

## Task Force Reports

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Manifestly, the findings, opinions, and conclusions of Task Force Reports do not necessarily represent the views of the officers, trustees, or all members of the Association. Each report, however, does represent the thoughtful judgment and consensus of the task force of experts who formulated it and it is considered by the Trustees a useful and substantive contribution to the ongoing analysis and evaluation of problems, programs, issues, and practices in a given area of concern.

Robert S. Garber, M.D.  
*President, APA, 1970-1971*

September 1970

## PSYCHIATRIC EDUCATION AND THE PRIMARY PHYSICIAN

A Report of the Committee on Psychiatry and Medical Practice of  
the American Psychiatric Association

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Approved for publication by the Board of Trustees  
March 1970

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# COMMITTEE ON PSYCHIATRY AND MEDICAL PRACTICE American Psychiatric Association

This Committee, created in 1956 as a liaison committee with the Academy of General Practice, assumed its present role and title in 1963. This report is based largely on the proceedings of seven "Colloquia for Postgraduate Teaching of Psychiatry" conducted under the Committee's auspices over these years. The names of all members of the Committee since 1956 follow.

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The Committee expresses its gratitude to the Smith, Kline and French Laboratories of Philadelphia for generous assistance in making publication possible.

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## PREFACE

In the midst of her struggles to educate Mongkut, the King of Siam, and his many wives and numerous children, Anna Leonowens paused to evaluate her program. She concluded that if nothing else she had become an expert on the subject she liked most. Furthermore, she reflected with some pleasure that the process of "getting to know you" had in itself been worthwhile. As with any good modern systems-oriented educator, her evaluation included historical perspective and an examination of the process involved: "It's a very ancient saying, but a true and honest thought, that if you become a teacher, by your pupils you'll be taught" (1).

In the following chapters the reader will find a distillate of much of what has been learned by numerous psychiatric educators, researchers, practitioners, administrators, and bureaucrats. In the process of helping physicians incorporate principles of psychiatry into their medical practice, "getting to know you" is stressed as a basic principle. These psychiatrist educators invariably remark upon how much their pupils have taught them and upon their respect and at times wonderment at the amount of service rendered by the physician in solo medical practice.

This growing respect is perhaps evidenced by the "teachers' " increasing dissatisfaction with the labels they have used for their "students." The students have been referred to in a number of ways beginning with the condescending "non-psychiatric physician" to the more accurate but still negative "non-psychiatrist physician" to the more recent but still clumsy "physicians other than psychiatrists."

In searching for a properly descriptive title for the physicians participating in our continuing education efforts, we have chosen the term "primary physician." The term "primary" expresses something about the actual situation of the physicians in these programs and expresses an expectation on the part of the patients, the student physicians, and the teaching psychiatrists. Usually these physicians are the most important medical persons to patients and their families and are primary in that they are the physicians consulted for general medical care. They are also primary because they are usually the physicians of first contact. Finally, they are primary in the sense of the word as used by the Millis Commission (2). Millis' primary phy-

sician retains continuing and comprehensive responsibility for patients and their families and arranges for specialized care when necessary. Participation in continuing education in psychiatry is evidence that the physician desires to broaden his understanding and make more comprehensive his style of medical practice.

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- (1) Rodgers, R., and Hammerstein, O.: "Getting To Know You," from *The King and I*. New York: Williamson Music, Inc.
- (2) *The Graduate Education of Physicians: The Report of the Citizens Commission on Graduate Medical Education*. Chicago: American Medical Association, 1966.

## INTRODUCTION

What follows is intended as a guide for those interested in planning programs of continuing education in psychiatry — to orient them to the general goals of the field, to summarize and review achievements to date, to identify issues that continue to be vexing problems, to describe specific methods and programs that have developed, and to indicate possible directions for future activities.

Most of the guide has been culled from the published proceedings of the seven APA Colloquia for Postgraduate Teaching of Psychiatry. Collateral sources of information include the minutes of Committee meetings, Proceedings of the Regional Workshops on Mental Health sponsored by the American Academy of General Practice, the *Psychiatry and Medical Practice Bulletin* published by the APA, and the *Mental Health Bulletin* published by the AAGP.

