enhanced because of the synonymy unveiled by the study. Each of the above areas is dependent on the other and all will be enhanced by the identification of commonalities for validity. The methods for isolating these common elements have been outlined below as sub-problems.

Subproblems

As is described in detail in the methodology of this paper, the common components of mental health technicians were isolated by the: 1) development, testing, and utilization of instruments for collecting data, 2) establishment of contact with data sources, and finally 3) the analysis of findings. Recommendations were proposed to inform the above mentioned areas of concern. A definition of terminology follows to provide reference points for the reader.

Definition of Terms

A definition of terms used in the study follows:

Agencies

Forty separate employers were identified in the study. The term agency, as referred to herein applies to these employers which were categorized into seven major units: 1) Community, non residential; 2) Residential, adult; 3) Residential, child; 4) Residential, adolescent; 5) Day care, child; 6) Public schools; 7) General hospitals.

Consumers

These are the recipients of services. The levels identified in this study will be referred to as primary and secondary.

Primary consumers identified as the receivers of the educational product, are graduates of the mental health technology programs. These people are the most direct consumers of the educational system.

Secondary consumers are the agencies employing the primary group. They are the recipient of the educational product through the mental health technicians.

Credentialing

Pennel (1973) depicted credentialing as the process of:

. . .recognizing professional or technical competence. The process may include registration, certification, membership in a professional organization, or the attainment of an (academic) degree. . . . It may take the form of licensure by a governmental agency or certification by a profession (p. 19).

Accreditation of educational institutions is also part of the credentialing process.

Curriculum

This term, as used in this study refers specifically to the educational programs producing the MHT practitioners. Curriculum usually consists of: 1) a core of liberal arts subjects, 2) MHT specialty courses teaching skills and theories peculiar to the profession,

and 3) a practicum (field) placement where the MHT student can practice and refine the techniques learned in the classroom (Hadley, True, and Keppes, 1970, p. 46).

Horizontal Mobility, Career

This entails movement from job to job at a similar pay scale and title. For example, a technician could move from drug counselling to counselling with dying patients with minimal on-the-job training. The basic skills are identical. A career lattice such as exists in the New York State Department of Mental Hygiene encourages such mobility since it is built around functions derived from goals and objectives of agencies as its basic units.

Horizontal Mobility, Curriculum

This entails movement from an educational program at one level to another program at the same level. If the basic skills and knowledge identified herein were taught in a core or cluster (Watkins, 1973, p. 2) setting, the student could freely move from one human service related field to another (i.e., from mental health technology to nursing or law enforcement) in a two-year college.

(Discrete) Identity

This term as used throughout the study distinguishes the mental health technician from other workers in mental health. The present status of the middle level profession is akin to what mental health workers refer to as an identity crisis, inherent in which is reduced efficiency. This study has sought to establish the core of the identity (Leopold, Address, November, 1973) through analysis of tasks and roles by methods outlined in the subproblems. The isolated components have been unique to mental health technicians regardless of area of employment and job title.

Mental Health

This is a term defying clear definition. Turner and Cumming (1967, p. 41) attest to its ambiguity and relate to the scores of professionals involved in pro-creating missions under its umbrella. For the sake of identification, normal human functioning will denote mental health, as opposed to emotional decompensation which will designate mental illness.

Mental Health Technician (MHT)

This person is a graduate of a two-year program in mental health technology holding an Associate degree from that institution. Synonymous terms include: community mental health technician, human services techni-

cian, mental health associate.

Paraprofessional

The term as used herein identifies a middle level worker who holds an Associate degree from a college or university. This person is directly responsible to a professional worker holding a graduate professional degree (i.e., psychiatrist, psychiatric nurse, social worker, psychologist), but assumes a great deal of independence in his work. Alternate terms used interchangeably in mental health literature are: preprofessional, subprofessional, middle level professional, and new professional.

Producers

These are the educational institutions selling the product of a curriculum in mental health technology. They are usually community colleges with an occasional program at a four-year institution, private junior college, hospital, and community mental health agency.

Role Group (R.G.)

This frequently referred to term consists of an arbitrary number of related tasks. The specific R.G.s were identified in an instrument devised by Magoon and Golann in 1963. One group has been added to the original list as a consequence of this investigation. The

eight R.G.s are: I) "Educating"; II) "Maintaining"; III) "Community professional"; IV) "Professional growth"; V) "Scientific"; VI) "Direct client services, evaluating"; VII) "Direct client services, helping"; VIII) "Indirect client services." Added was, IX) "Psychotherapies."

Tasks

These are all the behaviors typifying mental health workers in job performance as "generated from job descriptions and other sources" (Golann and Magoon, 1966, p. 347). Sixty-three were added to the Magoon - Golann original 108 which were isolated from the current literature in the field of mental health technology and from professionals having contact with these workers in a variety of employing agencies.

Traditional Professional

This term is used frequently throughout the study and in the mental health system. It denotes a professional person holding a graduate degree in psychiatry, nursing, psychology, and social work. All have the sanction of a national professional organization. The practitioners are bound by the tradition of their professional group and share in its firmly entrenched prestige.

Vertical Mobility, Career

This indicates upward movement in a career ladder. Experience and education are often a criterion, but the basic components would be specified. The New York State Department of Mental Hygiene Career Lattice is an example of a very expeditious model. Mobility is determined by the number of functions a worker can perform. Such basic units as determinants enhance the creation of new roles at various levels and allow for promotion to higher level jobs.

Vertical Mobility, Curriculum

Presently there are few Baccalaureate programs supplementing two-year mental health technology curricula. The lack of communication among educators (Pattison and Elpers, 1972, p. 328), program diversity, and lack of identifiable universal components of the Associate degree mental health technology programs are assumed to be the reasons for the educational lag. The mental health technician rarely has the choice of continuing educationally as a generalist in his field. The option is most often one of specialization in the ruts of the well established related disciplines in spite of the new movement in the mental health field toward a "general" model.

Delimitations

The study was limited to an exploration of the roles and functions of graduates of Massachusetts Community College programs in mental health technology who were employed in the capacity of mental health technicians.

The nine two-year programs, varying in age from one to six years, have trained a total of some 150 graduates. The size of the population, therefore, provided the rationale for restricting the survey to the Commonwealth of Massachusetts. It was large and diverse enough to provide statistically significant data, yet small enough to census, thereby avoiding the introduction of sampling error. All of the graduates employed as mental health technicians were interviewed.

Basic Assumptions

The basic assumption of the study was that there is a degree of commonality of roles and functions across all jobs performed by mental health technicians. They employ the same skills, albeit in varying proportions, whether employed in counselling capacity, crisis intervention, administration or providing referral services. This common base will not change with job mobility, nor as emphasis changes in the ever-evolving political game of mental health in the nation.

On the same level, it was assumed that there is also a stability of functions and roles within a job. A mental health technician is required by his employer to demonstrate certain specific skills which would not change significantly over a given period of time.

A second level assumption, but worthy of mention since it was a premise of the study was that roles and functions are observable. Questionnaires and interviews identified functions in behavioral terms. This method coupled with the professional background of the investigator was adequate for assessing the roles in which the worker was operating.

Secondarily also, was the assumption that the jargon that transcends the job is not a barrier to communication among professionals. The vocabulary employed by the interviewer was within the scope of the respondents. While admittedly there is an esoteric element peculiar to the mental health profession, it is shared by all workers, and did not limit the quality of the reply.

The assumptions having been identified became the launch pad for the study, for it was these commonalities across and between the jobs that were the focus as the significance of the study was outlined.

Significance of the Study

Until this time the only basis for the development of the paraprofession of mental health technology has been speculation. Curricula have been built on what educators felt the MHTs should be doing. Ever since the inception of the concept of a paraprofessional in mental health (Albee, 1959), community colleges have sought to isolate "the unique program characteristic." This has been a mandate for federal support. Instructors were recruited from varied disciplines falling into the mental health sphere. Each brought into his program an individual professional orientation. Curricula were accordingly developed from a variety of perspectives.

In Massachusetts, for instance, three of the programs have been developed by nurses. One of these is in a Department of Allied Health Science. The other two have strong emphases on the biological sciences. Another program, coordinated by a social worker, has its roots in that profession. Still another is called a program in human resources. This was conceived by an educator.

Many sub-specialists rather than generalists were consequently graduated into the ranks of mental health associates. Skaggs' "overspecialization trap" (1973) has become the rule. Critical academic scrutiny will be necessary if the programs are to survive as relevant in-

stitutions.

The findings will have valuable input to the planners of new curricula as well as to educators in existing programs. Impact on education will be from task analysis data which provide essential information on what should be taught as defined by the world of employment. With such input, education can, for the first time have a base of reality instead of conjecture. Accreditation and licensing, too, are in the winds to provide accountability (Greene, 1969, p. 1) for the profession.

Credentialing, the process of giving identity to a group of workers by licensure or certification, has a two-fold purpose. It protects the public from fraudulence of self-appointed practitioners and promotes high performance standards within a profession (Albee, 1959, p. 70). Licensing Boards may be staffed by members of the profession or by practitioners of related disciplines. Identification of specific components unique to mental health technologists will constitute a springboard for implementing the effort in a conglomerate field consisting of practitioners numbering in the thousands. (Greene, p. 1)

Certification will lend professional recognition to these workers, who under a myriad of titles, share a

degree of commonality in educational background. "Technologist" or "therapist" indicates preparation at the baccalaureate level (Pennel and Hoover, 1970, p. 39). Both terms have been indiscriminately employed to describe the mental health associate along with the more valid "technician" and "assistant", which designate education at the associate degree level. Although many persons contend that labels are meaningless as long as the work is done, our society continues to operate on the accountability of titles. A single title with a minimum set of standards would be a key asset to a new group of workers in an area (mental health) which is already a battlefield of status seeking high powered professionals (Pattison and Elpers, P. 328). Groth-Marat (1971) very adeptly illustrated the plight of the paraprofessional in a letter to the Editor of The Clinical Psychologist (Long, 1973, p. 3).

Criteria for this should be related to the roles and functions of those who will be credentialed¹. To date, this study is the one of three which can provide such data. The other studies, (Baker and McPheeters, 1975; and Young, True, and Packard, 1974) are cited in

¹The SREB has implemented a Task Force to found a national organization with State and Regional tentacles to represent the new profession.

Chapter II. Each has its shortcomings (see Review of Literature, pp. 28, 30). Information from this study will be submitted to the body which will work on establishing the criteria.

The vast but nebulous area of career mobility in mental health services is also in great need of descriptive data. The roles and functions of mental health technicians as well as those of their team peers must be defined to provide mobility criteria. The research will exert an impact especially in relation to vertical career mobility. Many mental health technicians are presently in dead-end jobs because of ill defined job specifications. The Health Manpower Source Book 21, Allied Health Manpower Supply and Requirements: 1950-80 (Pennel, 1970) has no reference to MHTs, nor does the 1974-75 edition of the Occupational Outlook Handbook compiled by the Bureau of Labor Statistics. The Encyclopedia of Career and Vocational Guidance (1972) is without reference to the profession. There is, in fact, no official information about this job category.

With a goal of training for a universal profession, educators can plan with representatives in employment areas for specific slots in a career ladder. Advancement and horizontal mobility can become realities as boundaries are defined. The need to establish appropriate job classifications for graduates remains

paramount (Wellner and Simon, p. 166).

The results of this study can provide vital information to the Department of Labor about the new profession, which will ultimately find its way to employing agencies and to Federal and State Civil Service Commissions.

Lastly the findings will be submitted to the Massachusetts Legislative Committee on Mental Health Manpower to help fill the existing gap on the status of the paraprofessionals in Massachusetts.

The significance of the study lies in its provision of critically needed national statistics for a group of workers currently numbering in the thousands. This information will especially have an impact in the areas of curriculum development, credentialing and career mobility.

C H A P T E R I I

R E V I E W O F L I T E R A T U R E

Because the middle level professional in mental health still is a novelty, there is a limited amount of published research available. What has been published falls into three identifiable categories:

- 1) The paraprofessional concept in mental health
- 2) The role of higher education in the preparation of these workers
- 3) Defining job roles for mental health technicians

The literature will be reviewed from these headings.

Paraprofessionals in Mental Health

If we were to search the literature for the antecedents of the mental health paraprofessional movement, certainly the most salient historical development would be the passage of the National Mental Health Act of 1946 and the subsequent Report submitted by the Joint Commission on Mental Health and Illness which was authorized by this legislation. So pronounced a lag was observed at mental health facilities between the diagnostic prescription and the treatment, that George Albee, the chairman, proposed in an ensuing publication (1959) the training of a new type worker. This individ-

ual was to facilitate the transition of the client from the out-patient clinic to the community.

The response was explosive. Funded by the National Institute of Mental Health (NIMH) and the National Association of Mental Health, a profusion of training programs proliferated. The first, pioneered by Rioch, Elkes, and Flint (1965) of Johns Hopkins offered a master's degree level program to eight participants. As a first violation of the psychologist-psychiatrist "territorial imperative", this sortie was carefully controlled with selected placement of the graduates and a three year assessment by Magoon (Magoon, Golann, and Freeman, 1969). One of the principal conclusions arrived at by this study was that while training performance was at a consistently competent and productive level, "the greatest determinant of future activity in this direction would be the capacity of mental health professionals and their educators to overcome traditional attitudinal sets regarding vocational functions in mental health work" (pp. 129-130). These findings have since been corroborated and endorsed by a variety of workers (Collins, unpublished manuscript, 1969) Christmas, Wallace and Edwards, 1970; Matarazzo, 1971, Sobey, 1970, and who predicted (with increased sanction by professionals), expanded utilization and placement of the paraprofessionals in a host of tangential components

of the mental health system.

Others, however, saw this "Topsy-like" diversification as cause for concern. Vidaver (1969), Holler and Delong (1973), and Lubetkin (unpublished manuscript, 1969) underscored the need for constant redefinition of purpose and evaluation of performance. For these observations we are in their debt. Unfortunately their own recommendations regarding direction and depth of the mental health paraprofessional training served only to add to the diffusiveness they caution us against. How does one resolve the inconsistency of training in two years a generalist who can function as a specialist (Holler and Delong) and yet is "inherently capable of growth to full professional competence" (Vidaver)? Lubetkin admonishes us that training of the paraprofessional "should go forward on knowledge rather than fiction" and that we need more evaluation and feedback, but all this is pointless if goals remain ill-defined.

Mounting concern finally brought to fruition an NIMH funded study authored by McPheeters (1973) of the Southern Regional Education Board who attempted to provide order and legitimacy to the mental health paraprofessional concept by publishing a series of manuals outlining:

- 1) their training and utilization characteristics

- 2) their roles and functions
- 3) community college curriculum objectives
- 4) their induction and use in the mental health system
- 5) methods for reviewing mental health programs

Once again, as will be developed more fully in the following section of this chapter, the study suffers from the lack of clear definition. Symptomatic of this confusion of identity is the diversity of titles assigned to training program graduates. True and Young (1974) listed over 30 different titles while Long (1973) listed 11 in the State of Washington alone. Beside identity and role identification, however, Hadley, True, and Kepes (1970) and SREB identified two other critical areas threatening the establishment of a mental health paraprofessional. These are: 1) environmental constraints (society's built in resistance) and, 2) professional mystique. Collaboration was proposed as the key to unlock these doors but this solution seems frankly simplistic. As with the acceptance of the lamb by the flock, survival is ultimately placed on identity.

The paraprofessional movement continues, however, in spite of the obstacles. Licensing and accreditation are offered as stabilizing solutions to prevent and relieve the conflict and disfunction cited by Pattison & Elpers (1972, p. 327). One purpose of licensing is to

promote high performance standards. Licensing boards are traditionally staffed by practitioners (Greene, 1969, p. 1). Movement in this direction can be a major contribution of the new profession seeking to claim its ownership.

The Role of Higher Education in the Preparation of the Workers

Community needs assessments were the basis for curriculum development in the beginning. The industrial model of compartmentalizing existing professions, and subsequently training the technicians toward intensive specialization in a few selected components, was frequently used (Cowen et al, 1967, p. 81). Pattison and Elpers (1972, p. 327) observed that mental health technology was quickly synthesized from psychology, psychiatry, social work, and nursing, a conglomeration which has given rise to ambiguity and confusion regarding role identity. The authors pleaded for a definition apart from a factoring of the present parent professions. Tasks performed, they asserted, should be the criterion for defining the new paraprofession. Although Robert Kinsinger observed (1966, p. 11) that the American Association of Junior Colleges (AAJC) should "help provide some of the uniformity and quality for programs" at a two-year level, it was the SREB which pioneered the education of paraprofessionals in mental

health. The initiative oddly enough, came from the prompting of Kenneth Skaggs, the staff specialist of the American Association of Junior Colleges concerned with development of health curricula. In a paper entitled "The Community College in Mental Health Training" given at a SREB conference, Skaggs challenged the Board to ". . .take the initiative (for developing mental health worker education programs) in a very forthright manner" (SREB, 1973, p. 6). Shortly after his exhortation, the Board implemented a project which culminated some five years later in a series of manuals.

The first of the sequence was Plans for Teaching Mental Health Workers: Community College Curriculum Objectives (McPheeters and King, 1971), which was the distillation of a number of curriculum development meetings convened to analyze and improve the mental health worker community college curriculum in the South. The base for the concepts was a publication by the same group (1969), defining Roles and Functions for Mental Health Workers, in which a "developmental" rather than the traditional "job factoring" approach was used.

The projection consisted of a training program developed from preconceived (in vitro) roles not yet tested in the in vivo situation of employment and agencies. The sophisticated task of curriculum development

in the absence of a valid data base did not seem to deter them from extrapolating to unfounded conclusions. Their publication defined a "core of competence" in terms of terminal skills, knowledge, and attitudes (p. 19). It unpretentiously stated that it "represents the best consensus of experts who have critically explored each item. . .Without such a consistent core. . ." the authors further stated, ". . .graduates are not likely to be accepted or used." This well written, undocumented and subjective presentation provided the foundation and rationale for the subsequently developed curriculum, placement and evaluation manuals. Sadly the prestige and status of these leaders demanded an uncritical acceptance by the educators. The significance of the contribution was further diluted by the authors' incorporation of the observations of Hadley, True and Kepes at Purdue University, the founders of the first Associate degree program. Although based solely on conjecture, their identified needs were completely assimilated by academicians and SREB staff alike. Recall that Lubetkin cited this program as one that had not undergone an evaluative study to date (unpublished, p. 21). As was stated by Hadley et al (1970):

A mental health generalist is a person with a core of liberal arts: universal education with

an emphasis on behavioral science, and with specialized courses and field experiences related to emotionally disturbed, mentally retarded, community programs, and social welfare. Such a person must have positive attitudes, human relationship skills, sensitivity, and broad knowledge. Such a person will be the arms and legs of the professionals in a wide variety of mental health settings (p. 46).

It must be remembered that this program had been cited by Lubetkin (unpublished, p. 21) for not having had an evaluative study to date.

