Mental health training added to a generic allied health curriculum affords a choice of careers in health disciplines and career advancement for 16 Boston inner city residents selected by peers.

Education in Mental Health

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THE NUMBER of health workers in the allied health occupations rose threefold during the years 1950 through 1967. More significantly, the number of such personnel with less than baccalaureate training doubled during the same period, constituting 29 percent of the total medical care work force in 1967. Taken with the segment of allied health workers with baccalaureate level training, all allied health personnel contributed 47 percent of the medical care work force during the same year (*1*).

Since 1967 many programs to create new kinds of allied health workers have appeared; these include, among others, training for duties as nurse practitioners (*2*), nurse-midwives (*3*), child health associates (*4*), health education aides (*5*), physician's assistants (*6, 7*), and family health workers (*8*). The mental health disciplines, in particular, have seen the advent of mental health technicians (*9, 10*), mental health assistants (*11*), and specific programs for the training and use of indigenous nonprofessionals in community mental health programs (*12–14*).

The growth and development of community mental health centers, as well as the extension of psychiatric services to previously unreached segments of the American population, have accentuated an already recognized shortage of mental health manpower. In addition, the emphasis on preventive services in mental health has highlighted this shortage even more. The need for not only increased numbers but also for new kinds of health and mental health manpower has been widely publicized.

While many programs for training new kinds of allied health workers have concentrated on providing exposure to one medical specialty only, such as nurse-midwifery, mental health technician, nurse practitioner, and so forth, an attempt to create a generic educational program which allows candidates a choice among several allied health disciplines—whether related to public health, traditional medical practice, or mental health—has been more unusual.

A program designed to permit such a choice to trainees from a

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disadvantaged community, in addition to providing academic accreditation through active linkage with a major university, is the subject of this paper. The importance of including mental health education in this type of a generic curriculum, allowing a wider range of career choices as well as more effective on-the-job performance, is also stressed.

The Community

The area served by the project consists of a 2,000-acre segment of the city of Boston, including a large portion of the district of Roxbury and smaller sections of the districts of North Dorchester and Jamaica Plain. Collectively, this area has been considered the most socioeconomically deprived in the entire city and was selected as the target of a Model Cities demonstration project in 1967. The total population was 63,000.

In order to meet one of the community's major developmental priorities for the area—improved health services—three Model Cities health centers and one neighborhood health center sponsored by the Office of Economic Opportunity were planned in 1967–68. Among the priorities city officials and neighborhood residents stressed early in planning was creation of new service and employment opportunities for residents in the three areas served by the Model Cities health centers. The locally elected community board of the Model Cities program described large reservoirs of unused talent among its membership for whom career opportunities in health might be created as part of the total Model Cities effort.

Although the most frequently voiced complaints concerning health care related to the absence of neighborhood health facilities, the long waiting periods in the local emergency rooms and clinics, and the shortage of private practitioners in a disadvantaged community, the problems of creating entry into the health system and prospects for career advancement for local residents were considered equally important. Through a contractual agreement with the Laboratory of Community Psychiatry at the Harvard Medical School and with the cooperation of Northeastern University and the local official antipoverty agency, Action for Boston Community Development (ABCD), a university-based educational and training program was developed. This program was directed to selected Model Cities residents who were interested in a health career in one of the planned Model Cities health centers.

The Program

Several goals formed the foundation of the training program which was eventually developed. Apart from providing a meaningful entry into the health care system, the program's sponsors hoped to (*a*) enable trainees to acquire academic credentials as a means of insuring career mobility, (*b*) establish a multipurpose generic health curriculum which would permit a wide choice of future health careers, (*c*) create an alternative to the more common inservice or totally on-the-job training programs, (*d*) prove that valuable untapped human potentials exist in disadvantaged communities—potentials which can not only be oriented toward human service, but are capable also of academic achievement, and (*e*) demonstrate possible models for change in educational and training programs related to the disadvantaged (*15*).

Students for the program were selected by ABCD and the community board of the Model Cities program. Demonstrated or perceived motivation to pursue a career in health was the major basis for selection. High school graduation or the equivalent was not used as a criterion.

Candidates selected were enrolled in a standard allied health curriculum offered at Northeastern University to students planning careers in medical laboratory technology, nursing, and dental hygiene. The curriculum also included liberal arts courses such as English composition, psychology, and sociology. Concurrent fieldwork with community health agencies, such as the Visiting Nurse Association and a local health department clinic, was included, and in some instances additional college credit was earned for this work. Rotation to three mental health centers which served the Model Cities area was also part of the academic and fieldwork curriculum described subsequently.

Although the trainees attended classes with regular enrollees at the university, special tutoring was available when needed. Some of the trainees also took noncredit high school equivalency courses at other schools in addition to their curriculum at Northeastern University. Successful completion of 1 year's work at Northeastern guaranteed 30–40 credits toward an associate in arts degree—a degree which could be obtained by all candidates after successful completion of a second collegiate year.