Because much of what is presented is a result of trial-and-error learning in a relatively uncharted field, there are few points that have been made by only one contributor at only one time during the years of the Committee's existence. In view of this, with few exceptions, no attempt has been made to identify discrete sources of information or to trace the often painful evolution of inchoate hypothesis into established and acceptable technique. Rather, the guide is to be viewed as a cross-sectional survey of the current status of postgraduate training in psychiatry.



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## GOALS

Among the difficulties in preparing this summary and guide, two have been paramount. One is the lack of a specified goal on which colloquia participants, training faculty, and students have agreed. Some training programs, for example, seemed to have as their only discernible purpose the running of a course. A second difficulty is the lack of agreement on what constitutes a satisfactory body of knowledge in psychiatry for other physicians.

Recent committee meetings have, in fact, focused on the former difficulty, and it is appropriate to formulate a tentative statement of our current goals, recognizing that goals and purposes require periodic modification and redefinition.

### *Current Goals*

Current goals include that the physician will understand and be sensitive to the emotional needs of the patient, his family, and the (other) biosocial systems within which he functions; that the physician will develop skills to meet those needs and thereby foster emotional growth and mental health in his patient; and that the physician will utilize collateral resources appropriate to those ends.

While these goals may not have been explicitly stated in the past, most of the work of the Committee may be understood in terms of specific achievement tasks derived from the goal and as attempts to bridge the gap between what is and what ought to be.

### *Achievement Goals*

Relatively little attention has been given to defining concretely and quantitatively the nature of the present condition that is presumed to need improvement; perhaps because of this, most attempts to measure change and to evaluate results of training programs have been far from satisfactory. Nonetheless, it has been generally assumed that the primary physician fails to take adequate account of his patients' emotional needs and/or lacks the skills to meet those needs. And when achievement goals have been specified, they have ordinarily been based upon those assumptions. Among such stated goals are the following:

1. Give the physician enough understanding of himself so that he can recognize the emotional problems of his patients, especially insofar as they constitute a barrier or hindrance to his therapeutic approach.

2. Make the physician aware that his problems in medical practice may reflect the kind of relationship that has been established with the patient, which depends as much on the personality of the physician as on the emotional needs of the patient.

3. Teach the physician ways of handling patients that are consonant with his own personality and style of practice.

4. Promote patient-centered treatment as distinguished from only a frontal attack upon disease per se.

5. Teach the physician how to listen to patients, to recognize and to deal with emotional factors (psychotherapy, drugs, etc.), to make proper referrals at the right time and to the right person, and to make optimal use of community resources.

6. Prevent the physician from becoming overinvolved and/or overwhelmed by unexpected or resistant behavior by his patients.

7. Improve communication between psychiatrists and other physicians.

8. Teach the physician to make personality diagnosis.

9. Teach interviewing techniques so that the physician will recognize dynamic, interpersonal factors and will understand both content and interaction in his relationship to his patients.

10. Help the physician to set realistic goals and thus use his time with patients more efficiently.

11. Help the physician to understand the meaning of his usual approach by recognizing, utilizing, and fostering development of his strengths and skills.

12. Help each physician to recognize his particular style and the patients to whom it is best suited and to learn how to modify or adapt his style to meet some of the needs of the patient to whom it is not suited.

13. Teach the primary physician to recognize and treat minor disturbances and to diagnose and refer patients with major psychiatric illnesses.

14. Improve the art of medical practice by giving the physician knowledge of learning theory and the behavioral sciences so that he can observe and understand people as a whole.

15. Help the physician to develop a personal and continuing interest in his patient, to combine curative with preventive services, and to broaden his care to include the biosocial unit of which the patient is a part.

## PROGRAM PARTICIPANTS

If it be granted that needs exist for the kinds of programs implied by the previously stated goals, then among the questions to be answered are: What physicians, if any, are in particular need of such training, and at what point should they be engaged in such a learning experience?

### *Types of Physician Participants*

Some aver that all physicians need such training, but experience suggests that the number of physicians who can be meaningfully engaged in any kind of course will always fall far short of the total. In fact, one of the few consistent findings of programs reported to date is that within any medical community, the number of physicians who will actually become involved in courses in psychiatry will be about 10 percent of the total. It has been estimated that the usual medical community consists of 10 to 20 percent who have no interest in post-graduate medical programs, who will maintain an active resistance to such programs, and who may have good reason to avoid psychologically oriented courses in any event; 50 percent who have little interest in psychiatry but can be approached; 20 to 30 percent who have an adequate interest in psychiatry; and 10 percent who have a special interest.