In identifying roles and functions for mental health workers, Cowen, Gardner, and Zax (1967, p. 81), adopting SREB's tac, admonished educators against training for traditional professional subunits as did Rioch et al (1965). "We must train for innovation," they wrote, "this cannot be done with training that is technique and situation bound" (p. 441). They further proposed learning encompassing issues, conceptualizations, and systems. Program development must incorporate "definition, implementation, and articulation" (p. 391), with "research" as a built in component (p. 444). Contributions of this type are either postulative or documentary, citing what might or has been done. There are no guidelines available other than those published by

SREB.

This is not to say, however, that innovative controlled experimental training programs are not being implemented and evaluated. Siegel described at the 13th annual meeting of the Association of Medical Superintendents of Mental Hospitals (1973), a two-track program (hospital/community college) by the Veterans Administration system in which research was a built-in component. Substantiating data are presently being compiled at the Veterans Administration Hospital, Salem, Virginia (Frankel, 1973; Rebecca Hale, personal communication 1/22/75). Another innovative program has recently been proposed at Empire State College in New York ("A Competency Based Mental Health and Human Services Model," unpublished). This institution will emphasize the liberal arts in the program to enhance the students' problem solving capabilities. These aspects of learning will include technical skills, related studies, and liberal arts. The curriculum is designed to interface with the transdisciplinary career lattice of the New York State Department of Mental Hygiene. Criteria for development of this intricate program are rooted in the SREB roles discussed earlier.

Most of the training programs, however, are not housed on university or four-year college campuses but

in community colleges. True and Young (1974, p. 304) reported a total of 174 colleges granting associate degrees with 37 in the process of either developing or considering developing such programs in 44 states. True to the generalist concept which these programs espouse, the faculties are interdisciplinary in their traditional professional backgrounds. Forty different academic specialties are cited (Young et al, in press, p. 3, manuscript). Practicum experiences are diverse. This multifaceted approach both in the classroom and field enable graduates to perform "a wide range of mental health services in multiform settings" (p. 4).

In spite of the diversity of program titles, faculty training, and the differences in course titles and content, all programs exhibit certain homogenous characteristics. True and Young list these commonalities (1974, p. 305):

1. An introduction to the Mental Health/Human Services area
2. An overview of helping approaches
3. Specific skills training in interviewing, the observation and recording of behavior, individual counselling, group dynamics, activity therapy, and behavior modification.

Curriculum philosophies generally center around humanism with an ". . .aim to develop attitudes in graduates that emphasize the unique, human qualities of

the individual client as a whole person. Related to this is a set of objectives that promote self understanding (insight) in mental health associates as well as an orientation toward continued personal growth after graduation" (True and Young, 1974, p. 306). Lynch and Gardner (1970, p. 1476) emphasize the importance of instilling a positive self-image into the student as a vital part of the educational process. This is a necessity for a person who must learn to ". . . think critically and creatively while grappling with his deficiencies as well as his strengths."

In spite of the generalizations cited by True and Young, the programs are highly varied. The programs with their many titles and variable standards for qualification and curriculum development are graduating practitioners qualified to be generalists in mental health. Remarkably the product remains as marketable as any in the current employment market. Attempts are being made at standardization, again by SREB. Until such a time, the ". . . ambiguity may have as its consequence the generation of a variety of different approaches" (Iscoe, 1970, p. 121). Caution must be exercised not to standardize until the many facets of the new profession have been explored even at the risk of frustration and error. Analogy is found here in speciation, for without inno-

vation (mutation) there can be no adaptation (evolution). The same lack of standardization generating uniqueness and ingenuity may also be a barrier to sound education. True (1974, p. 389) stated that the programs lack collaboration between faculty and the supervisors in clinical settings. This gives rise to cloudy course objectives which do not coincide with the job functions of the graduates (p. 390), a deficiency explored also by Baker and McPheeters (1975), and Euster (1971, p. 389).

Other educational lags were in the area of personality theory and psychodynamics (True, 1974, p. 389). Both were indicated as academically deficient areas in a survey of agency professionals (1972) by the investigator in Franklin and Hampshire Counties (Massachusetts). It is postulated that the weakness may be due to newness and lack of research in the profession.

Still another problem requiring resolution is the duplication of educational experiences within community colleges. True et al (1974, p. 349) refer to a lack of communication in planning as between nursing and mental health technology. It is for such reasons that educators have begun to address themselves to career clustering (Gleazer, 1968, p. 72; Kinsinger, 1966, p. 23; McPheeters et al, 1972, p. 531; Pattison and Elpers, 1972; Watkins, 1973, p. 2; Coler, unpublished manuscript). Under such an arrangement the student enters a

single field and then has the option to branch into a specialty.

In the present economic crisis, the shortage of monies demands program scrutiny to avoid inter-departmental duplication. Programs will come to ". . .merge and blend with the college's overall purpose and not exist apart" (Cohen, 1969, p. 137). Service for the community is the banner of the new educational movement in mental health. It is the same for other occupational programs in the community college system. Herein lies the key for seeking other commonalities.

The educational programs, in summary, although diverse in titles, share a common mission - the education of a beginning professional generalist in mental health. Because of the uniqueness of the new profession, there remain unresolved but not insurmountable issues, as the wheels of standardization gain momentum.

Defining Job Roles for Mental Health Technicians

The ambiguity decried in the preceding section extends to the graduates. A field where the traditional professionals themselves struggle for turf and identity will be anything but cordial to a newly arrived closely related group. Cowen et al (1967, p. 439) felt that a new profession threatens the power and control needs of

the established professionals.

A statement by Lynch and Gardner (1970, p. 1476), might well preface this section for their observations are a reality of our culture (Collins, unpublished manuscript):

A demonstration program (the MHT positions fall into that category, since they represent a new profession), particularly one that is dependent upon public funds, is to some extent dependent upon the vacillations of politics and public will and must often concentrate on immediate goals rather than an uncertain future (p. 11).

So it has been with the employment picture of the graduates of the new training program.

Because immediate goals are often vaguely defined due to lack of feeling for permanency, many jobs were implemented on a "We need it, let's create it" philosophy. Siegel (1974, p. 320) provided a vivid account of the experience of a new MHT in the Veterans' Administration system: "When I first reported to the hospital, the staff had no idea what I was there for. Some thought I was a spy planted by management. Every one agreed I was not needed. For sure I was not wanted!" This feeling has been expressed also by Groth-Marat (Long, 1973, p. 3) who in a letter to the editor of the Clinical

Psychologist stated, "My experience indicates that most of our professional colleagues (PhD's and MD's) are not ready to accept us or give us the opportunity to prove ourselves. . . . The door was firmly closed in my face at every turn because of 'no graduate degree'."

Other MHTs have reported similar experiences. Siegel (1973; p. 8) quoted R. G., "When I first got here nothing was assigned to me. I soon found ways in which I could be useful to the professional team and gradually I developed a role for myself." The self image (Lynch & Gardner, 1970, p. 476) of the worker seems to have a great deal to do with his/her finding acceptance with traditional professionals, as does a clear definition of limits of responsibility (Eisdorfer and Golann, 1969, p. 350). Role conflict frequently stems from those who define the roles (Ivey et al, 1970, p. 65). Christmas et al (1970, p. 1483) have written that joint sensitivity training, cooperative work, and experience as functional teams have been successful in breaking the rivalry barrier, not only between traditional professionals and the new workers, but between the new group and a resistive clerical staff (Euster, 1971, p. 284).

The role pictures of MHTs vary. Coler and Bloomberg (1971, p. 17) referred to MHTs as role models for patients in a therapeutic community. Other duties included community liaison and the carrying out of specific

portions of an individualized treatment plan as a team member (p. 18). This role concept was shared by others writing about these workers in hospital situations. Gottesfeld et al (1970) compiled an extensive list of 29 tasks described by administrators of 10 institutions in New York City. There were no formal qualifications nor were there many opportunities for advancement. Hadley et al (1970) also cited the lack of adequate job descriptions as a constraint, as did McNeer (1974), McPheeters (1973), and Pattison & Elpers (1972).

Proposals for resolution of this state are varied and interesting. Gleazer (1968, p. 76) would lay the blame on a continual lag which seemed to exist between the classroom and the world of employment. His solution required an extension ". . . beyond the call of duty" on the part of faculty and agency personnel. Few are able or willing to make the extra time commitment. True et al proposed filling the gap with more continuous information from community agencies about manpower requirements (1974, p. 347).

Job analysis is another solution. This is basic for supplying occupational information (U. S. Department of Labor, 1972, p. 1). The U. S. Training and Employment Service of that Department proposed a formula for looking at jobs (a group of identical positions) via 1) positions, 2) tasks, and 3) elements (p. 3). These compo-

nents are studied in terms of how the job exists at the time of analysis, not how a job should be or has been. Such analysis might be possible if one were to give up trying to find a non-existent common mold and pay heed to Siegel (1973, p. 19) who proposed that job descriptions be written to describe the duties of individual workers. If a collection of such descriptions were subsequently analyzed, unifying elements would emerge that would provide a central thrust to the new profession.

McPheeters et al (1972, p. 329), on the other hand, constructed a job synthesis rather than analysis. Two approaches were proposed: 1) job factoring, and 2) the developmental. Factoring would consist of breaking existing professions down into "component tasks," some of which would then be assigned to new workers. Much of the literature advocated this approach. Since a major reason for the emergence of a new professional concept has been the unsatisfactory delivery of services, McPheeters et al contended (1972) that factoring of existing jobs would not be adaptive. It is for this reason that the group advocated the developmental approach, which theoretically begins with the needs and problems that brought the traditional professionals into being (p. 330). Service providers

should be generalists, the group contended, with a focus on the needs of clients not professions or organizations.

While the literature is replete with reference listing attributes to be incorporated into the profession, there remains a paucity of scientific research treating a significantly large population or sample.

Because of the lack of identity, the group of workers are at the mercy of those who hire them. McNeer (1973, p. 26) reported that MHTs are making 50% less money than their professional colleagues. Siegel (1973, p. 6) stated that one of the present problems of employment was that ". . .salaries are too low to hold competent people."

Problems such as these can only be solved by standardization. Jobs must be defined. Provisions must be made to provide mobility for lateral, as well as vertical mobility (Christmas et al, 1970, p. 1483). Most employment presently continue to be cul de sacs in the world of mental health (Pattison and Elpers, 1972, p. 326). One solution toward providing lateral mobility is the "growing trend toward use of human services or 'human resources,' since many graduates are finding employment in agencies not directly related to mental health. . .A less restrictive title (than MHT) seems

appropriate" (McPheeters, 1972, p. 334).

Horizontal mobility is proposed by a generalized career ladder in mental health with many entry levels (McPheeters, 1973, presentation; Grosser et al, 1969, p. 147). This would require reorganization and redefinition of jobs both for professionals and non-professionals (Long, 1973, p. 4) similar to that of the New York State Department of Mental Hygiene Career Lattice. Career ladders require standardization. Lynch (1970, p. 1478) prescribed formal educational credentials. "The reality of status via prescribed credentials remains blantly apparent as does the needs to establish a career rather than a job." "Credentials reflect appropriate competence and training" (Grosser et al, 1969, p. 2). They provide "a worker with an orientation to his profession" (Pennell, 1971, p. 13).

With a young profession numbering in the thousands providing the challenge for a new career ladder, caution must be exercised not to fall into the comfortable rut of traditionalism. The credential monopoly (Newman, 1971) held by professions and institutions of higher education can be broken, as has been demonstrated by Illinois and New York, both of which are pioneers in opening up ladders of alternative routes for providing credentials.

There is a real need for research to provide an identity for a new profession. Tasks and roles must be isolated, and standards established to provide educational and career mobility. The investigator has attempted herein to provide such data.

We see, then, the undirected growth of a new profession in an exponential phase of expansion. The lag in effective leadership may in the main, be ascribed to:

- 1) territorial fears and tradition limited perspective of the established professions from whose ranks the leaders are drawn,
- 2) the lack of quantitative data and a surfeit of unsubstantiated opinions coloring the literature,
- 3) the consequent failings of community college educators to produce a standardized but still flexible program that would afford career mobility and the credentialing process.

C H A P T E R I I I

RESEARCH METHODOLOGY

Overview

Because mental health technicians originated as facilitators to implement the transition of the client from an institution to the community, their role required no definition at the onset. It was not until the evolution of their full potential that distinctions became fuzzy. Defining the role of mental health technicians has, to date, been largely done by speculation. Since the existing professions have been only models, certain concepts were taken from each and developed into the technology under discussion.

Necessity was put into action by Albee's report of the findings of the Commission on Mental Health and Illness (1959) which indicated that mental health needs of the American populace were not being adequately met. The need set into motion the wheels of education, and programs were developed to fill the service gap. The sky was the limit in the development of programs. Uniqueness was rewarded by the allocation of Federal monies. The innovative nature and flexibility of the many educational programs in this discipline, however, as outlined by Baker (1972, p. 281) militated against

the establishment of universal standards required for their systematic control and evaluation. In a pioneer evaluation attempt, she used three instruments to determine what these workers were doing: 1) The Inventory of Job Functions developed by Golann and Magoon (1963), 2) a Job Satisfaction Scale (Baker, 1972, p. 282), and 3) open-ended statements of Objectives of Mental Health Workers (Baker, 1972, p. 286).

The Inventory of Job Functions was developed to investigate job functions ". . . performed by professional staff of mental health agencies. . ." in a systematic way (Golann and Magoon, 1963, p. 2). The design proved ideal for the research proposed herein since it was very detailed in the description of task and role components. The "item pool of 175 functions" of ". . . varying levels of responsibility" (p. 3) consisted of eight content categories which were an attempt by the authors to classify the items according to similarities. The tasks were independently assigned to one of these groups by five judges (three agency directors, and the authors). Criteria for inclusion of a task into a role category consisted of agreement by both authors and two of the outside judges (Golann and Magoon, 1963). As a consequence, the following classification was evolved:

<u>Educating</u>	Providing supervision, training, consultation
<u>Maintaining</u>	Administrative work, including secretarial and clerical
<u>Community Professional</u>	Performed outside of agency: i.e., professional activities, public relations, committee work
<u>Professional Growth</u>	Receiving supervision and training. Self-improvement through workshops and seminars, courses, and library work
<u>Scientific</u>	Research activities
<u>Direct Client Services, Evaluative</u>	Diagnostic, judgmental, and evaluative services directly to the client
<u>Direct Client Services, Helping</u>	Service of a "helping nature" directly involving the client
<u>Indirect Client Services</u>	In the interest of but not directly administered to the client (p. 4).

The respondents were asked to indicate: 1) the degree of supervision they received for each activity, and 2) the activities they performed. This, compared with independent ratings of the MHTs by supervisors using the same instrument yielded an 84% agreement (Magoon and Golann, 1969, p. 21). The other two instruments used by Baker have no bearing on this study and therefore need no elaboration. The significance of her study is in her summary statement which centers

on ". . .the need for continuing systematic analyses of various factors relating to the training and utilization of non-professional mental health workers. . . ." A task analysis such as proposed herein will be a step in such a direction.

McPheeters of the Southern Regional Education Board indicated concern about the identity of the mental health generalist early in the paraprofessional movement (1971). They owed the development of the "Roles and Functions" to Dr. Sidney Fine of the W. E. Upjohn Institute for Employment Research in Washington, who suggested the "developmental" approach based on the needs and problems of the clients that originally brought the traditional professions into being, instead of the common job factoring methods most often used in new job syntheses. The theory justifying the approach is that the client has a multitude of people working individually to attend to his problems. The mental health worker would thus not be another sub-specialist "concerned with a narrow technology" but a single person who would know his way through the "maze of agencies and professions to bring the necessary assistance to bear on behalf of the client or family." He indicated further that, "The task has meaning only when you know for what purpose it is being done." From this philosophy the SREB has published a sophisticated report entitled

Roles and Functions for Mental Health Workers. The work is meritorious but fails to outline specific skills or techniques that are observed commonalities transcending all of these, in spite of the fact that the mission of the study was to delineate such basic components.

Procedure for Collecting Data

Since the purpose of the study was to describe the professional roles and functions common to practicing mental health technicians, identification of graduates from two-year training programs was necessary, since this is the principal source of MHTs. The two-year programs in Massachusetts were selected because the size of the population permitted the investigator to exercise control through access to a state-wide telephone system and uncomplicated travel arrangements. Appointments were made by phone, and travel to employing agencies was feasible within a one-day period.

Identification of the Mental Health Technicians

The identification of mental health technicians was accomplished by: (1) locating the mental health technology programs in Massachusetts, (2) identifying the directors of the programs, (3) requesting a list of graduated mental health technicians of the programs,

and (4) contacting the mental health technicians for background information.

Identification of mental health technology programs in Massachusetts. This was accomplished by three methods. First, a letter of inquiry (see Appendix B) was sent to the registrars of all two-year post high school institutions in the Commonwealth to determine whether a program in mental health technology was currently being offered. The Community and Junior College Directory (American Association of Community and Junior Colleges, 1973) was used to locate the thirty-seven institutions. Once a 65% return was achieved, no further attempts were made to follow-up on non-responding institutions or agencies.

Secondly, a telephone call was made to the Massachusetts Regional Board of Community Colleges to inquire which institutions offered such programs. This identified all of the existing community colleges offering programs in mental health technology.

A mailing list of the New England Board of Higher Education served as a reference source for program directors which included one private junior college not identified by the Massachusetts Board of Community Colleges, bringing the total to eight institutions.

Identification of the graduates of mental health technology programs. Upon identification of the eight programs, the respective directors were requested to submit the names, addresses, and place of employment of the graduates (see appendix B, letter to coordinators).

Of the eight operational programs only five had graduated students prior to April, 1974. Each director cooperated fully in providing the requested information. The identified Massachusetts programs were in Bay Path Junior College, Longmeadow; Bristol Community College, Fall River; Greenfield Community College, Greenfield; Mt. Wachusett Community College, Gardner; and Springfield Technical Community College, Springfield.

Development of Instruments

Two instruments were developed to: (1) identify practicing mental health technicians, and to (2) subsequently collect data for the study.

A survey questionnaire (see Appendix A) was devised to identify the mental health technician practitioners, the agencies in which they were employed, and the name and title person whom the investigator should contact (usually the Director) to obtain permission to interview the MHT. Other pertinent information for negotiating the interview phase included the home and business telephone numbers of the MHT and his hours of

work.

The information facilitated the process of contacting the practitioners to make arrangements for the subsequent MHT Task Assessment. Geographic location was a consideration in the scheduling of appointments so that three or four persons in one area could be interviewed in a day.

Some questions having no direct bearing on the study were included to provide data for subsequent research. These isolated:

1. The job levels at which the MHTs were employed;
2. Respondents who indicated they were looking for jobs in mental health;
3. The types of jobs the respondents were looking for;
4. The length of time the respondents had been looking for employment.

A section designated "Comments" to give the MHT an opportunity to express himself beyond the perimeters of specific items, appeared at the end of the instrument. This was the final question. Since the responses to this were either strongly positive or negative regarding the concept of mental health technology, they were coded for future reference. "An ego trip for the faculty," and "the program gave me the tools for my present job," were two extremes.