Training stipends as well as tuition were awarded by ABCD and the Model Cities Administration. None of the students had

previously worked in an allied health occupation above a nurses aide level, and the majority had had no prior health-related work experience. Employment as family health workers in any of the three Model Cities health centers which were just being organized was guaranteed upon completion of the first year at Northeastern University. In the role of family health worker, the trainee was expected to function as an ombudsman for the community he served and as a liaison between the programs of the health centers and of the community.

Mental Health Curriculum

Training in mental health was considered an essential component of the allied health curriculum for several reasons.

1. The planned Model Cities health centers were scheduled to provide comprehensive ambulatory health care, of which mental health services would be a part.
2. Existing fragmentation of health, mental health, and social services would require that each candidate have some knowledge of existing mental health systems and resources in order to function successfully as a family health worker.
3. Such training could be expected to enhance the ability of the worker to serve patients treated at the health centers as well as persons in the community.
4. A basic understanding of group process and individual behavior would prepare a trainee for eventual roles in community outreach activities, patient followup and aftercare, and in family and community health education and health promotion.

Since only one mental health course could be included in the first year's curriculum at Northeastern University, a broad-ranged exposure to basic principles and techniques of current community mental health theory and practice was sought. Three mental health agencies were available for fieldwork or technical consultation or both. These agencies, Boston State Hospital and two affiliates of Harvard Medical School—Massachusetts Mental Health Center and the Laboratory of Community Psychiatry—all had extensive experience in developing inservice training programs for mental health aides.

The course which eventually evolved lasted 12 weeks, including a minimum of 2 hours of didactic course work and 3 hours of fieldwork per week. The university granted three semester credits for this course, although it was taught almost entirely at the participating mental health centers rather than at the university. Basic to the course were the following objectives:

1. Integration of concepts of mental health with material previously taught in general public health
2. Exposure of the trainees to concepts of prevention of mental illness through an understanding of the natural stress points in life, such as adolescence, marriage, childbirth, or death-in-family, and the manifestations of such stress
3. A basic introduction to the tools of mental health casefinding, including recognition of mental illness and mental retardation
4. An orientation to the mental health system, its organizational structure and operations
5. Developing the natural personal and communicative skills of the trainees which could be applied further to interviewing, teaching, and group process roles (*15*).

Selected topics of special interest to the group, such as management of the chronically ill patient, problems of children and of the elderly, delinquency, drug addiction, and alcoholism, were included in the course.

Sessions were informal with much dialog between students and instructors. A concerted attempt was made to correlate didactic seminar material with the fieldwork of each trainee. Fieldwork placements, in conjunction with didactic instruction, included assignments to psychiatric inpatient and outpatient units, a day hospital, a neighborhood service center, drug addiction programs, services for the mentally retarded, and adolescent mental health programs.

Students had the opportunity to study one patient in depth in at least one of these settings and were able to develop some confidence in relating to mentally ill or retarded persons. Students also observed firsthand the relationship and interaction of various members of the mental health team with patients and with one another. In almost all instances during fieldwork, students integrated well into ongoing ward and clinic activities, causing minimum inconvenience to health center staffs.

Results

Of the 20 students who enrolled in the program, 16 completed the first year's curriculum satisfactorily; the remaining four —including the only two men in the program—dropped out during the first month, primarily for personal reasons unrelated to the program. The only two men in

the program were among the four students who withdrew.

All 16 successful candidates maintained grade-point averages sufficiently high to insure continued matriculation at the university; one achieved a 3.5 grade-point average which placed her in the honor student category. Eleven candidates were high school graduates at the start of the program, and the remaining five had completed only eighth or ninth grade.

The majority of the group was married and had at least two children. Ages of the candidates ranged from 18 to 54 years, with a median of 32 years. Collectively, the candidates had engaged in a variety of previous occupations, including work as waitresses, housekeepers, clerks, nurses aides, and nightclub entertainers. Several had worked only as housewives or were unemployed at the time of selection.

Two of the candidates are employed by the Model Cities Administration and have postponed further college work at this time. In addition to commencing employment in the Model Cities health program, 14 of the 16 candidates have continued matriculation toward an associate in arts degree following the first year's program. Two of these have chosen medical records technology as their career goal, another is enrolled in a program leading to a bachelor of science in sociology, and the remaining matriculating students have continued a generic associate in arts health curriculum without yet choosing a special field of concentration.

All of the students successfully completed the 3-credit course in community mental health, and as a group they unanimously recommended inclusion of more advanced courses in this discipline in their second-year curriculum. The content of the mental health curriculum most frequently praised by the trainees included the didactic sessions dealing with the management of behavioral problems and the sessions providing an introduction to more severe forms of mental illness. Topics such as drug addiction, juvenile delinquency, mental retardation, and the problems of the aged also evinced more than usual interest.

Students most enjoyed the opportunity to observe, study, and interact with many types of mentally ill patients in a variety of ambulatory and hospital settings. Most felt that many stereotyped concepts and fears they had held regarding mentally ill or retarded persons had been dispelled by the opportunity to work with such persons under supervision and by having modalities of treatment and theories of pathogenesis explained to them. The students were also almost unanimous in their view that such exposure had enhanced their capacity to relate to and work with mentally ill as well as healthy persons. A heightened sense of personal identity and perceived value of their skills was also evidenced by the majority of the trainees.