Such estimates are in accord with the findings of a few programs distinguished by their high involvement of physicians within a specified area; even when special efforts are made to involve participants in planning the program and to limit case material to their own patients, there remain about 20 percent of the total physicians who do not become involved.

To date, approximately 11,000 physicians have been enrolled in NIMH-sponsored programs; 65 percent of these have been general practitioners, 15 percent internists, 10 percent pediatricians, and 10 percent other specialists. Median age of students is 46 years; 14 percent are under 35, 63 percent are between 35 and 55, and 23 percent are over 55. About 10 to 20 percent of those taking courses are "repeaters," and it has been of some concern that ongoing programs



may be reaching only those with preexisting special interest and/or that portion of the medical community that is least in need of the kind of training being offered.

### Timing of Program

Even among those involved in training programs, there is diversity of opinion as to what stage of the physician's professional life produces the greatest need for further training in emotional aspects of medical practice and at what stage he is most susceptible to such training. Some believe that physicians in practice are more ready for psychiatric training than they were during medical school. They feel more secure in their mastery of purely biological problems, they have learned through practice that most problems have an emotional component and that the doctor-patient relationship is a powerful diagnostic and therapeutic tool, and they are more interested in psychosocial developmental processes because of personal experiences within their own families.

Others, however, have the opposite view; they believe that the medical practitioner, consumed with social, professional, and economic pressures, is not likely to alter his habits of practice and particularly not when a training program is interjected in homeopathic doses of one night a week into a busy schedule. Still another viewpoint emphasizes the interaction of the physician's own emotional needs with the patients he sees in his practice; the kind of person he is largely determines his reaction to psychological components of his patients' conditions, whether this be outright avoidance, diagnosing "virus" whenever the patient evidences depressive symptoms, rejecting the person with strong emotional concomitants, "overgiving" and overinvolvement, or premature closing of the treatment process by insertion of a medication, inappropriate environmental manipulation, or unnecessary referral.

Whatever the viewpoint of the various program directors might have been, the physicians who have enrolled in the programs have generally been physicians in practice. As indicated earlier, more than half have been general practitioners. Some of the physicians appear to have enrolled because of their own emotional problems, as part of an attempt to seek therapy for themselves. (It is believed that this group contributes heavily to early "dropouts" in training programs.) But the majority, whether general practitioners or specialists, participate in a program because they are conscious of disappointments, failures, or mistakes in their practices and because they recognize the need for more understanding of emotional factors if they are successfully to treat, manage, and refer the patients they see.

There have been few attempts to establish criteria for the selection of program participants, one thought being that those most likely to be winnowed out in any selection process might be the very physicians who are most in need of help. At the same time, however, because little attention has been paid to establishing the needs and lacks of any potential 'student' population, it seems questionable to assume that participants who are largely self-selected represent a majority of those who need the help existing programs have been able to offer. The apathetic, uninterested, uninvolved physicians who do not enroll in programs continue to be a source of major concern to the Committee, particularly since they seem to comprise as much as 90 percent of the medical community in many areas.

### Recruitment

Recruitment of participants is not only a matter of publishing an announcement that a course will be offered — quite the contrary. Elaborate preparations are essential to the success of any program — the core curriculum must be set, the faculty selected, the teaching format chosen, funding obtained, and the site of the program must be fixed. At least as important as any of the foregoing is gaining grass-roots support — the sponsorship, support, and effective collaboration of appropriate local organizations, be they professional groups (APA district branch, state hospital, state or local mental health authority, medical school, county medical society, local hospitals, Academy of General Practice, American College of Physicians) or nonprofessional organizations (mental health association, lay boards of hospitals, Junior League, Chamber of Commerce). Only then can one begin to appeal directly to the potential participants — ideally, by personal contact or a personalized letter, followed by descriptions of the program and faculty and by orientation seminars or other illustrations to demonstrate the value of training.

The majority of postgraduate programs have been directed to the generalist or the family practitioner, but obviously this is not essential. A few programs have been designed for physicians from particular specialties; one program, for example, has focused on pediatricians and has set as one of its goals the detection of families with a high risk for psychosocial disorders.