Each mental health technician graduate practicing

in Massachusetts was assigned an identification number (1-99). Respondents employed in mental health fields outside of Massachusetts were numbered in the three hundreds; and those not employed, in the two hundreds. The target population for interviews was restricted to those MHTs employed in Massachusetts. Follow-up on non-respondents to the survey questionnaire was made by telephone from the lists supplied by the program directors.

Collection of Data

The purpose of this step was to identify the common tasks and roles of MHTs employed in a setting appropriate to their credentials. An instrument for such a purpose had been developed by Magoon and Golann (1968). It had been used to assess the tasks and roles of a similar population in 1962-1965. Although their study group was on the graduate level (M.S. in mental health counselling) the effort (Rioch, Elkes, and Flint, 1965) is traditionally regarded as a pioneer program in the development of new manpower sources in mental health. The tasks and roles listed in the instrument were examined and judged to be well defined and applicable to the population used in this study. The original instrument was, however, twelve years old. Since that time the field of mental health has undergone drastic changes in

roles of manpower, types of therapies, and treatment modalities. Accordingly, it was necessary to revise the instrument by adding new tasks and roles as defined in literature and by professional practitioners.

Copies of the original Magoon and Golann questionnaire categorized by role groups and a list of the new tasks isolated from journal articles defining the new profession were sent to ten professional colleagues of the investigator who had expressed an interest in the project and had indicated a willingness to help. The new tasks were listed by the author(s) who had defined them (see Appendix B). In an accompanying letter of explanation (see Appendix B) the colleague was asked to assign a role group to each task and to add any tasks with role group identification not heretofore isolated. Provision was made for equal representation for the dominant professional groups in mental health leadership roles. Two psychiatrists, two psychiatric nurses, two educators, two social workers, and two psychologists were consequently selected to provide input into the categorization of new tasks in role groups. The professionals were also given an opportunity to list additional heretofore unidentified tasks in a space provided under each role category.

Pilot Test

The results of this effort, a prototype of the "MHT Task Assessment," as compared to Golann and Magoon's (1963) "Inventory of Job Functions" (IJF) contained 171 functions instead of the 108 in the IJF. The role groups remained the same. The new tasks were assigned to the role groups categorized by the majority of professionals. No new role groups were added at this juncture.

The MHT Task Assessment was pilot tested on six second-year MHT students (a month from graduation) interning in a variety of clinical areas in a Veterans' Administration Hospital in Northampton, Massachusetts. This test group was chosen because they and their supervisors were readily accessible to the investigator and had indicated a willingness to serve as the test group. Since the purpose of the instrument was to measure time spent in the performance of tasks and roles by the technicians, the answering format was changed from that of the IJF, which measured only task performance versus non-performance (not degree of) and the amount of supervision received.

The prototype MHT Task Assessment had three columns requiring the respondent to circle a number indicating their response.

TABLE 1

A Portion of the Prototype Mental Health Technician Task Questionnaire used for Pilot Testing

Tasks	Functions Performed		
	Frequently	Infrequently	Not Performed
1. Provide on-the-job training for new agency personnel	1	2	0
2. Explain what led to your opinion about a client to other agency personnel	1	2	0
3. Supervise students working in the agency	1	2	0

Five respondents had difficulty defining the parameters between "Frequently" and "Infrequently," especially with tasks performed on a weekly basis. They also felt that circling a number was time consuming. The time range for the completion of the MHT Task Assessment was 20 to 45 minutes. The supervisors of the six students were given the same questionnaire a

week later with a consequent revision of time columns. This pilot group was used, instead of MHTs, the second time because the MHT Task Assessment was originally to be administered to both MHTs and their supervisors. There were four designations by "hours per week," requiring checkmarking in appropriate columns rather than the encircling of numbers. The new time designation was selected in lieu of the ambiguous (as indicated by the students) "Frequently" and "Infrequently." Since the first group had also expressed annoyance at having to encircle numbers, checkmarking was used as a new answering format. The answers of the supervisors pertained to their perception of tasks performed by their MHT charges. The time range required to complete the Assessment was 10 to 20 minutes.

Neither group experienced difficulty in understanding the accompanying written directions, nor was the vocabulary alien. This instrument was subsequently used on the MHT practitioner population (see Appendix A).

The time categories of the second pilot test reduced the ambiguity of "Frequently" and "Infrequently." The new format (see Appendix A) was adopted after much deliberation and consultation with specialists in the area of scientific research. Another alternative which was considered was a measurement of percent of time

spent in task performance. (This, however, seemed too involved because the total percentage of the 171 tasks would have to equal 100%.) Also considered was asking the respondents to record the actual amount of time spent in task performance but the herculian effort of approximating this for 171 tasks seemed an overwhelming task and consequently an imposition to the respondent. Militating against this also would be the large measure of task diffusion. Since the new time categories seemed not to hinder the supervisors in the pilot situation, the instrument was duplicated in that format for in vivo implementation.

Selection of Population

There now exist thousands of workers falling into the category of mental health technicians. A small population such as that in Massachusetts would lend itself to being defined and analyzed with accuracy and relative ease. The geographic boundaries were small enough to permit travel to all practitioners within the allotted three month study period (May - July, 1974); yet, both private and community college programs which were located in both rural and urban areas assured a diversity of perspective that would provide a greater than regional level of relevance. The population was

diversified in age, sex, and economic background. In no other study has an entire population been interviewed at the place of employment.

Implementation

Each of the 65 identified practitioners was telephoned. The purpose of the forthcoming interview was delineated and an appointment was made for a meeting at the place of employment. The interview/questionnaire method at the employing agency provided standardization and clarification for the interviewee. For the interviewer, the method afforded an opportunity for agency assessment (which subsequently provided the data for recategorizing the individual agencies into seven major groups); an opportunity to meet and talk to the MHTs; and not least, assurance of having input from the entire population. The meetings gave the investigator a sense about the composition of the jobs and the working environment.

The objective of the study was explained in detail at the beginning of the interview before the MHT read the directions. Examples were presented and discussed. One task relating to the agency was selected from the instrument. For example, if the MHT were working in a day care facility for retarded children, the investigator might use "Provide a role model for

the client." The respondent would be asked to indicate how he would answer it. Clarification would be made as indicated by the respondent's ability to complete the task of providing a suitable answer. The respondent was assured that he could ask questions as necessary. The investigator remained with the respondent until completion of the instrument. When questions were asked, the answers were reflected back to the judgment of the MHT. No decisions were made by the investigator with respect to how much time was spent by the respondent.

At the termination of the interview, inquiries were made of the respondent regarding classmates who had not answered the original survey. The names forwarded by the directors of the educational programs served as a checklist. The list of non respondents was reviewed with the MHT, who in some instances was able to provide new addresses, telephone numbers, or employers of classmates. Approximately ten practitioners were consequently identified and subsequently contacted by telephone. Survey questionnaires were sent to those who had not received them. With others, it was just a matter of their getting into the mail the original one which they put aside. The respondents of this group were incorporated into the research population. The same follow-

up procedures were used (i.e., an appointment for the interview at the employing agency was made by the investigator upon receipt of their survey questionnaire).

Four who were identified at the end of the interviewing period received the same initial follow-up supplemented by comprehensive telephone explanations regarding the MHT Task Assessment form. Fortunately all of their agencies had formerly been site visited. The MHT Task Assessment form was mailed to this segment of the population with a letter containing more comprehensive directions than appeared on the original form. This communication (see Appendix B) contained several examples along with the investigator's home telephone number. A stamped return envelope was enclosed.

Two other assessment methods: 1) on-the-job observations, and 2) completion of the MHT assessment form by the supervisors were proposed but discarded because of the human factor of unpredictability. The mechanisms of projection (Rowe, 1970, p. 35) and transference (Rowe, p. 196) became the rule as a MHT tried to act as a MHT; a supervisor, as a supervisor, and the investigator, as an investigator. Only the clients, it seemed, acted in an unstereotyped way in this "assessment game." The investigator was relegated the role of "trespassing" observer and consequently became a foreign body in the normal function of an agency. Clearly,

agency time and space was infringed upon by the investigator's presence.

On-the-job observation of the technicians using the MHT Task Assessment as the instrument proved unsuccessful for two reasons. First, the tasks were rarely discrete but tended to overlap. A typical example of task diffusion might have been that while the technician was doing "Behavior Modification" (MHT Task Assessment, number 92G), he might at the same time have been "Chatting informally with the client" (96), possibly, "Determining what type of problem the client has" (86), and "Providing a role model for the client" (145). Consequently, recording and timing tasks virtually became an impossibility.

The other deterrent to observation was the seemingly unnatural behavior of the technicians because of observer intrusion. Informal conversation between workers was noticeably absent, and/or attempts were made to bring the observer into the situation either by the workers or the clients/patients. (One cannot remain a non-entity in a mental illness or retardation setting. Curious clients do not feel inhibited about seeking out a newcomer.) Such circumstances immediately changed the tenor of the situation.

The other assessment method proposed but discarded after a few visits was asking the supervisors of the

agencies to indicate their perception of the MHTs functions on the same questionnaire. Although a few supervisors were very cooperative, most showed irritation at having to spend a portion of their work time answering the questions. Since it was the intent of the study to identify the tasks and roles of the technicians and not a second party's perception of these tasks and roles, the supervisory input was not pursued. Every attempt was made to seek out and speak with the supervisors during the site visits, however, because their attitudes were considered to be important facets of an agency's profile. These informal conversations helped considerably in classifying the agencies into seven major categories, as did, of course, the site visits.

Procedures for Analyzing Data

Survey Questionnaire

The first instrument, the Survey Questionnaire, was analyzed according to: 1) employment status of graduates, 2) geographic location of employment, 3) type of institutions employing those who worked in mental health fields, and 4) colleges from which the MHTs graduated. Other information (such as job status, educational status, and feelings about the college program from which the respondents graduated) was coded for future reference. This will be used for background

material for future research. Geographic coding facilitated the planning for site visits. Appointments were scheduled according to the geographic location of the agencies so that several in close proximity of each other could be visited the same day. The 40 agencies were grouped into seven major categories following the visits. These were determined through site observation and feedback from the MHTs.

MHT Task Assessment

Responses to the MHT Task Assessment were analyzed according to:

Task frequency distributions across all respondents. A calculation of item frequencies (N=171) across all respondents (N=65), the first step in the analysis of the data, was accomplished by tallying the total number of responses for each time category per task. This provided data for determining the percent of performance. All items falling into the upper and lower tenth percentile of performance were isolated and ranked. This point was arbitrarily selected because it would isolate those tasks that were discrete to the majority of the population of practitioners, and because the tasks and roles identified were a large enough number from which to make assumptions, yet small enough to work

with experimentally.

Task frequency distributions across all respondents within role groups. The median, obtained from the tasks performed in a role group by all respondents per time category, was selected as the measure of central tendency because of the varying number of tasks per role group. This measure provided an index of the average amount of time spent per task in a R.G. For example: R.G. IV consisted of ten tasks. The 65 respondents made 159 responses in Time Category (T.C.) 1 (not performed); 277 responses occurred in T.C. 2 (up to one hour); 148, in T.C. 3 (one to five hours); and 56 in T.C. 4 (five plus hours). There were 10 "no responses." The following formula was used for calculating this parameter:

$$Md=L + \left[\frac{N/2 - N_b}{N_w} \right] i$$

Md= Median

L = Lower limit of interval containing median

N = Number of scores in the total distribution

N_b = Number of scores falling between the lower limit of the interval containing the median

N_w = Number of scores within the interval containing the median

i = The size of the interval

$$Md= 1.5 + \left[\frac{\frac{650-10}{2} - 159}{277} \right] 1 = 2.08$$

Role group frequency distributions across all respondents within each agency. The median was used as the indicator, as in the preceding analysis for the same purpose, but the respondents were categorized by agencies. Role group medians for each of the seven agencies calculated from the number of tasks performed by all the respondents working within particular agencies were plotted for facilitating inter and intra agency comparisons.

Task frequency distribution per respondent by role group. Since the tasks assigned to each role group differed in numbers with a range from 10 to 63 (see Appendix A), calculations were made to determine a reasonable estimate of time spent per role group with an adjustment factor for task number variance. For example, the role analysis indicated that 9% of MHTs spent a minimum of five hours per week in R.G. IV, "Professional Growth" which consisted of 10 tasks, whereas R.G. VII, "Direct Client, Helping" consisting of 63 tasks, showed 12% spending the same amount of time. The effect of task discrepancy on total time spent became a consideration. Contemplated was the possibility of R.G. VII having more time involvement than R.G. IV because of the greater number of tasks.

A method of time analysis per respondent within

role groups was subsequently devised. The index was calculated for each R.G. from the responses of each MHT per time category. For example, in R.G. IV, respondent 003 indicated that she did not perform two of the 10 tasks. Four were performed "up to one hour"; two, "one to five hours"; and two, "five plus hours." To provide a somewhat representative figure in terms of hours per week, the total number of tasks per column was weighted (multiplied) by a designated columnar number (1, 2, 3, or 4). The product of one times the number of tasks as identified by the respondent was subtracted from the sum of the weighted products to compensate for non performance (see Table 2). The resultant index, 14, was considered representative of the amount of time spent by respondent 003 in R.G. IV. The median of the indices of all 65 respondents in that role group was computed and subsequently compared with other role groups.

Task frequency distributions per respondent by role groups within each agency. The preceding procedure was replicated by agencies to give an indication of role profiles in relation to task number variance.

TABLE 2

Illustration of Method Used to Assess Relative Time Spent
per Role Group by Mental Health Technicians
(as determined by number of tasks / R.G.¹)

Time Category	Number of Tasks	Calculation (Time category times number of tasks)
1 (Not performed)	2	1 X 2 = 2
2 (0-1 hr.)	4	2 X 4 = 8
3 (1-5 hrs.)	2	3 X 2 = 6
4 (5+ hrs.)	2	4 X 2 = 8
		<u>24</u>

Sum Total - (1 X No. of Tasks) =

$$24 - (1 \times 10) = 14, \text{ Median time index}$$

¹Example represents responses of MHT 003 in R.G. IV.

C H A P T E R I V
INTERPRETATION OF FINDINGS

MHT Survey Analysis

Of paramount importance to the launching of the study was identification of the MHT practitioners. This was accomplished by screening and coding the replies to the initial Survey Questionnaire. The four community and one private institutions reporting MHT graduates prior to April, 1974, had a total of 205 graduates (see Table 3 for distribution by individual colleges). Of these, 141 (69%) responded to the Survey Questionnaire. Greenfield Community College, where the investigator is a member of the MHT faculty, had the highest return rate of 86%, and Bay Path Junior College, where two of the four graduates of the program responded, had the lowest (50%).

Of the 141 respondents, 47% were employed in a mental health related field in Massachusetts (including those employed outside the Commonwealth, 52%). Greenfield Community College was again the upper extreme showing an employment figure of 70% nationally, and 57% within Massachusetts. Bristol Community College had the lowest rate, with 40% nationally, and 37% within the State. The national employment figure in mental

TABLE 3

A Profile of Graduates of Mental Health Technology Programs in Massachusetts (April, 1974)

Group (Mental Health Technicians)	Colleges				Total
	Bay Path Jr. College	Bristol Community College	Greenfield Community College	Mt. Wachusett Community College	
Number	4	50	43	33	205
Number ^a	2	35	37	21	47
Percent ^a	50	70	86	64	69
Graduates					
Respondents					
Employed in Mental Health					
Employed in Ma.					
Number ^b	1	13	21	9	23
Percent ^b	50	37	57	43	49
Employed in Other States					
Number ^b	0	1	5	1	7
Percent ^b	0	3	13	5	5
Total Employed					
Number ^b	1	14	26	10	23
Percent ^b	50	40	70	48	49

TABLE 3 continued

Group (Mental Health Technicians)	Colleges				Total
	Bay Path Jr. College	Bristol Community College	Greenfield Community College	Mt. Wachusett Community College	
	Not Employed in Mental Health				
Number ^b	1	15	7	6	15
Percent ^b	50	43	19	29	32
	Full-time Students				
Number ^b	0	6	4	5	9
Percent ^b	0	17	11	24	19

^aFigures based on total graduates

^bFigures based on respondents

health related jobs for these paraprofessionals through October, 1972, as reported by Young, True, and Packard (unpublished) was 61%. Thirty-one percent of the total number of respondents were not employed in mental health settings, as compared to the national figure of 29% (True, Young, and Packard, unpublished).

A mission of two-year colleges has been to encourage those who so desire to pursue a more advanced academic degree. It was, therefore, not surprising that 17% of the respondents indicated that they were full time students. This figure was higher than the 9% cited in the Johns Hopkins study (True, Young, and Packard, unpublished). Although this research involved only the 47% of respondents who are employed in Massachusetts, the remainder of the returned questionnaires will be excellent data sources for other investigations concerning this population of MHT graduates. Fertile fields for further exploration in this new profession include areas such as: 1) What are the MHTs doing who are not employed in mental health type jobs; 2) What academic fields are the graduates who have continued their education seeking; 3) How actively have the graduates looked for jobs for which they were trained? All information has been coded and is available for such analysis.

MHT Task and Role Analysis

Task Analysis

The major purpose of the Survey Questionnaire was to identify the graduates who were current practitioners in mental health. This population was site visited individually to ascertain the completion of the MHT Task Assessment.

The calculation of item frequencies (N=171) across all respondents (N=65), was the first step in the analysis of data from the MHT Task Assessment. All items falling into the upper and lower tenth percentile of performance were isolated and ranked. Across all respondents, seven items were identified in the 90% performance category. Of these, four fell into the Role Group (see Appendix A for identification of role groups), "Professional growth" inherent in which was active participation of the MHTs in their self improvement. Two of these tasks (62, 63) were additions to the original Golann-Magoon instrument.

"Direct client services, helping" was the other major category identified by collating item frequencies. These tasks indicated involvement with a client in a direct, supportive way (see Table 4).

The items which typified the MHTs most (over 94% performed this function) appear in Table 5.

TABLE 4

Tasks Performed by Greater Than 90 Percent
of Mental Health Technicians

Role Group	Task Number	Task	Percent of MHTs Performing Task
IV	57	Read professional literature	94
	58	Ask another staff member to explain how he/she came to his/her opinion about a client	92
	62	Progressively assumes more responsibility at work	95
	63	Evaluates own weaknesses and strengths	92
VII	96	Chat informally, play cards, walk, etc., with client	94
	98	Participate in leisure activities with clients	91
	109	Attempt to enhance client's self understanding and self acceptance	91

TABLE 5

Tasks Performed by Greater Than 94 Percent
of Mental Health Technicians

Role Group	Task Number	Task	Percent of MHTs performing task		
			up to 1 hour	1-5 hours	5 + hours
IX	57	Read profession- al literature	54	31	9
VII	96	Chat informally, play cards, walk, etc., with client	15	35	43

It is worth pointing out that while these items were performed by 94% of the technicians, the majority of the individuals indicated that Task 57 was performed "up to one hour per week," while Task 96 ranked highest in the column labeled "over five hours per week." Tables 4 and 5, representing a frequency of task performed, indicate that practicing MHTs in Massachusetts spend the majority of their time in two role groups, "Professional growth" (IV), and "Direct client services, helping" (VII).