Implications

The authors of the project thought several features of the program were particularly significant. The realization that important mental health as well as public health services can be successfully rendered by nonprofessional and indigenous persons without advanced (and traditional) education has been frequently discussed and well documented (*12, 13, 15*). Several associate in arts and other collegiate curriculums have been initiated incorporating this concept (*16–18*).

Among the significant innovations of the program reported in this paper were the linkages developed between an academic institution (Northeastern University) and a future employing agency (Model Cities), merging mental health training into a generic allied health curriculum, and placing neighborhood residents with or without a complete high school education in regular university classes. Northeastern University's award of college credits for field and didactic work organized outside the institution and selection of program participants by community review boards rather than by professionals were also considered new features.

Joint planning of the program by the Model Cities Administration and Northeastern University proved to be a definite asset. Not only were the goals, and in some cases, limitations of the program known by each agency, but additionally, the future service role of the students was well defined and understood by all parties concerned in advance of the program, including the students who were selected. Guaranteed meaningful employment in the Model Cities health centers was an especially positive feature, avoiding possible inability to place students following training. The students were thus able to spend an entire year devoted to acquiring skills and credits, secure in the knowledge that specific jobs awaited them following completion of their academic work. Some degree of career choice and job mobility could be expected as a result of even 1 year's participation in the program—college credits being viewed as a valid and negotiable credential.

With only a limited number of semester hours available for the inclusion of community mental health training in the curriculum, some problems arose and considerable negotiations were required with the participating mental health agencies in order to develop a curriculum meaningful to the trainees. The didactic and fieldwork practicum eventually offered was well received by the students and, in retrospect, probably enhanced their effectiveness in working with other patients as well as the mentally ill. The curriculum also provided a valuable initial exposure to the discipline of community mental health which would allow the students to make an informed choice or rejection of this specialty as a future career possibility.

Northeastern University exercised no direct control over several fieldwork courses for which they offered course credit, although the faculty contributed substantially to designing the necessary curriculums. Thus, credit was offered for the community mental health course as well as for fieldwork offered by the Visiting Nurse Association. Flexible, but monitored, arrangements of this type are being proposed more frequently as a means of generating academic recognition of basic life skills or employment-derived skills. Such skills abound in disadvantaged communities and all too often go unrecognized and unappreciated.

Selection of candidates by nonprofessionals did not appear to detract from the success of the program as might have been anticipated. Since personal motivation and interest, rather than academic achievement, were the predominant criteria, it could well have been a situation in which candidates were better selected by their peers than by very differently oriented "experts." The strong community ties generated by the Model Cities program necessitated this type of an approach.

Perhaps the most significant outcome of the program was the demonstration that there is no special mystique attached to higher education. Students who completed the program carried an average number of freshman courses, and those without high school accreditation often enrolled in remedial noncredit courses in addition to the courses at Northeastern University. While many trainees experienced moments of anguish while attempting to master subject matter in several courses, and some occasionally failed an individual course, all maintained sufficient grade-point averages by university standards to insure continued matriculation. Tutorial supervision offered by the Model Cities health careers director, and occasionally by others, was an important element in maintaining the academic performance of the trainees.

However, given the age range of the students and the length of time since most had attended school, an extremely high attrition rate could have been anticipated and did not occur. Overall, the performance of the trainees appeared to prophesy well for many similar programs attempting to bring nonprofessionals from disadvantaged communities into the core of the health and human service professions.

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Twenty residents of the most socioeconomically deprived area in Boston, Mass., were selected by their peers to be trained as family health workers in Model Cities health centers. As family health workers, the 16 trainees who remained with the program were expected to serve as ombudsmen for the area's residents and as liaison between the health centers and the community.

Under contract with the Laboratory of Community Psychiatry at Harvard Medical School and with the cooperation of Northeastern University and Action for Boston Community Development (a local antipoverty agency), a university-based educational and training program was developed. The Boston State Hospital and the Massachusetts Mental Health Center also provided technical consultation and fieldwork.

In addition to providing meaningful entry into the health care system, the program was designed to (*a*) enable trainees to acquire academic credentials as a means of insuring career mobility, (*b*) establish a multipurpose generic health curriculum which would permit a wide choice of future health careers, (*c*) create an alternative to totally on-the-job training programs, (*d*) prove the existence of valuable untapped intellectual capacities in disadvantaged communities, and (*e*) demonstrate possible models for change in educational and training programs for the disadvantaged.

Training in mental health was essential because mental health services were included in the mission of the health centers. Candidates would need knowledge of mental health systems and resources so they could function successfully as family health workers, and such training would enhance the workers' ability to serve patients treated at the health centers as well as persons in the community. A basic understanding of group process and individual behavior would also equip trainees for community outreach activities, patient followup and aftercare, and family and community health education and health promotion.

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