## TRAINING PROGRAMS— COURSE CONTENT

Course content will obviously vary from program to program, depending upon the perceived needs of the students (if these have been assessed), the implicit as well as the explicit aims of the program, the availability of faculty, location of the course, type of program format, and the range of case material available for demonstration. Almost every conceivable combination of contents and format has been used at one time or another, ranging from formal lectures on drug dosage and organic aspects of psychiatry to continuing long-term supervision of cases carried in psychoanalytically oriented psychotherapy by primary physicians. It is common practice for programs to develop in phases, from basic to intermediate to advanced courses, for instance, and/or to have several programs at different levels proceed concurrently.

In one program the basic course focused on interpersonal relationships, the attitudes of the doctor toward his patient, and his awareness of patients' emotional reactions. The intermediate program was developed as a "how to" course on selected psychiatric topics, covering early signs and symptoms of psychosis, psychiatric emergencies, specific problems such as alcoholism, children's problems, marital discord, questions of the treatment of hospitalized patients in general hospitals, geriatric problems, psychopharmacologic agents, suicide, hypochondriasis, and mental retardation. The advanced program consisted of formal instruction and supervised training in psychotherapy (which may be limited to individual therapy or also include training in joint, family, or group therapy).

### *University of Kentucky Program*

Another program, aimed specifically at the middle 50 percent of physicians already described as having little interest but approachable (distinguished from the 10 to 30 percent with adequate or special interest), was organized as follows (reported in the Second Colloquium by Beverley T. Mead, M.D., Department of Psychiatry, University of Kentucky):

1. Meetings were held no more often than once per month (rather than the usual once per week).
2. The instructors went to the physicians (rather than asking them to come to the university).
3. The first session was a brief (30 to 40 minutes), get-acquainted session during which the psychiatrist attempted to sell himself and his subject; time was allowed for discussion and establishment of a pattern for subsequent meetings.
4. The second session consisted of a review of psychotropic medications as an attempt to present psychiatry in its most tangible, acceptable, and practical aspects.
5. In the third session the general topic of psychotherapy was introduced in a concrete and understandable way as follows:

Thus the indications for and selection of treatment methods were described as being based on the evaluation of (a) the kind and quantity of stress presented by the environment; (b) the unique drives or needs of the patient; and (c) the type of defenses the patient uses to deal with his environment. Environmental adjustments will help many patients, and since these are easy and dramatic they should be given first consideration. If that is not feasible, merely directing the patient's attention to more constructive defenses may be enough (as A.A. does with alcoholics). If personality alteration is required, limited uncovering techniques may be tried, or the patient may be referred to a psychiatrist. Finally, it must be recognized that the patient's adjustment may be the best possible, or even the only one possible, under the circumstances, in which case a simple supportive program with limited goals is indicated.

6. Later sessions were not as ordered, but often included the following (as well as whatever the participants felt they needed or had special interest in): management of the chronic neurotic, depression, the anxious and hysterical patient, geriatric problems, children, sex and marriage, and alcoholism.
7. For interested participants a second series of case-oriented seminars was offered, or each subject seminar was followed by an extra hour of case discussions.

### *Mt. Sinai Program*

Another program (Mt. Sinai Hospital, New York City) is given every Wednesday and Saturday, from 9:00 a.m. to 1:00 p.m., for a nine-month period, to a group of six to eight students. The first three sessions consist of orientation lectures about the physician-patient



relationship, history-taking and the initial interview, and how to pick up cues given by the patient. The lectures are followed immediately by interview practice sessions on patients from the medical and surgical wards of the hospital. In subsequent sessions, the eight hours a week are divided as follows: three 45-minute interviews with clinic patients; one 45-minute session of individual supervision; one 45-minute session for dictating; and 90-minute case presentations that involve discussion by the entire group (including social workers, psychologists, etc.).

Later in the course, the 90-minute period may also include formal lectures by liaison psychiatrists from different departments of the hospital. Several of the conferences are devoted to formal presentations by the psychologist on testing. Students are assigned patients for supportive psychotherapy — the first patient immediately after the orientation sessions, the second two weeks later, and a third after another two weeks. Instruction in nosology and dynamics is centered around clinical case material so that the student can experience for himself "how it's done." During the first three years in which the program was offered, formal lectures were reduced from a total of 25 to 14. Within these lectures, the time given to psychopharmacology tripled, the interview technique demonstrations doubled, and two entire mornings were devoted to hypnosis.