Reference to Role Group IV is completely lacking in the literature except for occasional reference to

the fact that paraprofessionals work under professional guidance. A review of literature on the curricula of educational MHT programs revealed a void in the teaching of skills and theories of "Professional growth." The question is, however, if such an area is considered in paraprofessional curriculum development.

"Direct client services, helping" is a familiar phrase among mental health workers. Curricula are, in fact, centered around this role. In contrast to the aforementioned role group (IV), this group appears in every publication. It is the backbone, the *raison d'être* of the mental health movement.

The tasks representative of the opposite extreme (i.e., being performed by only 10% or less of the practitioners) totaled nine. These represented three role groups: 1) "Scientific", 2) "Direct client, evaluating", and 3) "Psychotherapies." Table 6 is a representation of these task frequencies.

Question 92 (not in the original Golann-Magoon instrument) included a list of psychotherapies currently being performed by professional mental health service providers. Four separate items were identified as having been performed by less than 10% of the practitioners.

Since so much emphasis has been placed on the psychotherapeutic process in the mental health/retarda-

TABLE 6

Tasks and Roles Performed by Less Than 10 Percent
of Mental Health Technicians

Role Group	Task Number	Task	Percent of Performance
V	64	Publish research in professional journals	1
	71	Plan research programs	6
	76	Formulate a grant request for a study within the agency	8
VI	88	Administer psychological tests	8
	89	Evaluate and interpret client's psychological test performance	6
IX	92B	Primal Therapy	1
	92C	Gestalt Therapy	6
	92F	Transactional Analysis	9
	92H	Bioenergetics	1

tion professional system (True, 1974; Baker, 1973), and since new therapies such as: 1) Primal (Janov, 1971); 2) Bioenergetics, and 3) Transactional Analysis (Berne, 1961); are constantly evolving, the question (92) was taken out of the compilations of Role Group VII and treated separately as R.G. IX, "Psychotherapies," consisting of 10 tasks (with the individual therapies listed in the text of the questionnaire as subheadings). Role Group IX, therefore, was pronouncedly represented as an area of non performance. It may be noted that two of the items in this role group fell in the performance percentile of 1% (see Table 6).

Role Analysis

A method of analysis, in addition to the identification of individual tasks, was an inquiry into the composite roles as a potential identity factor of the new profession. Each role category consisted of all the tasks assigned by a majority of professional practitioners. They were, therefore, not balanced according to the number of items per group.

The median response of time spent across all tasks within each role group by the MHTs was computed and plotted (Figure 1). Group IV is identified as ranking the highest with a median time index of 2.03. The figures were derived from the total number of tasks

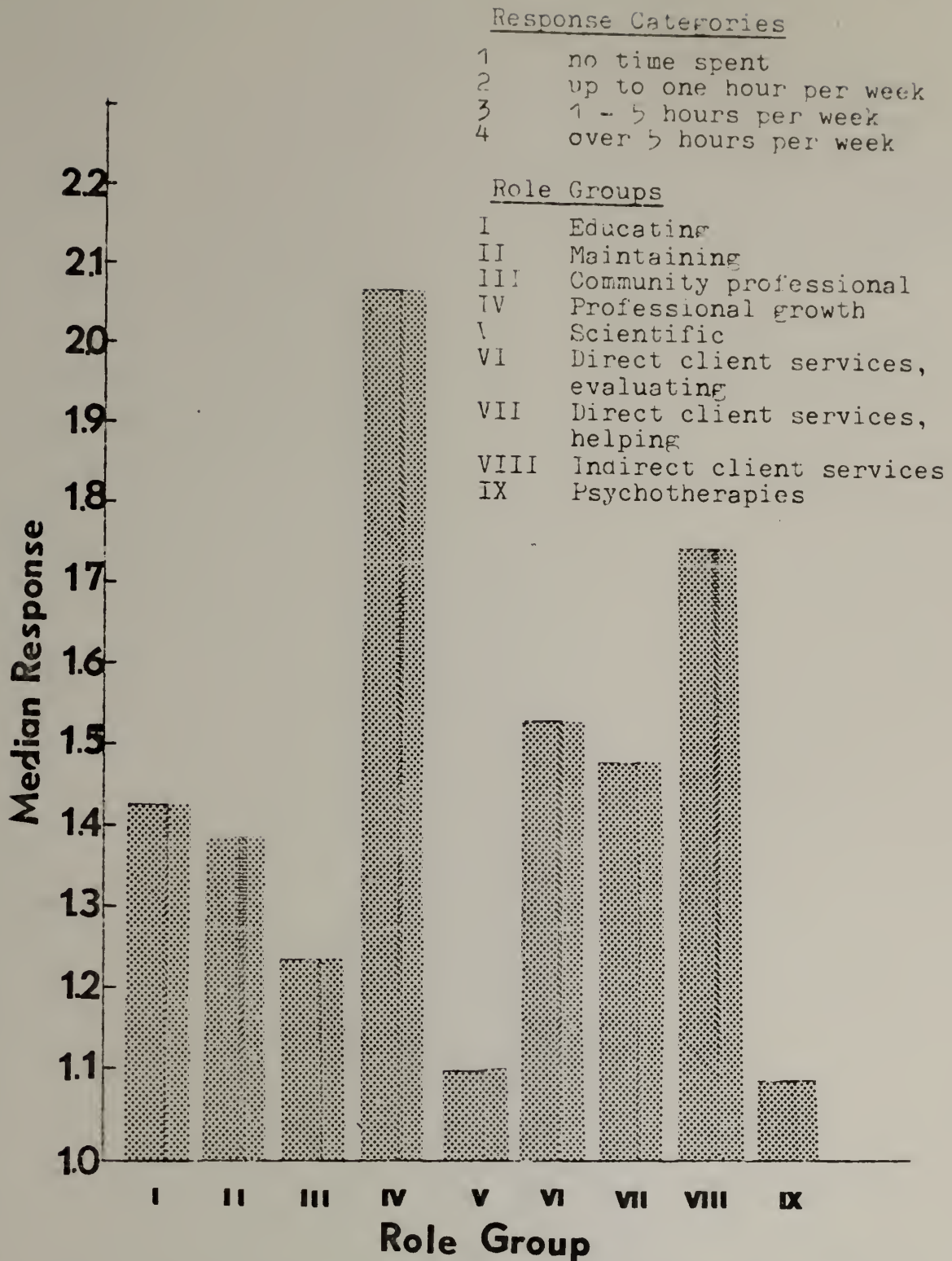


Figure 1. Median response by MHTs (N=65) across all tasks within each role group. (Responses to time categories 1-4 representing approximate time per week.)

per role group performed by the 65 practitioners in each time category. For instance, 75% of the MHTs spent some time in R.G. IV. More specifically, 43% spent "up to one hour," 23% spent "one to five hours," and 9% spent "five plus hours" in the Role Group of "Professional Growth." The second most represented group according to this method of analysis was R.G. VIII with a median time index of 1.76. It may be recalled that Group IV was also identified by the analysis of task frequencies as being most representative of the practicing technicians by having four tasks in the top decile of performance. R.G. VIII, although not isolated in the task frequency counts, and appearing insignificant at first glance at total time spent in each role, showed, upon scrutiny to be second to R.G. IV in percent of time spent in time columns labeled "up to one hour" (36%), and "one to five hours" (18%). The 60% performance rate was the highest after R.G. IV, (75%).

Baker (1972) who used the Magoon-Golann questionnaire on 29 graduates representing nine MHT programs within the Southern Region of the United States, reported a median of 83% jobs performed in R.G. IV, "Professional growth," and 91% in R.G. VIII, "Indirect client services." A time study was not involved. Instead, tasks performed were checkmarked.

A similar analysis within agencies appears in

Table 7, and is graphically represented in Figure 2 (a-g). R.G. IV, it may be noted, is only significantly high in two employing groups, 1) Community, non residential, and 2) Adolescent residential facilities. Its absence is conspicuous in the public schools where the median time index across all roles was only 0.55.

At variance with literature in a field which stresses the roles of "Community Professional" and "Psychotherapies" (R.G. III and IX) as being representative of all mental health workers, is the low level of representation of these roles in every agency except "Community, non residential" where R.G. III appears to be average. R.G. "Psychotherapies" has a low profile across all agencies.

Gottesfeld et al (1970, p. 285) cited all tasks appearing in R.G. III, "Community Professional," as having major representation in a list of tasks described by administrators of agencies employing paraprofessionals in community mental health. The majority of roles proposed by McPheeters et al (1972) are related to "Direct Client Services" (R.G. VI, VII). Siegel (1974, p. 19) on the other hand, stated that it was impossible to describe roles for mental health technicians because of the generalist nature of the paraprofession. The scientific-research potential of MHTs was rarely noted in the literature. This group, R.G. V, "Scientific" had a con-

TABLE 7
 Median Responses of Mental Health Technicians Across All Tasks
 Within Each Role Group by Agencies

Type of Agency	Number of Respondents	Role Group								
		I	II	III	IV	V	VI	VII	VIII	IX
Community (non-residential)	21	1.64	1.63	1.68	2.14	2.14	1.87	1.67	1.83	1.04
Residential (adult)	19	1.39	1.46	1.22	1.27	2.0	1.71	1.82	2.02	1.09
Residential (child)	5	1.39	1.29	1.05	1.28	1.39	1.27	1.30	1.35	1.07
Residential (adolescent)	2	1.61	1.5	1.14	2.07	1.65	1.5	1.71	1.39	1.06
Day Care (child)	6	1.5	1.13	1.10	1.05	1.24	1.14	1.18	1.21	1.1
Public Schools	5	1.13	1.14	1.01	0.55	1.44	1.31	1.15	1.19	1.03
General Hospital	7	1.59	1.43	1.14	2.07	2.25	1.86	2.17	2.21	1.17

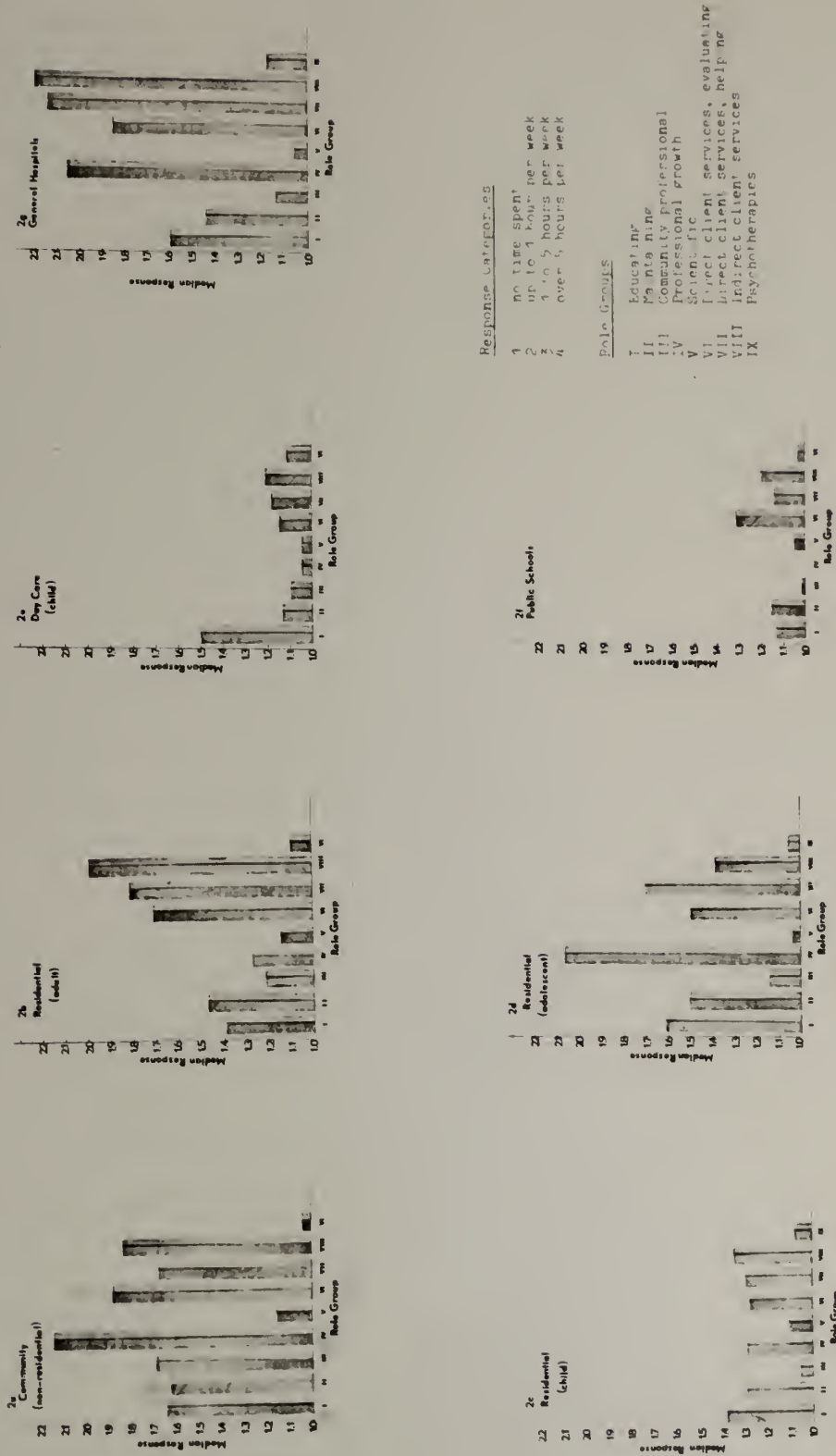


Figure 2. Median response by Mills across all tasks within each role group by agencies.

sistent low profile throughout all agencies which is in line with the task frequency analysis. Also inviting speculation is the consistent low profile across all role groups of agencies involving children (schools, day care, residential).

Although the foregoing analysis gave a composite profile both in totality and within individual agencies, it did not deal with the task number diversity per role group. To compensate for this, a median was calculated for each role group from every respondent's answers per time category. A figure representing non performance was subtracted from the total of each response for a reliable time index. These indices representing a reasonable estimate of hours per week are plotted in Figure 3. A comparison between this and the index not taking tasks per role group into account shows differing profiles. R.G. VII now attains visibility as that group in which most of the time is spent (It also has the greatest number of tasks). R.G. II (having the second greatest number of tasks), is the second most represented. This profile remains consistent throughout analyses by agencies (see Table 8, Figures 4 [a-g]). It may be recalled that the evaluation across all tasks showed the greatest time expenditure in R.G. IV, with R.G. VIII showing a significant amount of involvement.

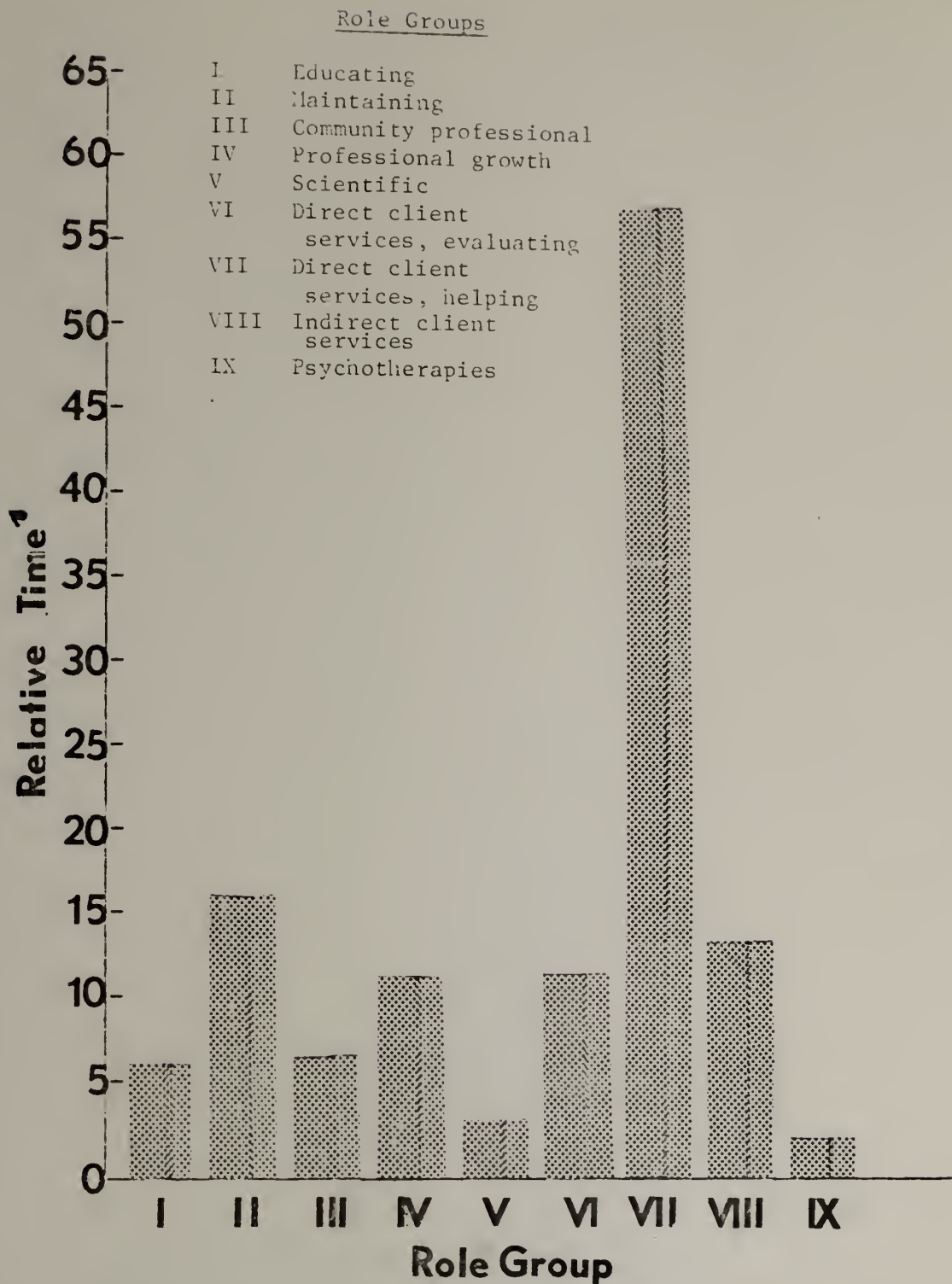


Figure 3. Median index of MHTs' total time spent per Role Group (calculated from responses to individual tasks.)

¹Relative time is a rough approximation of hours/week.

TABLE 8

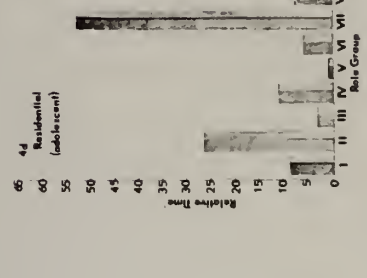
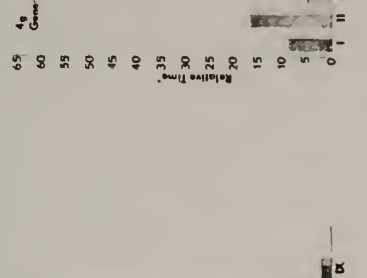
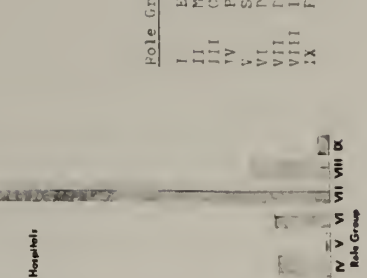
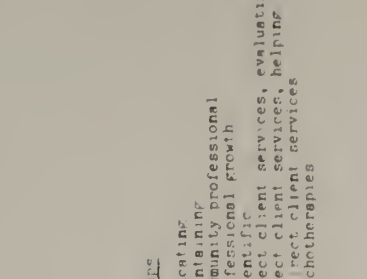
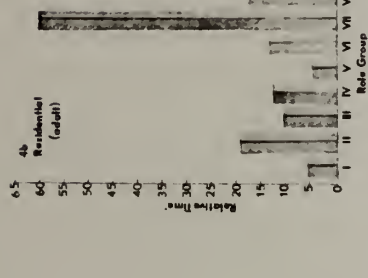
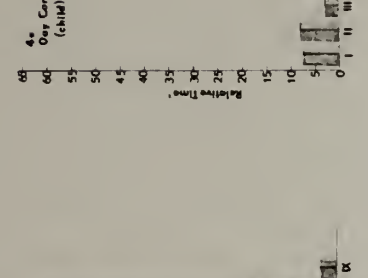
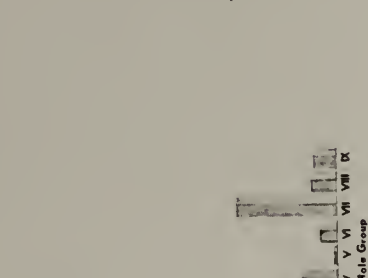
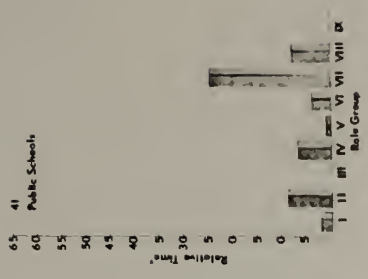
Median Indices of Typical Time Spent by Mental Health Technicians in Role Groups by Agencies (calculated from responses to individual tasks)

Type of Agency	Number of Respondents	Role Group								
		I	II	III	IV	V	VI	VII	VIII	IX
Community (non-residential)	21	6	17	12	11	2	11	42	12	1
Residential (adult)	19	5	19	10	12	4	13	61	17	2
Residential (child)	5	2	13	10	14	1	8	57	9	3
Residential (adolescent)	2	9	27	3.5	11.5	1	6	53.5	8	2

TABLE 8 continued

Type of Agency	Number of Respondents	Role Group								
		I 10a	II 27a	III 16a	IV 10a	V 15a	VI 13a	VII 63a	VIII 16a	IX 10a
Day Care (child)	6	7.5	8	3	7.5	0.5	3.5	20.5	5	4.5
Public Schools	5	2	9	0	7	1	4	25	8	0
General Hospital	7	9	17	5	11	1	12	74	17	3

^aNumber of tasks per role group



Role Groups:
 I Educational
 II Maintaining
 III Community Professional
 IV Professional Growth
 V Scientific
 VI Direct client services, evaluating
 VII Direct client services, helping
 VIII Indirect client services
 IX Psychotherapies

Figure 4. Median index of MIHS' total time spent per Role Group in agencies (calculated from responses to individual tasks).

Relative time is a rough approximation of hours per week.

Role groups V and IX continued to have a constantly low profile, as did two child agencies.

When the number of tasks within each role group was taken into account, there was a change in the role profile of the MHT. The greatest amount of time was spent in the role groups having the greatest number of tasks, with a consequent profile consistency across all employing agencies. The greatest amount of time spent in the role group typifying the MHT most (VII) by this analytical method was in general hospitals. The least amount of time spent in the most representative role group was in day care facilities for children. Hospitals are traditionally places where "Direct Client Services, Helping" is the role assumed by the employees. Mental health is also a field stressing helpful relationships. The literature affirms this role for MHTs.

It is proposed that the data obtained by the analytical method under discussion show significant external validity because the identified role groups are consistent with literature. The internal validity between the two methods of role analysis is questionable, however, since the dominant role group in one method attained no visibility being either first or second most representative by the other method.

Two exceptions are identified by a more than surface appraisal of the two methods. In both studies,

two role groups are identified as having negative correlation with MHT identity. These remained constant across both methods. The other factor visible across both analytical methods of roles is the task frequency analysis. The tasks, most representative of the workers appeared in R.G. IV and R.G. VII, each of which was identified as being most representative of MHTs, albeit by a different method of analysis.

The findings, then, revealed only seven of the 171 tasks that could be more clearly identified as being carried out by 90% of the MHTs in Massachusetts. These were distributed into two role groups, "Professional growth" and "Direct client, helping." (see Table 3). Nine tasks in three Role Groups: "Scientific"; "Direct client, evaluating"; and "Psychotherapies" were identified as having been non representative (less than 10% performance) of the practitioners.

A subsequent analysis of role groups identifying the median response across all tasks per time category, revealed that R.G. IV, "Professional growth" typified most of the MHTs. A second method of role analysis taking into account the number of tasks per role group pointed to R.G. VII, "Direct client, helping" (the group with the greatest number of tasks) as the most representative of the workers. Each, it will be recalled,

was also identified in the analytical method involving the percentage of MHTs performing each task.

Comparison of Figures 2 and 4 representing both methods of role analysis points to a disparity between a gross method of role analysis (across all tasks) and the subsequent refined technique involving number of tasks per group. (Baker, 1972, and Magoon and Golann, 1969, both used a method that did not take the task number discrepancy into consideration in their earlier studies.) From these differences, it may be surmised that the task analysis produced the most accurate descriptive data. The results invite speculation regarding the contribution of the role categorization in pointing out the unique characteristics of the new profession. A week showing an excess of the typical 35 to 40 hours claimed by the practitioners pointed also to an existence of task diffusion within the roles.

The plotting of role groups by agencies demonstrated, once more, the general lack of involvement by MHTs in R.G. V and IX. The method of role analysis through individual tasks, did reveal a similar profile across all agencies (see Figure 4 [a-g]), always showing the group (R.G. VII) with the greatest number of tasks as being the most representative of MHTs. There was no interagency pattern from which deductions could

have been made in the across task role analysis. No analogy could be detected between a single agency and the composite profile of MHTs by roles. Individual profiles did demonstrate some uniqueness for each agency group which might merit future consideration especially in the area of career mobility.

Finally, comparison among Magoon and Golann's study, Baker's research, and the present project showed strong collusion. (see Table 9). It was not until the task number differentiation within role groups coupled with an index of approximate time spent that a disparity in the data between the previous studies and this research appeared. None of these previous studies took either factor into consideration. Instead of identifying the Role Groups of "Professional growth," "Direct client services," and "Indirect client services" (in that order), this heretofore unexplored method pointed to "Direct client services," as being the most representative and "Maintaining" as having the second largest time commitment from the practitioners. "Maintaining" is consequently identified as a role group warranting further scrutiny.

The following chapter will further discuss the repercussions from the data in relation to the goal of the research. This goal, the isolation of commonalities

TABLE 9

A Comparison of Role Groups Representing
the Median Percentage of
Function Performed^a

Role Category	Magoon, Golann, and Freeman	Baker		Coler	
	1969 ^b N=8	1970 ^c N=29	1971 ^d N=22	1972 ^e N=21	1974 ^f N=65
Educating	15	30	40	30	40
Maintaining	25	35	45	40	41
Community professional	29	57	57	20	31
Professional growth	75	83	92	83	80
Scientific	06	11	22	11	13
Direct client services, evaluating	56	67	56	44	53.9
Direct client services, helping	74	72	67	69	54
Indirect client services	82	91	86	81	69
Psychotherapies ^g	-	-	-	-	10

^aBaker, 1972, p. 285; Baker and McPheeters, 1975, p. 33

^bConverted to median percentages by Baker from the original Rioch group of mental health counselors (Baker, 1972, pp. 284, 285)

^c"...some of the first employed MHAs" (Baker and McPheeters, 1975, p. 32)

^dSome 1970 graduates in the Southern Region (Baker and McPheeters, 1975, p. 32)

^eForty-one percent of graduates from six schools in the Southern Region (Baker and McPheeters, 1975, p. 32).

^fSixty-nine percent of graduates from Massachusetts schools.

^gNot a category in IJF

of MHTs will be further explored as it pertains to development, credentialing, and career mobility for a new profession, mental health technology.

C H A P T E R V

SUMMARY, CONCLUSIONS, RECOMMENDATIONS
AND IMPLICATIONSSummary

The purpose of this study has been to isolate the tasks and roles which typify a population of practicing mental health technicians in Massachusetts. The research was undertaken to add refinements to the pioneer efforts to date.

Mental health technology, a beginning level profession, and a product of the last decade, has lacked to date, valid identifying data. Descriptive literature has consisted of armchair speculation by expert mental health professionals of firmly entrenched traditional disciplines. Each has contributed his own concept of how the new worker might function. The input from such people was assimilated into the pioneer educational programs, and most often approved and funded by personnel in the National Institute of Mental Health whose backgrounds were also those of the traditional professional.

The impetus for the conception of a beginning level professional arose from the findings of the National Commission on Mental Health and Illness which illuminated the disparity between client need and the provision of service. This was attributed to, among

other things, the glaring lack of manpower. George Albee, the director of the Commission, subsequently published the findings (1959) and offered as a solution the utilization of quickly trained workers. Within two years, the first of such training programs initiated a logarithmic growth phase in mental health training programs. Rapid growth combined with a new concept left little time for assessment as educators devoted their energy in quest of the Federal training dollar. The consequent lack of documentation created a new profession of incertitude.

The ambiguity of the new profession has been expressed in a number of ways. True and Young (1974, p. 304) reported 30 different names for the educational programs and their degree recipients. Community mental health technicians, human services workers, mental health associates are a few labels for those, all of whom had the potential to perform the same type of work upon graduation.

Descriptive research unique to mental health technicians has come from two major sources: 1) The Southern Regional Education Board, which published the first manual on roles and functions of beginning level mental health workers, as well as curriculum guides for implementing educational programs based on these proposed role concepts has, in fact, become the unofficial

clearing house for anything concerning beginning level mental health workers. 2) The Center for Human Services Research at Johns Hopkins University is the other resource for descriptive data. Until November, 1974, there were no publications regarding a national survey they implemented several years ago of graduates from two-year training programs. The only source of information available prior to that date was an unpublished manuscript citing figures but lacking in related background information and specific methodology.

Because of the paucity of quantitative data regarding the identity of the new profession, the objective of this research became to isolate what MHTs do in their jobs so that this information can inform the areas of curriculum development, credentialing, and career mobility. This was accomplished by analysis (via an interview and questionnaire) of tasks performed by practicing mental health technician graduates of two-year junior college programs in Massachusetts. The size of the population, the size of the State's geographic boundaries, and the investigator's familiarity with the State mental health system, facilitated implementation of the research.

The collated data from the study were isolated and analyzed in terms of percentage of, and approximate time spent in task performance and role representation.

Seven tasks which represented two role groups were identified as typifying MHTs. Nine tasks falling into three role groups were earmarked as being non representative of the population. Role groups were also examined by agency categories in which the MHTs found employment. Unique agency role group characteristics were cited as a potential source for inter and intra agency career mobility studies.

The approximate amount of time spent in task and role performance, heretofore unexplored, changed somewhat the role profile reported by earlier investigators using Golann and Magoon's Inventory of Job Functions (the predecessor of the MHT Task Assessment). Role Group VII, "Direct client services, helping," showed the most representation, whereas Role Group II, "Maintaining," gained visibility as having the second largest time commitment. R.G. II had heretofore not been singled out by any of the investigators.

On the basis of the discrepancy of the role group rank changes because of the newly introduced time factor, the recommendation was made to refine and investigate that area before any conclusions regarding role groups were made.

A discrete identity base may, however, be initiated from the isolated tasks which identify the behavioral components of the MHTs. Such a base could

provide the beginning data for reassessment of curricula, credentialing, and career mobility for this new professional group in mental health.

Conclusions

On the basis of the data, three major conclusions were drawn:

1. Utilization of the MHT Task Assessment was instrumental to identification of seven tasks which characterize the MHTs in Massachusetts

These tasks have the potential of serving as an identity base for these workers. Three of the skills are in the role group of "Professional growth" to which little recognition has been accorded in the literature. Instead, emphasis has been on the mastery of technical skills to generate an "instant" product (MHT) to compensate for the professional manpower shortage. A focus anticipating needs and goals for the future is conspicuously absent in ongoing training programs.

The other identified skills in Role Group, "Direct client, helping," have been alluded to in the literature, but have not been clearly defined. The MHT Task Assessment has served to put these in specific behavioral terms. The identified tasks can, without much difficulty, serve to shape curriculum develop-

ment, credentialing and career mobility, thereby facilitating the identity process of the new profession.

2. The median percent of time spent by the MHTs in Role Groups across all tasks generally corroborates and is corroborated by the findings of Baker and Magoon and Golann.

The role ranking in this research was identical to Baker's most recent study, which also used MHTs with Associate degrees as a study group. Magoon and Golann cited the same four major role groups of involvement but did not rank them. Although the original Inventory of Job Functions had been revised for this study and was offered in a different geographic area, the results clearly indicated areas of commonalities between the new professionals in mental health. Because of the strong agreement among the three studies, a beginning step in the legitimization of some identifiable characteristics for the new group of workers can be instituted.

3. Time is a dependent variable in the increasingly complex task and role analysis of MHTs.

The weighting of each task by the approximate amount of time spent per week affected the role group rank order. The earlier investigators made no attempt

to categorize time spent in task or role performance. It was through this method of assessment that different conclusions between this study and the preceding ones appeared. It will be recalled that before the time factor combined with the task variance per role group was taken into consideration, the rank order of the role groups (by the investigators) was:

1. R.G. IV, "Professional growth"
2. R.G. VIII, "Indirect client services"
3. R.G.s VI, VII. "Direct client services"

With the inclusion of the weighted time factor, the profile changed to:

1. R.G. VII, "Direct client services, helping"
2. R.G. II, "Maintaining"
3. R.G. IV, "Professional growth"

Since there has been the introduction of a heretofore inconspicuous Role Group (II), "Maintaining," and since the time factor seemed to be pertinent in establishing facets of a proposed identity base, it may be concluded that more refinement is needed in this neglected area of time approximation.

Limiting Factors

Specific components for an identity base for the new profession have been isolated as a result of this

study. One must bear in mind certain limitations, however, requiring further investigation:

Geographic constraints. Although the Commonwealth of Massachusetts has MHT programs in urban and rural areas, community and private colleges, it represents but one segment of the nation. Given time and funding, the research could be instituted on a national basis, with a staff for negotiating and conducting site visits. The value of this type of an investigation should not be minimized for a new profession, such as mental health technology, requiring a solid foundation.

Time constraints. In this study the element of time has been refined over previous works (see Chapter IV), but has continued to impose research limitations because of the selected range. (i.e., "Up to one hour a week" could mean anything from a one time, five minute performance; to a task lasting ten minutes a day; to a task requiring 55 minutes once a week. "Over five hours" might involve seven hours per day in a 40 hour work week or a six hour once a week commitment.) A subsequent investigation would refine this factor considerably. Again this would require an investment.

Human constraint. A third constraint would be the error introduced by the MHT's estimation of time spent in the performance of a task. For example, the

investigator was quite unaware of the passage of time while interviewing a respondent. On the other hand, unpleasant tasks often seem to take longer than the actual time spent in performance.

Time, human, and geographic constraints, then, are in need of further refinement. Such an effort would require an expenditure of time and money but is not without the range of feasibility.

Recommendations

The study was initiated to provide data to give identity to a new profession, thereby catalyzing:

- 1) curriculum development, 2) credentialing, and
- 3) career mobility. A review of the literature has, to date, revealed research that has been largely qualitative in emphasizing the postulative over the experimental approach. The result has been not only the lack of a solid data base but the inclusion of fuzzy concepts and inaccuracies. These deficiencies stem from uncritical generalizations by professionals in allied fields whose status has permitted their uncontested dominance in mental health. The new profession, mental health technology, has been armchaired by these professionals who are themselves victims of an identity crisis, in areas of curriculum and job development. No community needs assessment has been made, nor has there

been an attempt to relate the job functions of the graduates to the curriculum that shapes their competencies.

It has been the intent of this study to identify tasks and roles common to practicing mental health technicians in Massachusetts. Although these tasks/roles are not unique to the new profession, little is in the practice of mental health. The traditional professionals continue to guard their territory jealously, while paradoxically giving lip service to press for the "generalist" merger and the employment of a career ladder with classification of practitioners according to academic training within the mental health designation.

The goal of this study has been to make a relevant contribution to a field foundering from the influences of traditionbound leaders. Conclusions and recommendations will, therefore, be made in relation to curriculum development, career mobility, and credentialing.

Curriculum Development

One of the most critical areas in the establishment of a new profession is that of curriculum development, for here is where the skills, techniques, and subject matter are imparted to the future practitioners.

It is from this area that accountability to agencies and clients is derived.

The curriculum for MHTs to date has been arm-chaired by competent but traditional professionals who responded to Albee's (1959) citation of a critical need for middle level workers. A great deal of effort was showered into curriculum preparation by individuals and groups, but since there was no data base, practitioners' conjectures was the only available tool.

There are presently approximately 11,000 (True and Young, 1974, p. 304) of the new practitioners working in the area for which they were trained, who can now be used as a data source for the development of their profession. The tasks they perform can provide information for what should be taught. The information in terms of tasks can be used to inform the directors of the training programs in Massachusetts. The potential of this information benefiting faculty in areas served by the SREB has also been noted since similar role components were defined in Baker's studies.

The identified tasks are ideal beginning for a systems approach to curriculum. Analysis of tasks is a first step in such a system after the purpose has been defined. The seven tasks can be broken down into behavioral components from which the curriculum can be

derived. Continuous assessment is a built in mechanism of such an approach to curriculum, the format of which can be derived from the behavioral objectives.

The tasks were identified by an accepted method for this type of curriculum development - a field survey. From these tasks the learning environment can be structured toward effective teaching.

An example is cited from Task 57, "Read professional literature" which was performed by 94% of the MHTs. Behavioral objectives relating to this task might be stated in the following way:

1. Given a series of: 1) titles, 2) authors, 3) subjects, the student will locate the specific journal or books and compile a bibliography which will be submitted to the instructor in two weeks.

The learning environment in this case would incorporate the library and its facilities. These measureable skills might be a unit of a course taught in a MHT curriculum.