### Discussion

In general, courses considered the most successful are those in which theoretical instruction and presentation of a body of clinical information are combined with training in the very techniques that the instructors talk about in orientation sessions. But even though courses that are limited to lectures and case discussions may fall short of the ideal, there are nonetheless specific topics and various situations where such courses provide the most appropriate and most practical approach.

In medical communities with a low level of initial interest in psychiatry, for example, and particularly when there is minimal support from the medical leadership, short lecture courses or small discussion groups designed to impart "useful information" may be the best starting point. Such informational courses usually include any or all of the following content: management of psychiatric emergencies, phenomenology of frequently encountered disorders (sexual problems, behavior disorders, problems of adolescence, alcoholism, marital problems, mental retardation, drug abuse, involutional psychoses, geriatric problems), use of psychopharmacologic agents, use of social

and psychiatric resources in the community, and theoretical concepts or basic science background to be used as a framework within which to place more practical information.

At least in some instances, such courses have appeared to break down barriers in communication between psychiatrists and other physicians and have fostered participation in later courses that were broader and more intensive in scope and design.

The number of sessions planned for a course will similarly vary. While most educators agree that a 30-session course is better than a ten-session course, which in turn is better than a one-weekend, two-day course, the shortest course may nonetheless be the most appropriate when one is introducing the whole notion of postgraduate psychiatric education to a rather cool audience. In contrast, when interest in a course is high and is distributed among a wide variety of groups, the course should allow for maximal exposure and intensive case study. The majority of programs surveyed to date have consisted of 10 to 20 sessions of two to three hours in length; less than one-quarter have offered more (24 to 50 sessions) and less than one-quarter have offered fewer than 10 sessions.

### Core Content of Family Medicine

As already noted, there is no consensus as to what constitutes a satisfactory body of knowledge in psychiatry for physicians other than psychiatrists. The Core Content of Family Medicine (as of November 1966, prepared by the Committee on Requirements for Certification, a joint committee with representatives from the AAGP and the AMA Section on General Practice) includes the following areas relevant to psychiatry:

I. *Clinical aspects.* Within this category are: 1) doctor-patient relationships, which covers such points as types of doctor-patient relationships (activity-passivity, guidance-cooperation, and mutual participation); role of illness in society (patient expectations and physician expectations); patient characteristics of all age groups: prenatal, infancy, preschool, school adolescent, young adulthood, middle age, older age, and the dying (physical, cultural, and psychological); continuing care; physician participation; interview technique and setting, self-knowledge, technical skills, and attributes (consideration, compassion, interest, acceptance, empathy, responsibility, and flexibility).

Also included under clinical aspects are: 2) preventive medicine, covering health education; normal growth and development; environmental influence; crisis information; and community relations; 3)



diagnosis, including history; recognition of normal, early detection and recognition of deviations; 4) treatment and management, including physical, mental, and environmental illnesses; chronic and debilitating illnesses; emergency care; family counseling; and terminal care; 5) techniques in diagnosis, therapy, and management, covering such fields as psychiatry and psychology, pharmacology, preventive medicine, and behavioral sciences; 6) rehabilitation, including convalescent care and family adjustment; and 7) consultation and referrals.

II. *Sociological aspects.* Within this category are: 1) family and community, including sociology and the family group and related institutions; psychology of the person and group; ecology of the home and community; and religious beliefs, practices, and creeds; 2) community resources; and 3) allied and paramedical personnel.

Since both content and format of any training program will be dictated by the goals of the course and since these will be derived from an assessment of the participants' felt needs as well as their needs as perceived (or assumed) by the faculty, there can clearly be no hard and fast check-list for inclusion in the core curriculum. As long as the program is designed in such a way as to allow for modification of its content in accordance with the desires of both "students" and faculty, no weighty problems need be anticipated in this area. The fact that more has been written about course content than any other aspect of program planning points more to the ease with which lists can be drawn up than to their importance to the overall success of a training program.

## TRAINING PROGRAMS — EDUCATIONAL PRINCIPLES

In the Third Colloquium (1964), some principles of educational planning, teaching, and learning were outlined by Stephen Abrahamson, Ph.D., Director of the Division of Research in Medical Education, University of Southern California School of Medicine. Those principles are helpful both in assessing ongoing courses and in planning new educational programs.