There are more behavioral components which can be isolated from this task (57). Other tasks have similar potentials for such beginning steps in the development of a curriculum.

On the other hand on the basis of the research, some items demanding urgent reassessment have been

isolated. Much has been written, for instance, regarding the psychotherapeutic potential of the new workers, yet the data from this study did not corroborate this.

Curriculum planning using the identified tasks as a data base can be a primary step in providing educational accountability and consequent professional identity for the new profession. Curriculum revision will take kid glove collaboration, for much money and effort has been invested in SREB publications. One solution might be to incorporate the "non representative" items into senior college curricula so that a person desiring a bachelor's degree in the new profession would learn the additional skills that have been deleted from the beginning level curriculum because of new task priorities. The lack of educational programs at the second level attests to the identity confusion presently existing at the bottom of the educational scale. It has been pointed out that a significant number of graduates seek higher education. Unfortunately the majority of these seek the traditional disciplines, since there is nothing else available. Many mental health generalist programs at the baccalaureate level duplicate the associate degree mental health programs, since there has been little

collaboration between upper and lower level college academicians. An identity base built on a universal lower level curriculum would enhance vertical educational mobility.

Horizontal mobility between lower level colleges and between departments within a college would also be facilitated, since there would be specific information available. Certain skills and theories would be learned by all students across the nation. These could be concretely validated as the student seeks transfer into programs such as nursing and law enforcement, both of which presently have national credibility. Inter-college transfer would be enhanced for the same reasons. MHT faculties need no longer be concerned about what might have been learned in a similar program at another institution. There would be across the board transfer of skills and theories which could also be the basis for standard national examinations.

Credentialing

The process of credentialing is unavoidable in any profession, especially in one that is related to human services. Without the controls of accreditation of educational programs and licensing (or certification) of practitioners by a central body of experts, quackery could be freely practiced. Presently, an associate de-

gree from a program identified nationally by 30 different names could at best mean very little to employers. This would be especially true as graduates from the programs leave the communities in which they receive their education.

Inherent in credentialing are three identifiable processes which define the beginning competence of workers and provide a standard set of skills facilitating movement from one institution to another (Pennell et al, 1974, pp. 11, 12). State licensure of practitioners, one such process, often inhibits geographic mobility because recognition of the workers is confined to those having passed licensing examinations of the State imposing this statute. This has often been circumvented by a reciprocity system where one state may accept the licensing procedures of others.

Pennell et al (1971) stated that accreditation is used ". . . as the primary management device for validating and improving the quality of education of professions." Control for the process the authors continued ". . . should be vested in the community, and the public should have representation on accrediting bodies." Finally, this facet of the credentialing process is presently ". . . fragmented and disjointed in higher education." (p. 12)

The third process, certification, is controlled

by professional associations to meet the standards of a profession. It is helpful to potential employers as a guarantee of quality. Pennell, Proffitt, and Hatch (1971, p. 12), stated "It also provides the worker with an orientation to his profession" as well as a sense of prestige and a set of professional values. "Certifying examinations," the authors continue, "could be an excellent measurement of the proficiency of the practitioners. Unfortunately, most tend to measure knowledge instead." (p. 13)

The identified areas of practice (tasks and roles) have the potential of being a data base for the credentialing process. Licensing exams could be built around theory and skills involving identified functions. A position statement on the profession could be formulated by the credentialing body and dispersed to educational institutions, employing agencies, and job developers. No longer need each institution have a myriad of titles for an ambiguous worker with a fuzzy purpose.

Angel (1970) cited in a historical review of licensing groups, that the trend has been for occupational groups to form associations, which would consequently be powerful enough to urge legislation to protect their codes of ethics and standards of competence. Such action is now needed with over 10,000

graduates in need of organization and in search of a common identity. Care must be exercised to avoid control by the aforementioned traditional professionals who already, under SREB leadership, are firmly entrenched in finalizing the by-laws of a national organization (McPheeters, personal communication, 1974). An analogy is the American Medical Association, which recently has assumed control of another beginning level profession, the paramedics. Mental health technology can still avoid such a dilemma by seeking to attain the autonomy of their profession by moving in the direction of establishing a credentialing body staffed by its own practitioners. An identity base developed from this study could provide the foundation for such a group. Such a base could be derived in a fashion similar to that of curriculum development. The identified behavioral components could form the skills and knowledge base for the profession. Examinations could be criteria-referenced in that they would test the behaviors which have been identified as representative of the profession.

Task 96, "Chat informally, play cards, walk, etc., with client," exemplifies the above statement. A component of this task might be stated as, "The MHT practitioner will be able to initiate a conversation with a client." A testing device to measure such be-

havior might be analysis of a video tape in which the prospective practitioner would display the components of attending behavior such as eye contact and body posture. Listening skills could also be measured by such analysis. Another measureable component of the same task might be the practitioner's ability to motivate clients to take walks. Whereas video taping might be inappropriate in such an instance, the observation could be made by an examiner located on the premises of an institution.

Credentialing not only involves licensing of practitioners but also the accreditation of educational programs. Again, with the identification of a data base of measureable components identifying the MHTs, assessment instruments need only be developed. The systems format cited for curriculum development seems to be a logical tool for the credentialing process using the identified tasks as a data base.

Career Mobility

One area commanding a great deal of scrutiny is that of career mobility in the mental health system. Until the hazy career boundaries are settled on the traditional professional level, it is virtually impossible to neatly plug in a middle level worker. Consequently the area of career mobility is one that has

been well documented in MHT literature.

Siegel (1974) of the Veterans Administration (V.A.) has enumerated the paths MHTs have traveled in that system. To date their movement has been largely horizontal and designed to fit individual needs.

Most MHTs have not fared as well as those in the V.A. since their jobs have been ill defined. Many positions were created to fill a vacuum within agencies having little or no foresight about mobility of the person filling the job.

One problem has been what to label these practitioners. In occupational publications from the United States Department of Labor, there is clear differentiation between technician, technologist, aide, associate, assistant, etc. Pennell and Hoover (1970, pp. 1950-80) listed these titles in terms of academic qualifications. To date educators and employers of the MHTs have paid little heed to such classifications. The myriad of titles serve to confuse, not enhance an area where there are ambiguous professional boundaries.

Pennell et al (1971) addressed themselves to issues of maximum use of health manpower. Essential for delivery of services is "task analysis and investigation of skills" (p. 11). Mobility (vertical and horizontal) can be attained by an evaluation of abilities.

The tasks identifying MHTs evolving from this study could serve as a data base for career mobility. Since nothing has been identified as being unique to MHTs, it is necessary to isolate the components that typify this profession. "Few jobs are totally self contained" cites a United States Department of Labor document (1970). "Normally a job is interrelated with other jobs in a system; it involves tasks that accomplish only a segment of a larger process. . . .Before an analyst can convert an establishment job, he must have a concept of its duties." (p. 6) The derived data base will aid in providing such a concept.

There is to date no description of an MHT in the Dictionary of Occupational Titles, a United States Department of Labor publication, and the bible of job classification in this country. The tasks identified in this research can provide the necessary information for implementation of an MHT category.

Once the job has been defined, it can be inserted into a flow-chart for job restructuring. Such an instrument could have the potential of providing horizontal and vertical mobility within a system.

Implications

The foregoing has been a study in mental health technology. This effort is proffered to colleagues,

both "tradition-bound," and "new careerist" to help in the solution of a still existing identity crisis of the new profession. The identification of the discrete tasks and somewhat fuzzy roles could serve as a springboard for research to alleviate the condition.

Paramount is the clarification of a title for an Associate degree recipient who is at once referred to as a "generalist" and a "technician." Inherent in the former is the ability to adapt to a variety of situations which requires a strong, broad theoretical orientation. The latter, by definition, is a person trained in techniques with a narrow knowledge base. There exists a disparity between the two terms. A two-year educational period cannot provide both. Either the route of educational specialization providing proficiency in a narrow range of skills or the pursuit of a broader range of tasks and theories with a lesser level of expertise should be followed. The inconsistency between theory and skills is difficult to reconcile in the MHT graduate. Educators must decide on the academic route of their clients to provide validity to the new middle level profession. Specialization and depth could be introduced at the baccalaureate or graduate level.

Since we cannot consider credentialing, curriculum, or career mobility until we agree on which path to follow, there can be no standardization on the product. We must decide between the generalist and the specialist. Once directions and goals are agreed upon, the next order of business can be a structure established to insure communication among the user agencies, educators, researchers, and the MHTs which must include a homeostatic feedback mechanism to insure continued relevance and quality control.

A P P E N D I C E S

APPENDIX A

Data Collecting Instruments

- I. Survey Questionnaire
- II. MHT Task Assessment
 - a. With task frequency compilations
 - b. Identification by Role Groups
(R.G.s were not identified in instrument administered to the study population)

SURVEY OF GRADUATES FROM TWO-YEAR MENTAL HEALTH PROGRAMS

=====
 Directions: Would you please check the appropriate boxes, or write in the blank space, and return this at your earliest convenience? Additional comments may be made at the end of the questionnaire.

Name:

Address: _____

Telephone: (home) _____ (business) _____

=====
 1. From which Mental Health program did you graduate?

- a. Bay Path Junior College
- b. Bristol Community College
- c. Greenfield Community College
- d. Mt. Wachusett Community College
- e. Springfield Technical Community College
- f. Other (specify) _____

2. What degree did you earn?

- a. Associate in Science
- b. Associate in Arts
- c. Other (specify) _____

3. When did you get a job in the mental health field?

- a. Had one before I came to school and went back to the same agency
- b. While at school and continued after graduation
- c. At graduation
- d. After _____ months (fill in number)
- e. Did not get one

page 2

Name _____

4. How soon after graduation were you looking for a job?
- Wasn't looking because I already had a job
 - Right away
 - After _____ months (fill in number)
5. Are you presently working as a Mental Health Technician? (You may not have that title, but may still be doing that type of work. If so, please answer "Yes")
- Yes
 - No (If "No", please procede to #14. Although you will only have three questions to answer, it is important to the study to have the questionnaire returned. . .Thank you!!)
6. If yes, how long have you had the job?
- _____ months (fill in number)
 - _____ years
 - Other (specify) _____
7. Name of agency in which you are employed:
- _____
- Address:
- _____
- _____
8. Name and title of the Director of your agency:
- _____

page 3

Name _____

9. Type of Agency:

Mental Health Center	Nursing Home
State Hospital	Private School
M. R. facility	Welfare Dept.
V.A. Hospital	Detention Ctr.
General Hospital	Probation
School Department	Senior Center
Other (specify) _____	

10. Your official job title _____

11. Department or service in which you work _____

12. Number of hours you officially work per week _____

13. Average work day is from _____ a.m./p.m. (cross out one) to _____ a.m./p.m. (fill in blanks)

IF YOUR ANSWER TO QUESTION #5 was "No" ANSWER THE FOLLOWING:

14. Have you ever been employed as a Mental Health Technician?

- a. Yes
- b. No

15. Have you been looking for a mental health job?

- a. Yes
- b. No

16. Indicate in what area you would like to work, if your answer to #15 was "yes". Use list in #9

COMMENTS:

THANK YOU

APPENDIX A

RESPONSE FREQUENCIES ON MENTAL HEALTH
WORKER TASK ASSESSMENT¹

Mental Health Technology graduates (Massachusetts, 1974)

	not performed (1)	up to 1 hour (2)	1 to 5 hours (3)	5 plus hours (4)	no resp (NA)
<u>Role Group I Educating</u>					
Task 1. Provide on the job training for new agency personnel.	29	23	8	5	0
2. Explain what led to your opinion about your client to other agency personnel.	18	17	21	6	3
3. Supervise students working in the agency.	31	14	11	8	1
4. Supervise volunteer workers.	39	9	13	3	1
5. Review and suggest improvements in reports about clients written by others.	32	24	4	1	4
6. Serve as consultant to related staff members (nurses, aides, teachers, etc.)	20	17	15	2	1
7. Supervise others in their work with clients.	35	14	8	7	1
8. Train volunteers to work with clients.	40	13	7	4	1

¹In order of appearance as in the MHT Task Assessment²Role groups were not identified in instrument administered to MHTs.

	(1)	(2)	(3)	(4)	(NA)
9. Provide in-service training to non professional agency personnel.	46	9	7	2	1
10. Train clerical staff in the use of record forms.	55	4	4	1	1

Role Group II Maintaining

11. Regulate the assignment of cases to agency staff.	56	6	2	2	2
12. Serve on committee made up of agency personnel.	36	16	7	5	1
13. Meet with agency director(s) to discuss matters such as duties, agency policies, as they affect you.	15	26	19	5	0
14. Express views to fellow staff members on professional issues such as promotions, duties, etc.	19	22	17	7	0
15. Attempt to improve interpersonal relationships of the staff within the agency.	15	24	13	13	0
16. Agency administration (funds, budget, staffing).	47	9	4	3	2
17. Make merit evaluations of agency staff.	53	10	1	0	1
18. Plan staff conferences.	41	18	4	2	0
19. Keep count of the number of clients served by the agency.	23	21	12	7	2
20. Score objective paper and pencil psychological tests.	58	6	0	0	1

21.	Arrange appointments for clients of other staff.	44	14	4	2	1
22.	Participate in staff business meetings.	26	15	19	5	0
23.	Determine what fee client should pay.	55	5	4	0	1
24.	Collect fee payments from clients.	57	4	4	0	0
25.	Fill out a record form for your contacts with client.	21	15	18	10	1
26.	Type reports prepared by other agency personnel.	56	4	2	3	0
27.	Assign the clients one will see.	55	6	3	1	0
28.	Keep inventory and order supplies.	40	17	5	3	0
29.	Formulate personnel practices for clerical staff.	56	6	1	1	1
30.	Develop methods of improving the agency's service to clients.	17	29	14	5	0
31.	Have a voice in determining the policies that control services to consumers.	29	18	12	4	2
32.	Act as a receptionist to provide information and assistance to newcomers to the agency.	28	20	10	7	0
33.	Expedite changes in agency rules and regulations.	31	22	10	2	0
34.	Do evaluation of agency "in house" problems.	27	22	11	4	1

35.	Do routine filing	31	24	9	1	0
36.	Answer routine telephone inquiries.	17	23	13	11	1
37.	Maintain problem-oriented records.	31	13	15	6	0

Role Group III Community Professional

38.	Help organize agency Boards and/or Advisory committees.	55	6	2	1	1
39.	Act as a liaison between community agencies	26	19	11	9	0
40.	Write articles for local newspapers on agency or multi-agency functions.	57	6	2	0	0
41.	Organize "Open-house" or other invitational programs.	44	18	1	2	0
42.	Report complaints originating from the community to the agency	33	25	5	1	0
43.	Is available in places where people congregate (Street Worker).	50	2	10	3	0
44.	Help families and small groups know how to go about getting services.	26	24	10	5	0
45.	Participate in local planning (Serve on Boards, committees of recreation, aging, rehabilitation programs, etc.).	48	11	5	1	0
46.	Do evaluation of neighborhood problems.	54	9	2	0	0
47.	Participate in consultation to community groups.	50	11	4	0	0
48.	Interpret the work of the agency to lay or professional individuals (other than client's relatives).	30	23	8	4	0

49.	Serve as consultant to community groups and agencies.	50	10	41	1	0
50.	Give lectures on mental health to community groups.	56	6	3	0	0
51.	Represent agency at a convention.	47	12	5	1	0
52.	Represent agency at a meeting with other agencies.	34	19	12	0	0
53.	Participate in programs for the public concerned with mental illness and mental health.	44	15	5	0	1

Role Group IV Professional Growth

54.	Attend professional conventions to keep up with new ideas.	27	26	11	1	0
55.	Attend special workshop(s) and/or seminar(s).	13	36	13	3	0
56.	Get further training in Mental Health	43	9	7	5	1
57.	Read professional literature.	4	35	20	6	0
58.	Ask another staff member to explain how he/she came to his/her opinion about a client.	5	27	25	7	1
59.	Sit in as observer in client groups to learn about group interactions and dynamics.	32	14	12	4	3
60.	Request orientation before assuming full responsibility for job performance	12	39	8	5	1
61.	Seek evaluation of work.	15	38	9	3	0

62.	Progressively assume more responsibility at work	3	25	24	11	2
63.	Evaluate own weaknesses and strengths.	5	29	18	11	2

Role Group V Scientific

64.	Publish research in professional journals.	64	1	0	0	0
65.	Survey community to determine mental health needs.	55	7	2	1	0
66.	Expand on previously reported research.	55	9	1	0	0
67.	Interpret research and its relevancy to the agency.	51	13	1	0	0
68.	Tabulate or record data obtained by others.	44	13	5	0	0
69.	Prepare graphs, charts or tables to present research findings.	51	8	5	1	0
70.	Cooperate as judge, subject, data collector in research of agency colleagues.	51	7	5	0	2
71.	Plan research programs.	61	3	1	0	0
72.	Prepare research reports.	58	6	1	0	0
73.	Analyze research data.	58	7	0	0	0
74.	Do research on areas of personal interest	33	20	9	1	2
75.	Do research studies on issues of agency interest.	50	11	4	0	0

76.	Formulate a grant request for a study within the agency.	60	2	2	0	1
77.	Review the research literature on a topic.	43	18	4	0	0
78.	Abstract research articles.	57	7	0	0	1

Role Group VI Direct Client Services, Evaluating

79.	Reports changes in vital signs	37	15	9	3	1
80.	Write progress notes.	17	19	20	9	0
81.	Monitor client's work assignment.	30	19	6	9	1
82.	Visit client at home to assess home situation.	34	16	9	6	0
83.	Assess client's motivation and desire for help.	8	18	24	15	0
84.	Make decision regarding client's need for this agency's service.	15	20	19	10	1
85.	Assess the client's adjustment after agency service has terminated.	31	19	12	3	0
86.	Determine what type of problem the client has.	12	24	17	12	0
87.	Determine what psychological tests are appropriate.	54	9	2	0	0
88.	Administer psychological tests.	60	4	1	0	0
89.	Evaluate and interpret client's psychological test performance.	61	4	0	0	0
90.	Obtain educational and vocational history from client.	27	21	14	3	0

91. Obtain social history information from client.	27	17	18	3	0
--	----	----	----	---	---

Role Group VII Direct Client Services, Helping

92. (See Role Group IX Psychotherapies)					
93. Discuss the treatment plans with the client.	64	1	0	0	0
94. Aid the client to understand what services the Mental Health Technician can offer.	61	2	2	0	0
95. Give educational or vocational advice to client.	25	20	10	14	1
96. Chat informally, play cards, walk, etc., with the client.	4	10	23	28	0
97. Teach skills to the client.	20	16	9	20	0
98. Participate in leisure activities with clients.	6	17	20	22	0
99. Conduct groups where clients discuss their problems.	28	14	14	9	0
100. Tell the client what you would do in his/her position.	25	28	8	3	1
101. Talk with children about their problems.	35	15	7	8	0
102. Talk with adult clients about their problems.	17	14	18	15	1
103. Talk with adolescents about their problems.	36	14	10	5	0
104. Conduct play therapy sessions with children.	52	2	4	6	1