Principles of educational planning include the following:

1. Start where the learner is — not where he already has demonstrated competence and not so far beyond his usual range of operations that the program has no meaning for him.

2. Begin with the learner's felt needs. Sound out what the students want and decide how psychiatry can best give it. (In one survey of physicians, reported in the Second Colloquium, only six percent were interested in referral problems and only seven percent in hospitalized psychiatric patients. But 66 percent were interested in psychopharmacological agents and 60 percent in diagnosis. Physicians also expressed a need for more specific information on patients from psychiatric hospitals who are referred back to them for aftercare.)

3. Proceed from the learner's felt needs to other needs that he has not recognized or thought about; included here would be ways to meet his perceived needs that might be different from the ways he believes they could be met. Many physicians, for example, indicate initially that they would like a "how to" course, with many practical aids. But a program limited to such methods tends to develop a promotional approach that ultimately palls on the participant because of its superficiality and concreteness.

4. Involve the learner in planning the program. (A corollary of this principle is that the planner will give consideration to what may be wrong with the way he wants to implement his teaching goals.)

5. Promote involvement in the total learning experience and active participation in the program. To be effective, teaching must be a therapeutic learning experience, not merely an academic exercise.

Principles of teaching are as follows:

1. Effective teaching is based on principles of learning, and every teacher should know something about the learning process, how learning takes place, and what helps or hinders learning.



2. Teaching behavior is influenced by the nature of the learner, and the teacher should know something about his learners: what they are like, what helps them, what they are interested in, and what they want to do.

3. Teaching behavior is influenced by the objectives of the teacher, who should know his goals and be fairly specific about what he wants to accomplish.

Principles of learning include the following:

1. Rates of learning are not uniform; because the teacher does not know which students learn best or in what ways, he should use a variety of techniques so as to reach a large number.

2. Learning depends on motivation; the teacher should make every attempt to find the interests and understand the motives of his students and begin his work from there.

3. Learning is more effective when there is feedback to the student on how he is doing; such feedback should be given as frequently and as soon after the learning situation as possible.

A careful statement of educational objectives will give direction to the choice of course content, the techniques of instruction to be used, and methods of evaluation that are appropriate. A stated objective should be understandable, phrased in explicit behavioral terms, based on the needs of the learner, socially desirable, achievable, and measurable. Educational objectives may, for example, be stated as follows:

1. To help students acquire knowledge of . . . Appropriate techniques in this instance include lectures, demonstrations, etc.; materials include printed matter, films, programmed instruction, etc.; the best method of evaluation is the written examination.

2. To help students gain an understanding of . . . Such an objective requires the use of discussions and/or question-and-answer sessions in addition to presentation techniques; the most appropriate measure of progress is an essay test.

3. To help students achieve skills in . . . In this case the learner must participate in laboratory sessions, drills, etc., under the supervision of the instructor; the materials used should be as close to the reality situation as possible; the most appropriate measure is observation and rating of performance.

4. To help students develop attitudes of . . . Implementation here is similar to that outlined in part 3, except that the learning experience must generally continue over a more extended period, process and interaction within the reality situation are at least as important as content, and assessment of attitudinal change is much more difficult than measurement of the acquisition of skills.

## TRAINING PROGRAMS— FORMAT

In line with the previous discussion, course format in postgraduate training in psychiatry (and probably in the rest of medical education as well) can be divided as follows: the informational course; the case conference, using a living patient; the seminar, which may or may not be oriented around clinical material; and a continuing, supervised clinical experience.

In general, program directors agree that the most suitable approach in postgraduate training in psychiatry is the small-group case discussion in a dynamic setting that provides an arena for group interaction and better communication, to focus on resistances that hinder physicians' work with their patients and to resolve anxieties generated by specific cases. Nonetheless, certain types of material lend themselves best to an informational course, and brief, didactic presentations may be desirable as a way to introduce the idea of a training program and to define its objectives. Furthermore, informational lectures may be the only effective method of generating interest and cooperation among physicians who are antagonistic to or suspicious of psychiatrists as a breed apart from the mainstream of medicine.