105.	Work with clients for an extensive number of interviews (more than 24).	39	9	8	8	1
106.	Work with clients for a limited number of interviews (3-24).	31	11	12	11	0
107.	Work with clients for a few interviews (1-2).	33	14	10	7	1
108.	Attempt basic personality change in clients.	22	12	19	12	0
109.	Attempt to enhance client's self understanding self acceptance.	6	18	18	22	1
110.	Discuss those test results with a client which might help him.	54	8	2	1	0
111.	Help client clarify his/her problem and what can be done about it.	13	16	19	17	0
112.	Interview clients with intent to modify attitudes and behavior.	18	20	13	13	1
113.	Interview clients with intent to provide emotional support.	14	17	17	17	0
114.	Interview clients with intent to modify the client's defenses.	23	20	11	11	0
115.	Work for realistic decision making on client's part through interview.	17	20	16	12	0
116.	Discuss interpersonal problems with client.	18	19	19	9	0
117.	Discuss childhood events with the client.	30	23	9	3	0
118.	Discuss current life stresses with client.	14	21	18	12	0

119.	Discuss future plans and problems with client.	15	15	22	13	0
120.	Discuss client's feelings toward therapist.	29	27	8	1	0
121.	Discuss with the client one's feelings towards him/her.	21	24	12	8	0
122.	Aid the client to re-experience currently unconscious memories.	52	7	6	0	0
123.	Utilize the client's dreams in interviews.	55	7	2	0	1
124.	Utilize the technique of free association in the interviews.	52	9	4	0	0
125.	Interview clients with relatively simple problems.	22	17	19	7	0
126.	Interview clients with somewhat complex problems.	21	17	18	9	0
127.	Interview clients with extremely complex problems.	30	12	15	8	0
128.	Terminate one's interactions with client.	34	22	7	1	1
129.	Dispense medications.	54	8	0	2	1
130.	Act as a parent surrogate (house-parent).	49	3	6	7	0
131.	Assist client with homemaking.	48	7	6	3	1
132.	Organizes and works with client and significant others (principal, police, teacher, etc.) in a group.	43	11	7	4	0

133.	Reaches out and works with people who can't come to the agency (i.e., physically disabled, prisoners, etc.).	55	3	2	4	0
134.	Assist client in job placement.	39	17	5	4	0
135.	Listens to crisis calls, emergency calls on the telephone... coaches, and gives information.	38	14	9	4	0
136.	Helps with problem children in schools.	43	5	4	13	0
137.	Intervene in crisis situations.	22	22	15	6	0
138.	Provide tutorial and remedial work.	47	6	3	9	0
139.	Conduct ward meetings (patients).	50	6	9	0	0
140.	Translate to client's native tongue.	56	4	5	0	0
141.	Is actively involved with client in all aspects of his treatment from admission through discharge (milieu therapist).	39	5	5	15	1
142.	Help client understand expectations and goals of treatment.	25	13	18	9	0
143.	Visit client after discharge to assure that medication is being taken and activities of daily living are being performed.	45	10	8	2	0
144.	Assist client with legal problems.	40	18	5	2	0
145.	Provide role model for client.	26	10	12	16	1
146.	Help client with financial problems.	26	20	10	8	1

147.	Transport groups of clients or client via automobile or bus.	21	18	16	9	1
148.	Prepare client for a physical examination by a physician.	46	13	5	1	0
149.	Assist in patient care (physical).	42	12	6	4	1
150.	Takes vital signs (temperature, pulse, respiration, blood pressure.	50	13	2	0	0
151.	Performs emergency first aid.	39	23	2	1	0
152.	Orients client to agency.	19	28	13	5	0
153.	Go into the community with client as a support person to help find housing, job, etc.	35	17	8	5	0
154.	Visit client at home.	37	13	8	5	2
155.	Mans storefront office.	56	1	2	6	0

Role Group VIII Indirect Client Services

156.	Relate client expectations to the professionals involved in his treatment.	25	20	17	2	1
157.	Record pertinent information of your own observations on patient records.	16	15	24	10	0
158.	Assist families in early detection of recurring mental illness in client.	45	13	7	0	0
159.	Assess attitudes of families toward client.	21	32	10	2	0

160.	Report back to the treatment team the patient's progress at home.	44	16	3	2	0
161.	Discuss treatment plan with relatives of the client.	24	27	12	2	0
162.	Cooperate with representatives of other agencies also providing services to client.	20	28	12	5	0
163.	Arrange for referral of client to appropriate outside agency or person.	23	24	14	3	1
164.	Contact other professional staff within the agency so as to provide for the effective transition of the client between different services.	26	25	12	2	0
165.	Present progress of a case at a staff conference.	23	24	14	4	0
166.	Attempt to modify the behavior of client's relatives through interview(s).	34	23	7	0	1
167.	Participate with other staff in developing plans for amelioration of client's problems.	17	26	18	4	0
168.	Interview client's relatives to gain information about the client.	32	22	8	3	0
169.	Interview client's relatives to help them understand the client's problems.	30	24	9	2	0
170.	Communicate by telephone or letter with client's relatives.	19	32	10	4	0
171.	Aid other staff in providing a more suitable environment (home, school or job) for clients.	20	25	12	8	0

Role Group IX Psychotherapies

92. A. Psychodrama	54	3	5	2	1
B. Primal	64	1	0	0	0
C. Gestalt	61	2	2	0	0
D. Family therapy	51	6	5	3	0
E. Rehabilitative	44	3	11	7	0
F. Transactional analysis	59	2	3	1	0
G. Behavior modification	36	9	6	14	0
H. Bioenergetics	64	1	0	0	0
I. Other	57	1	5	2	0
J. Other	64	0	0	1	0

APPENDIX B

Related Correspondence



The Commonwealth of Massachusetts 130

University of Massachusetts

Amherst 01002

COMMUNITY COLLEGE AFFAIRS
SCHOOL OF EDUCATION

February 11, 1974

Letter to Directors of MHT programs in Massachusetts

Dear

Having brought to fruition one of the pioneer programs in Community Mental Health Technology, I share with you a growing awareness of the enormity of what remains to be done for our graduates.

I have, therefore, undertaken the project of trying to find identity for the Mental Health Technicians in Massachusetts for my doctoral dissertation. With a specific base of fundamentals, graduates from all programs will have a common bond in their profession. I shall be looking for such commonalities via questionnaires, interviews, and on-the-job observation.

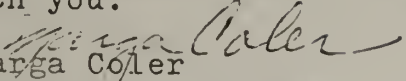
Rest assured that it is not my intention to lock the generalists into a box of specialization, but to help them achieve more mobility. Once having identified the skills and functions that transcend the profession, effort can be made toward instituting greater vertical and horizontal movement in the job market and in curriculum planning.

I would appreciate the following information at your earliest convenience:

1. Names and addresses of your graduates to date
2. A list of all the agencies in which your graduates have found employment.
3. The name and title of the contact person in each agency

page 2

Please feel free to offer suggestions. I shall, of course, share my findings with you.


Marga Coler
Doctoral candidate
Associate Professor
Community Mental Health
Technology
Greenfield Community College
Greenfield, Massachusetts

Note: Kindly forward the information to my home address:

294 Pelham Road
Amherst, Massachusetts 01002

cc. Denton Crews
Douglas Decker
Mary DiGiovanni
Mary Killeen
Thomas McNamee
Peter Trainor
Bernard Prescott
Joseph Correy



The Commonwealth of Massachusetts 132

University of Massachusetts

Amherst 01002

COMMUNITY COLLEGE AFFAIRS
SCHOOL OF EDUCATION

February 14, 1974

Letter to Registrars of Two Year
Institutions in Massachusetts

To whom it may concern:

Would you be kind enough to advise me if your institution offers a program in or akin to Mental Health Technology.

I am seeking this information in preparation for graduate research (doctoral dissertation) on the status of this paraprofessional in Massachusetts.

I would also appreciate the name of the program director if you have such a curriculum.

Thank you very much.

Sincerely,

A handwritten signature in cursive script that reads "Marga Coler".

Marga Coler
Associate Professor
Community Mental Health
Technology
Greenfield Community College



The Commonwealth of Massachusetts 133

University of Massachusetts

Amherst 01002

COMMUNITY COLLEGE AFFAIRS
SCHOOL OF EDUCATION

April 4, 1974

Letter accompanying Survey Questionnaire

Dear

I am writing to all graduates of two year programs in Mental Health Technology to ask for their assistance in making a study of this new career field.

My vested interest is that of a faculty member in such a curriculum. As you know, evaluation is a "must" if the courses are to remain relevant. I have, therefore, decided to once more join the ranks of students and make that project my doctoral dissertation.

Enclosed is a brief survey. Please take a few minutes to answer the questions as specifically as possible. Actually, there is not time like the present, for then the form won't get misplaced. A stamped return envelope is enclosed.

I hope this will be a cooperative venture. Please feel free to contact me if you have any questions or comments.

Thank you very much for your time!

Sincerely,

A handwritten signature in cursive script that reads "Marga Coler".

Marga Coler
Associate Professor
Community Mental Health
Technology
Greenfield Community College



The Commonwealth of Massachusetts 134

University of Massachusetts

Amherst 01002

COMMUNITY COLLEGE AFFAIRS
SCHOOL OF EDUCATION

April 26, 1974

Letter sent to ten professional mental health workers accompanying Magoon and Golann's "Inventory of Job Functions" and questions extracted from review of literature

Dear:

Enclosed, please find a questionnaire I shall be administering to practicing Mental Health Technician graduates of community college programs in Massachusetts. This project, part of my doctoral research, will seek to identify the in vivo tasks and roles of these practitioners.

I am forwarding the questionnaires to you as one of a select group of professionals for comments regarding its revision. The original survey was used by Golann and Magoon in an early study of mental health paraprofessionals (1963), but now, a decade later, needs modernization.

I would appreciate your analysis of the new tasks I have screened from the literature. These are enclosed herein. Kindly indicate under which category you would put each new task by listing the section number in the space provided.

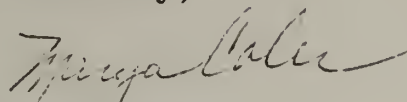
If there are additional tasks that come to mind but are not listed, kindly write these at the bottom of each section in the space designated "Others."

I can well appreciate the investment of time that granting this request imposes, and I thank you for sharing your expertise in helping me find an identity for these paraprofessionals in mental health.

page 2

Please feel free to contact me at 253-3779 if there are any questions. Thank you very much for your time and effort.

Cordially,

A handwritten signature in cursive script, appearing to read "Marga Coler".

Marga Coler
Associate Professor
Community Mental Health
Technology
Greenfield Community College

PROPOSED TASKS FOR MENTAL HEALTH TECHNICIANS

(to accompany the Inventory of Job Functions)

Directions: The following tasks have been screened from the literature as illustrative of Mental Health Technicians. These tasks do not seem to be identified in the Inventory of Job Functions (Golann and Magoon, 1963), and are proposed as addenda to the enclosed survey. Kindly:

1. Indicate by inserting the section number in the space provided under which main section in the Inventory of Job Functions you would categorize each proposed task:
 - 1 Educating
 - 2 Administration
 - 3 Community professional
 - 4 Professional growth
 - 5 Scientific
 - 6 Direct client services, evaluating
 - 7 Direct client services, helping
 - 8 Indirect client services

2. Indicate by inserting the listed task number (i.e., 66 for "Teach skills to the client") in the Inventory instead of the section number if you feel that the proposed task is redundant to one already listed.

3. Add tasks not listed that you feel should be included in the area marked "Others" following each section in the original Inventory.

Section # or
Task #

(Frankel)

- | | |
|---|-------|
| 109. Writes progress notes | _____ |
| 110. Intervenes in crisis situations | _____ |
| 111. Evaluates own weaknesses and strengths | _____ |

PROPOSED TASKS FOR MENTAL HEALTH TECHNICIANSSection # or
Task #

(Gottesfeld)

112. Visits patients at home _____
113. Mans storefront office _____
114. Provides tutorial and remedial work _____
115. Translates to client's native tongue _____
116. Plans aftercare services _____
117. Reports complaints originating from
the community to the agency _____
118. Relates clients' expectations to
professionals involved in his
therapy _____

(Long)

119. Is actively involved with the client
in all aspects of his treatment from
admission through discharge (milieu
therapist) _____

(Siegel)

120. Helps patient understand expecta-
tions and goals of treatment _____
121. Assists families in early detection
of recurring mental illness _____
122. Visits patient after discharge to
assure that medication is being
taken and activities of daily living
are being performed _____
123. Is available in places where people
with problems congregate (Street
Worker) _____

PROPOSED TASKS FOR MENTAL HEALTH TECHNICIANS

- | | Section # or
Task # |
|---|------------------------|
| 124. Maintains problem oriented records | _____ |
| (Southern Regional Education Board) | |
| 125. Helps families and small groups know how to go about getting services. | _____ |
| 126. Assist with legal problems | _____ |
| 127. Expedite changes in local rules, regulations | _____ |
| 128. Assess attitudes of families toward client | _____ |
| 129. Do evaluation of "in house" (agency) problems | _____ |
| 130. Do evaluation of neighborhood problems | _____ |
| 131. Provides role model for client | _____ |
| 132. Conducts programs prescribed by others- indicate appropriate one(s) | |
| Transactional analysis | _____ |
| Psychodrama | _____ |
| Gestalt | _____ |
| Bioenergetics | _____ |
| Primal | _____ |
| Behavior modification | _____ |
| Other (specify) _____ | _____ |
| 133. Dispense medications | _____ |
| 134. Directs and plans therapeutic recreation programs | _____ |
| 135. Monitors client's work assignment | _____ |

PROPOSED TASKS FOR MENTAL HEALTH TECHNICIANS

	Section # or Task #
136. Works with industry to creat jobs for mentally ill/mentally retarded	_____
137. Participates in local planning (serves on Boards, committees of recreations, aging, rehabilitation programs, etc.)	_____
138. Assists client with homemaking	_____
139. Acts as a parent surrogate	_____
140. Visits client at home to assess home situation	_____
141. Works with families for an extensive number of interviews (more than 24)	_____
142. Works with families for a limited number of interviews (3-24)	_____
143. Works with families for a few interviews (1-3)	_____
144. Follows up clients to assure that they are progressing with their rehabilitation in the community	_____
145. Works with client and "significant others" (teachers, principal, police) in a group	_____
146. Promotes and assists development of new programs and resources (i.e., alcoholics, offenders, ex-patients, etc.)	_____
147. Reaches out and works with people who can't come to the agency(i.e., prisoners, physically disabled, etc.)	_____
148. Listen to crisis calls (emergency calls, coach, give information	_____

PROPOSED TASKS FOR MENTAL HEALTH TECHNICIANS

Section # or
task #

149. Coordinates services on behalf of a specified small group of clients (i.e., mentally retarded, learning disabilities, etc.)

(Wellner and Simon)

150. Helps with "problem children" in schools

(Young et al)

151. Teaches patients specific skills

152. Conducts ward meetings

153. Does routine filing

154. Reads patients' files and records

155. Reports back to the treatment team the patient's progress at home

156. Helps client obtain educational assistance

157. Helps client with financial problems

(Undocumented)

158. Transports client or group of clients via automobile, bus

159. Answers routine telephone inquiries

160. Prepares client for physical examinations by a physician

161. Assists in patient care

162. Takes vital signs (temperature, pulse, respirations, blood pressure) of patients

PROPOSED TASKS FOR MENTAL HEALTH TECHNICIANS

	Section # or Task #
163. Performs emergency medical procedures	_____
164. Assists with Electroconvulsive therapy	_____
165. Orients client to agency	_____
166. Records pertinent information on client's chart	_____
167. Goes into community with client as a support person to help find housing, job, etc.	_____
168. Provides escort service for patients within institution/agency	_____



The Commonwealth of Massachusetts 142

University of Massachusetts

Amherst 01002

COMMUNITY COLLEGE AFFAIRS
SCHOOL OF EDUCATION

July, 1974

Letter Accompanying MHT Task Assessment Mailed to MHT
Practitioners Identified After
the Interviewing Period

Dear

Enclosed are the questionnaires I referred to in our recent telephone conversation.

Please try to be as accurate as possible in answering the questions. If you find that some tasks can't be easily measured on a weekly basis in that you do some of them only occasionally, try to estimate the time spent by you in hours per year (or month) and divide by 52 (or 4).

Ex: #151 Performs emergency first aid

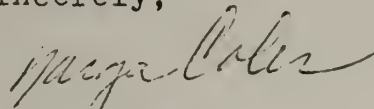
You may have done this only once during a two-year employment period. Yet it was part of your job at that time. The task took 45 minutes. Your answer would be in the "Up to one hour" column since it encompasses anything from one minute to one hour per week.

I would also like to stress the importance of answering the items honestly. For instance, if a task is not part of your official job description, yet you perform it anyway because of circumstance, please indicate how much time is spent. As I mentioned on the phone, the information you provide will be used for revision of MHT curricula. Every practitioner's feedback will be most important in helping to develop the MHT profile.

page 2

Thank you very much for you time and patience.
Feel free to call me at home (413-549-6169) if you have
any questions. I would appreciate your prompt attention.