It is important, too, to select the teaching format that is best suited to the abilities, interests, and desires of the faculty, since any flagging in their enthusiasm for the program is likely to spell disaster for the course. It has generally been found that no matter what the extent of advance preparation, the first course given leaves much room for improvement. Built into every program, therefore, must be the opportunity for restructuring its content and format to meet the needs of the participants.

Both in deciding on the content of the program and in choosing the format of the course, it is wise to find out what previous experience the community has had with postgraduate courses and whether any other similar programs are being offered concurrently.

### *Specific Educational Techniques*

Specific educational techniques that have been used include the following:



1. Case-centered seminars (often the cases are patients that the participants bring in for consultation or bring up for discussion).

2. Small group seminars, usually with six to eight participants, extending over a long period (months or years) with emphasis upon the relationship of the doctor to his patients (sometimes called the "Balint technique").

3. Consultations to individuals or a group of physicians by a psychiatric team.

4. Supervised experience in handling patients in a psychiatric facility (usually ambulatory or clinic patients).

5. A family-care approach in which the physician is assigned one or two families to care for, one of which has a pregnant mother and the other a number of children. The student is expected to take total care of these families.

6. A one- or two-day symposium on selected topics.

7. A mobile unit of "circuit riders" who go into the medical community (the program planner must take care that the circuit riders be welcome when they arrive).

8. Programmed instruction.

14 9. Television or videotaped series: Medical telecasts have been found to be convenient, simple, inexpensive, and capable of reaching a large audience; videotapes can also be used by the students in their own practice for later playback to the psychiatrist.

10. Two-way, shortwave FM radio programs consisting of a 15- to 30-minute question-and-answer period in which the psychiatric staffs of hospitals in an area participate.

Regardless of a course's format or content, it is generally considered wise to teach careful observation and accurate description of patients' behavior early in the program, and it is further agreed that the best way to accomplish this is through the use of live clinical material (or, failing this, the use of tape recordings, 16 millimeter films, or videotapes).

One colloquium participant sounded a note of warning about various technological developments that have been used as educational aids — television, special radio programs, tapes, telephone dial systems, computer teaching, etc. — in these words:

This is a part of a fractionating or alienating trend in our society. . . . Psychiatrists can make a special effort to emphasize the significance of the varieties of learning that go on in the relationship between psychiatrist-teacher and physician-student. Many of these trends which may not be valuable, become a fad, but will pass if we continue to underscore the significance of psychiatrist-teaching.

While this guide is concerned largely with organized courses and training programs, it must be recognized that training in psychiatry need not be limited to such formal courses. Indeed, a great deal of indirect teaching is performed through psychiatric consultations, attendance of psychiatrists at general hospital staff meetings, and participation in medical societies, committee work, etc. Not only can the primary physician be reached effectively through his own organizations, but he can also be brought into the network of continuous, comprehensive medical care through some of the psychiatrist's organizations — particularly within the framework of the community mental health center and the aftercare of patients released from psychiatric inpatient units and state mental hospitals.

### *Role of Primary and Family Physician*

As currently conceived, the community mental health center will depend heavily upon the primary physician in the community — primary in the sense that he will be the chief case-finder and the chief executive of preventive efforts at the family level. It also seems likely that the medical staff of most centers will include many physicians who are not psychiatrists, but who will need the kind of training that can be provided by postgraduate education programs in order to function best within the community mental health center.

In similar fashion, state mental hospitals as well as many local and private hospitals already depend heavily upon family physicians for aftercare of patients upon discharge. Yet one of the constant complaints from those physicians is that they receive no notification of pending discharge of former patients and little or no useful information as to how to treat them once they reappear in their waiting rooms. One obvious way to improve communications between psychiatrist and family physician, and at the same time to give the family physician a firmer base for managing emotional concomitants in the illnesses of all his patients, is to involve him more meaningfully in the treatment and disposition plans for hospitalized patients.

He may, for example, be invited to visit his patient regularly in the hospital and to discuss treatment and management with the attending psychiatrist. He may be invited to attend seminars, lectures, and case conferences even though they may not concern his patient. The regularity of such invitations is important as a way to convince the practitioner, over a period of time, that he is sincerely wanted as a participant and not just as another body to help fill the auditorium.

Certainly he deserves advance notification that a former patient is soon to be returned to him, and that notification should include



relevant information on how to treat the patient once he is back in the community. Further, the family physician should be given the information necessary to answer the inquiries of the patient's family about the nature of the disorder, the prognosis, and any special approaches to the patient that may be desirable.