Sincerely,



Marga Coler
Associate Professor
Community Mental Health
Technology
Greenfield Community College

Enclosure

APPENDIX C

MHT Survey Computer Program

APPENDIX C

Identification Guide for Graduate Mental Health
Technicians, Massachusetts, 1974
(Computer Series, 1)

Card Column	Specification (description)
1 - 3	ID Number of respondent (Survey question # unnumbered)
4 - 5	Type of agency (#9) <ul style="list-style-type: none"> 01 Mental Health Center 02 State hospital 03 Mental retardation facility 04 Veterans' Administration Hospital 05 General hospital 06 School department 07 Nursing home 08 Private school 09 Welfare department 10 Detention center 11 Probation 12 Senior center 13 Other 14 Recreation 15 Juvenile delinquency 16 Rest home 17 Half-way home (psychiatric) 18 Low income housing 19 Public Health Department 20 Social Service 21 Residential treatment (home for adolescent girls, homeless boys) 22 Anything 23 Community Action 24 Day care center 25 26 Youth resources agency 27 Rehabilitation center, sheltered workshop

APPENDIX C (continued)

Card Column	Specification (description)
6 - 7	01 Community Agency 02 Residential (adult) 03 Residential (child) 04 Residential (adolescent) 05 Day Care (child) 06 Public schools 07 General hospital
8 - 9	Department or Service (#11) 00 Pre-school (emotionally dis- turbed) 01 Pre-school (mentally retarded) 02 State school, residential (mentally retarded) 03 Young adult program 04 05 Young adult program 06 Mentally retarded, school age 07 Emotionally disturbed 08 Psychiatric unit (in-patient) 09 Emotionally disturbed resi- dential school 10 Behavior modification 11 Out-patient department 12 Social service 13 Management 14 In-patient clinic 15 Welfare 16 Activities, recreation 17 Senior citizens 18 Blind unit (mentally retarded) 19 Administration 20 Nursing 21 Special education 22 Residential school (mentally retarded) 23 Day care nursery 24 Psychology 25 Day care 26 Drug Abuse Foundation 27 Judicial

APPENDIX C (continued)

Card Column	Specification (description)
10 - 11	(blank) For possible use for recategorizing columns #8 and #9
12 - 13	Official job title (#10) <ul style="list-style-type: none"> 01 Mental Health Technician 02 Mental Health Associate 03 Community Mental Health Technician 04 Community Mental Health Associate 05 Child Care Technician 06 Outreach Worker 07 Mental Health Worker 08 09 10 Social Worker 11 Teacher's Aide, Teacher's Assistant, Assistant Teacher, Instructor's Assistant 12 Attendant 13 Associate Director 14 Special Service Assistant 15 Administrator (rest home) 16 Institutional Domestic Worker 17 Half-way House Operator 18 Counselor (alcoholism) 19 Case Aide 20 Activities Director, Program Director 21 Director 22 Coordinator Aide 23 Administrative Assistant 24 Developmental Day Care Assistant 25 Public Health Assistant 26 Behavior Manager 27 Perceptual Tutor 28 Child's Aide 29 Special Education Aide (Learning Disabilities, Remedial Reading Aide)

APPENDIX C (continued)

Card Column	Specification (description)
12 - 13	30 Coordinator 31 Child Care Worker 32 Housemother, Houseparent 33 Vista Worker 34 Assistant House Manager 35 Teacher 36 Investigator 37 Secretary
14 - 15	(blank) For possible use for recate- gorizing columns #12 and #13
16 - 18	Name of the director of your agency (#8)
19 - 20	Title of the director of your agency (#8) 01 Head Teacher 02 Unit Director, Program Director, Director of Activities 03 Director 04 Administrator 05 Self 06 Psychiatrist 07 Superintendent 08 Psychologist 09 Principal 10 Project Director 11 Acting Director 12 Judge 13 Chief of Psychiatry
21	Program from which graduated (#1) 1 Bay Path Junior College 2 Bristol Community College 3 Greenfield Community College

APPENDIX C (continued)

Card Column	Specification (description)
21	4 Mt. Wachusett Community College 5 Springfield Technical Community College 6 Other
22	Have you ever been employed as a mental health technician? (#14) 1 Yes 0 No
23	Have you been looking for a job in mental health? (#15) 1 Yes 2 No
24 - 25	Indicate in what area you would like to work if your answer to #15 was "Yes"
26 - 27	Use list in #9 (#16)
28 - 29	(Job Bank Information)
30	Wants to help politically (i.e., implement State Civil Service job slot)
31	Wants results
32	Additional comments 0 Negative about mental health technology 1 Positive about mental health

APPENDIX C (continued)

Card Column	Specification (description)
32	technology 2 Neutral
33	Is continuing education part time
34	Has advanced academic degree
35 - 37	(blank)
38	Number of hours officially working (#12) 1 30+ hours (full time) 2 Part time 3 40+ hours (overtime)
39	Average workday from () a.m./p.m. to () a.m./p.m. 1 8 a.m. - 5 p.m. (within) 2 4 p.m. - midnight (within) 3 midnight - 8 a.m. (within) 4 Rotating shifts 5 On call 6 Fluctuates 7 Around the clock 8 Split shifts
40 - 42	Name of agency in which employed (#7) 001 New Bedford Welfare Office 002 Community Clinical Nursery School 003 Belchertown State School 004 Youth Resources Agency 005 Hampden County Association for Retarded Children 006 Northampton State Hospital

APPENDIX C (continued)

Card Column	Specification (description)
40 - 42	007 Northampton Veterans' Administration Hospital
	008 Community Care Center (Springfield)
	009 West Springfield School System
	010 Our Lady of Providence Children's Center
	011 Colonial Manor Rest Home, Inc. 012
	013 Westfield Community Clinical Nursery School
	014 Ashram Halfway House
	015 Franklin County Public Hospital
	016 Rural Housing, Improvement, Inc.
	017 Gardner - Athol Mental Health Center
	018 Fall River Community Service Center
	019 St. John's Nursing Home
	020 Greenfield Senior Center
	021 Springfield Court Project
	022 Burbank Hospital, Fitchburg
	023 Department of Mental Health, Developmental Day Care
	029 Eliho White Nursing Home
	030 Springfield Public Health Department
	033 Erich Lindemann Mental Health Center
	036 Valley View Farm (private school)
	037 Hubbardston School System, Center School
	038 Fall River Mental Health Association
	039 Senior Services Project
	040 Dr. Franklin Perkins School
	041 Hatfield School System, Elementary School
	042 Hampshire Community Action/ Neighborhood Youth Corps

APPENDIX C (continued)

Card Column	Specification (description)
40 - 42	044 Cardinal Cushing School 045 Protestant Youth Services 046 Springfield Hospital Medical Center 047 People, Inc. 051 Franklin County Association for Retarded Citizens 052 St. John's Child Care and Development Center 053 Insight 70's 056 New Bedford Area Center for Human Services 058 Greenfield School Department
43 - 44	Degree earned (#2) 1 Associate in Science 2 Associate in Arts 3 Other (specify) (col. 44)
45 - 47	When did you get a job in the mental health field (#3) 0 (answer questionable) 1 Had one before I came to school 2 While at school and continued after graduation 3 At graduation 4 After (columns 46, 47, months) 5 Did not get one
48 - 50	How soon after graduation were you looking for a job (#4) 1 Wasn't looking because I already had a job 2 Right away 3 After (columns 49, 50) months

APPENDIX C (continued)

Card Column	Specification (description)
	If "Yes", how long have you had the job? (#6)
51 - 52	Years
53 - 54	Months
55 - 56	Weeks
57	Geographic location of job (#7)
	<ul style="list-style-type: none"> 1 Eastern Massachusetts 2 Central Massachusetts 3 Western Massachusetts
58	Column 57 (1)
	<ul style="list-style-type: none"> 1 New Bedford 2 Fall River 3 Braintree 4 Boston 5 Hanover
	(2)
	<ul style="list-style-type: none"> 1 Winchenden 2 Gardner 3 Fitchburg 4 North Brookfield 5 Hubbardston 6 Lancaster
	(3)
	<ul style="list-style-type: none"> 1 Springfield 2 Holyoke, Chicopee 3 Northampton 4 Belchertown 5 Greenfield 6 Westfield 7 Hatfield 8 Millers Falls 9 Amherst

APPENDIX C (continued)

Card Column	Specification (description)
59 - 60	Geographic location of job (#7) Out of State 01 New York 02 New Hampshire 03 Vermont 04 Connecticut 05 Minnesota 06 Rhode Island 07 Ohio 08 Florida
61	(blank)
62	1 Male Female
63	Card Series Number (1)

REFERENCES

- . Action for Mental Health: Final Report of the
Joint Commission on Mental Illness and Health. New
York: Basic Books, 1961.
- Albee, G. Mental Health Manpower Trends. New York: Basic
Books, 1959.
- American Association of Community and Junior Colleges, 1973
Community and Junior College Dictionary, American
Association of Community and Junior Colleges, 1973.
- Angel, J. Directory of Professional and Occupational Li-
censing in the U. S. New York: World Trade Academy
Press, Inc., 1970.
- Baker, E. "The Mental Health Associate: A New Approach in
Mental Health," Community Mental Health Journal,
1972, 8(4), 281-292.
- Baker, E. "The Mental Health Associate: One Year Later,"
Community Mental Health Journal, 1973, 9(3), 203-215.
- Baker E. & McPheeters, H. Middle Level Workers: Character-
istics, Training and Utilization of Mental Health
Associates. New York: Behavioral Publications, Inc.,
1975.
- Christmas, J., Wallace, H., & Edwards, J. "New Careers and
New Mental Health Services: Fantasy or Future,"
American Journal of Psychiatry, 1970, 126(10), 1480-
1485.
- Cohen A. Dateline '79: Heretical Concepts for the Community
College. California: Glencoe Press, 1969.
- Coler, M. "A Core Curriculum in Human Services," Unpublished
manuscript. Greenfield Community College, 1974.
- Coler, M., & Bloomberg, S. "New Aspects of Community Mental
Health," Journal of the Massachusetts Recreation and
Park Society, 1971, 1(1), 16-19.
- Collins, J. "The Mental Health Paraprofessional: Manpower
Issues," Unpublished manuscript, Harvard University
Medical School.
- Collins, J. & Cavanaugh, M. "Mental Health Training for the
Community Health Paraprofessional, Unpublished manu-

script, Harvard University Medical School.

- _____. "A Competency-Based Mental Health and Human Services Training Model," Unpublished manuscript, New York State Department of Mental Hygiene.
- Cowen E., Gardner, E., & Zax, M. Emergent Approaches to Mental Health Problems. New York: Appleton-Century-Crofts, 1967.
- Cross, K. P. Beyond the Open Door. San Francisco: Jossey-Bass, Inc., 1971.
- Deyo, D. Access to Quality Community College Opportunity. Massachusetts: 1967.
- Eisdorfer, C., & Golann, S. "Principles for the Training of 'New Professionals' in Mental Health," Community Mental Health Journal, 1969, 5(5), 349-357.
- Eisner, E. "Instructional and Expressive Educational Objectives: Their Formulation and Use in Curriculum," Unpublished manuscript, Stanford University.
- Fink, P., & Zerof, H. "Mental Health Technology: An Approach to the Manpower Problem," American Journal of Psychiatry, 1971, 127(8), 1082-1086.
- Frankel, A. "Evaluation of MHA Fieldwork Training at the Salem Veterans Administration Hospital," Unpublished manuscript, Salem, Va. Veterans Administration Hospital.
- Gleazer, E. This is the Community College. Boston: Houghton Mifflin Co., 1968.
- Golann, S. & Magoon, T. "The Development of a Mental Health Agency Job Function Inventory," Journal of Clinical Psychology, 1966, 22(3), 347.
- Golann, S. & Magoon, T. Development of a Mental Health Agency Job Functions Inventory and its Application with Non-traditionally Trained Therapists. Paper presented at the Eastern Psychological Association meetings, New York, April 12, 1963.
- Gottesfeld, H., Rhee, C., & Parker, G. "A Study of the Role of Paraprofessionals in Community Mental Health" Community Mental Health Journal, 1970, 6(4), 285-291.

- Greene, K. Occupational Licensing and the Supply of Non-professional Manpower, U.S. Department of Labor. Washington: U.S. Government Printing Office, 1969.
- Grosser, C., Henry, W., & Kelly, J., (Ed). Non-Professionals in the Human Services. San Francisco: Jossey-Bass, Inc., 1969.
- Groth-Marat, B. "Notes from a Paraprofessional," The Clinical Psychologist, 1971, 24(9), cited by R. Long, Clinical Psychologist, 1973, 26(4), 3.
- Hadley, J., True, J., & Kepes, S. "An Experiment in the Education of the Professional Mental Health Worker: The Purdue Program," Community Mental Health Journal, 1970, 6(1), 40-50.
- Hatch, T. "The Changing Scene in Allied Health Professions Education," Journal of the American Dietetic Association, 1973, 63(1), 15-18.
- Henry, W., Sims, J., & Spray, S. The Fifth Profession. San Francisco: Jossey-Bass, Inc., 1971.
- Hirschowitz, R. "Aide-Therapist Programs," Mental Hygiene, 1967, 51, 576-579.
- Holler, R., & DeLong, G. Human Services Technology. Saint Louis: C. V. Mosby Co., 1973.
- Hopke, W. (Ed)., The Encyclopedia of Career and Vocational Guidance. Chicago: J. G. Ferguson Publishing Co., 1972.
- Iscoe, I. & Spielberger, C. (Ed)., Community Psychology: Perspectives in Training and Research. New York: Appleton-Century-Crofts, 1970.
- Ivey, A., & Hinkle, J. "A Study in Role Theory: Liaison Between Social Agencies," Community Mental Health Journal, 1970, 6(1), 63-68.
- Janor, A. The Anatomy of Mental Illness. New York: G. P. Putnam's Sons, 1971.
- Kiffer, T. & Burns, M. Human Services Occupations in the Two-year College: A Handbook, University Park, Pa: Pennsylvania State University, 1972.

- Kinsinger, R. Education for Health Technicians - An Overview. Report to the American Association of Junior Colleges, February, 1966.
- League of Women Voters. Massachusetts State Government. Cambridge: Harvard University Press, 1970.
- Leopold, J. Seminar presentation to doctoral students in Mental Health Systems and Human Services Design department, University of Massachusetts, School of Education, November 16, 1973.
- Long, R. "Angry Paraprofessionals Versus Resisting Professionals," The Clinical Psychologist, 1973, 26(4), 3-5.
- Lubetkin, R. "Review of Associate Degree Programs for Training Mental Health Technicians," Unpublished manuscript, Harvard University Medical School.
- Lynch, M., & Gardner, E. "Some Issues Raised in the Training of the Paraprofessional Personnel as Clinic Therapists," American Journal of Psychiatry, 1970, 126(10), 1473-1479.
- Mager, R. Preparing Instructional Objectives. Palo Alto: Fearon, 1962.
- Magoon, T., & Golann, S. "Nontraditionally Trained Women as Mental Health Counselors/Psychotherapists," Personnel and Guidance Journal, 1966, 44(8), 788-793.
- Magoon, T., Golann, S., & Freeman, R. Mental Health Counselors at Work. New York: Pergamon, 1969.
- Matarazzo, J. "Some National Developments in the Utilization of Nontraditional Mental Health Manpower," American Psychologist, 1971, 26(4), 363-372.
- McNeer, L. "Everything You Always Wanted to Know about Mental Health Programs," Community and Junior College Journal, 1974, 44(6), 26-28.
- McPheeters, H. "The Middle Level Mental Health Worker: II His Training," Hospital and Community Psychiatry, 1972, 23(11), 334-335.
- McPheeters, H. Personal Communication, Mental Health Technology and Officialdom: Issues in Payment, Certification and Licensure, 1974.

- McPheeters, H. Personal Communication, January 15, 1974.
- McPheeters, H., & King, J. Plans for Teaching Mental Health Workers: Community College Curriculum Objectives. Georgia: Southern Regional Education Board, 1971.
- McPheeters, H., King, J., & Teare, P. "The Middle Level Mental Health Worker: I His Role," Hospital and Community Psychiatry, 1972, 23(11), 329-334.
- Newman, F. Report on Higher Education. Washington: U. S. Department of Health, Education and Welfare, 1971.
- Pattison, E., & Elpers, J. "A Development View of Mental Health Manpower Trends," Hospital and Community Psychiatry, 1972, 23(11), 325-329.
- Pennell, M. "Status of Credentialing for Health Personnel," Journal of the American Dietetic Association, 1973, 63(1), 19-22.
- Pennell, M., & Hoover, D. Health Manpower Source Book 21, Allied Health Manpower Supply and Requirements: 1950-80. Washington: U. S. Government Printing Office, 1970.
- Pennell, M., Proffitt, J., & Hatch, Z. Accreditation and Certification in Relation to Allied Health Manpower. Washington: U. S. Government Printing Office, 1971.
- Perkins, J. The University as an Organization. New York: McGraw-Hill, 1973.
- Reiff, R., & Riessman, F. The Indigenous Non Professional: A Strategy of Change in Community Action and Community Mental Health Programs. New York: Community Mental Health Journal (monograph), 1967.
- Rioch, M., Elkes, C., & Flint, A., (Farber, L., MacLennan, B., Newman, R., Shellow, R., Silber, E., Usdansky, B., Weigert, E.) Pilot Project in Training Mental Health Counselors, National Institute of Mental Health. Washington: U. S. Government Printing Office, 1965.
- Rowe, C. An Outline of Psychiatry. Dubuque, Iowa: W. C. Brown, 1970.

- U. S. Department of Labor, Bureau of Labor Statistics. Occupational Outlook Handbook (Bulletin 1785), Washington: U. S. Government Printing Office, 1974.
- U. S. Department of Labor, Manpower Administration. Dictionary of Occupational Titles. Washington: U. S. Government Printing Office, 1965.
- U. S. Department of Labor, Manpower Administration. Guide for Analyzing Jobs. Washington: U. S. Government Printing Office, 1966.
- U. S. Department of Labor, Manpower Administration. A Handbook for Job Restructuring. Washington: U. S. Government Printing Office, 1970.
- Vidaver, R. "The Mental Health Technician: Maryland's Design for a New Health Career," American Journal of Psychiatry, 1969, 125(8), 1013-1023.
- Watkins, B. "Student Demands for 'Practical' Education are Forcing Major Changes in Curricula." Chronicle of Higher Education, 1973, 8(10), p. 2
- Wellner, A., & Simon, R. "A Survey of Associate-Degree Programs for Mental Health Technicians," Hospital and Community Psychiatry, 1969, 20(6), 166-169.
- Young, C., True, J., & Packard, M. "A National Survey of Associate Degree Mental Health Programs," Community Mental Health Journal, in press.
- Young, C., True, J., & Packard, M. "The Current Status of the Associate Degree Movement in Mental Health and the Human Services - An Overview," Unpublished manuscript, The Johns Hopkins Hospital, Center for Human Services Research, (MH 12741) National Institute of Mental Health.

- Siegel, R. "Do We Really Need Paraprofessional Mental Health Workers?" Hospital and Community Psychiatry, 1974, 25(5), 520.
- Siegel, R. "The Training and Use of Mental Health Associates in the Veterans Administration," Hospital and Community Psychiatry, 1974, 25(5), 295-298.
- Skaggs, K. "Occupational Education: The Program Crises," Community and Junior College Journal, 1973.
- Simon, R. "The Paraprofessionals Are Coming: The Paraprofessionals Are Coming." Paper presented at the annual convention of the American Psychological Association, September, 1970.
- Sobey, F. The Nonprofessional Revolution in Mental Health. New York: Columbia University Press, 1970.
- Southern Regional Education Board. Induction and Use of Associate Degree Workers in the Mental Health System. Georgia: Southern Regional Education Board, 1973.
- Southern Regional Education Board. Proceedings, National Development Conference, 1971, Community College Mental Health Workers Program. Georgia: Southern Regional Education Board, 1971.
- Southern Regional Education Board. Roles and Functions of Different Levels of Mental Health Workers. Georgia: Southern Regional Education Board, 1969.
- True, J. "Training New Mental Health Personnel in Group Methods: 1. Education and Work Performance of Associate Degree Workers as Related to Group Therapy," International Journal of Group Psychotherapy, 1974, 24(4), 383-392.
- True, J. & Young, C. "Associate Degree Programs for Human Services Workers," Personnel and Guidance Journal, 1974, 53(4), 304-307.
- True, J., Young, C., & Packard, M. "An Exploratory Study of Associate Degree Programs for Mental Health Workers," Public Health Reports, 1974, 89(4), 345-352.
- Turner, R., & Cumming, J. "Theoretical Malaise and Community Mental Health," Emergent Approaches to Mental Health Problems, (Cowen et al., ed). New York: Appleton-Century-Crofts, 1967.