#### *Education of the Psychiatrist*

A point often ignored in psychiatry's zeal to train other physicians to deal more effectively with the emotional problems of everyday practice is that education is a two-way street. Part of effective collaboration with other physicians must also include continuing education of the psychiatrist himself in the many advances in other fields of medicine. The Committee on Psychiatry and Medical Practice has launched a series of meetings on recent advances in medicine, and in its attempts to achieve maximal infiltration of the medical community it has worked increasingly not only with AAGP and state steering committees on mental health, but also with the American College of Physicians and the American Academy of Pediatrics.

## LOCATION AND SETTING

Courses that provide a continuing, supervised clinical experience are probably best given in a medical center, where clinical material is most abundantly available and teaching facilities (including audio-visual aids) are usually most adequate. Not more than 10 percent of the participants in "basic" courses go on to advanced supervised-experience programs, which operate effectively only with participants who have had enough basic work in psychiatry to be familiar with the concepts and theories used in psychiatry and who are sufficiently motivated to be willing to give a great deal of time to the program.

Hospital or teaching centers, however, are not available in all areas, and if the program is to be made available to a significant proportion of the physicians in a large geographical region, it becomes necessary to take the course to the physician. Taking it into the participants' own environment has certain merits, such as helping to abolish the mystique of psychiatry and closing the gap between teacher and student. In certain locations, for example, a circuit-riding type of course might be desirable, whereas in others the best approach might be to use occasional weekend courses. In general, physicians prefer attending a course on Wednesday or Thursday afternoons or evenings (their traditional days off) to taking a weekend course.

In at least one program, in an area lacking psychiatric facilities, participation was not limited to physicians but included clergymen as well; extension of training efforts to other "gatekeepers" and non-medical personnel who are sensitive to the emotional and psychologic needs of a community may become increasingly important as community mental health centers develop throughout the country.



## FACULTY

Ideally, the training personnel will have some knowledge about learning theory and educational methods and will have had experience with teacher-training programs and continuous technique seminars (such as the annual teacher-training meetings conducted by the Western Interstate Commission for Higher Education (WICHE), the films of experienced teachers operating in the Staunton Clinic in Pittsburgh, and the annual colloquia for teachers conducted by the APA). They should be interested in community health, be affiliated with teaching or general hospitals, and be active in their local county medical societies. Group therapy experience and/or broad experience as a consultant are also often desirable.

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The teacher should know his physician students well enough to appreciate their needs, and he must also be adaptable enough to be able to change his approach to conform to those needs. The faculty need not be confined to psychiatrists, but depending upon the participants it may include psychologists, social workers, and allied mental health personnel.

Sometimes students from long-term, continuing courses have been used successfully as teachers for brief, short-term courses; this has been especially valuable within specialty groups, where the specialist is sometimes more effective than the psychiatrist in communicating with others from his own specialty. The authoritarian, academic teacher is often too category-bound to be effective with the general practitioner, whose overpowering interest (and experience) is in providing service to troubled people.

Whether the same psychiatrist should be used to train one group continuously over a long period of time or whether different psychiatrists should participate in the training of one group remains a debatable issue. Some program directors have found that dual moderators in a session provide advantages over a single instructor: The anxiety of the psychiatrist-moderator is often less when he can share responsibility with another psychiatrist; and the presence of two psychiatrists gives the students an opportunity to see how psychiatrists may differ among themselves and how they resolve those differences.

## COMMUNICATION AND COLLABORATION

Recognition of the fact that effective teaching must be a therapeutic learning experience makes it apparent that the most important factor in the success of any program is the teacher-student relationship. That relationship in large part depends on the effectiveness of communication and collaboration between psychiatrists and other physicians; both sides have long recognized serious difficulties in this area.

In general, a communications channel is opened because one person wants some kind of information from another or because one person wants to change a situation that is under the control of the other person or both. In postgraduate education this is often expressed as a wish for information on the part of the primary physician and, on the part of the psychiatrist, as an attempt to meet the needs of the other physicians as the psychiatrist perceives them. The implied purpose on both sides is that an improved style of medical practice will foster better patient care.

### *Teacher-Student Relationship*

Note has already been made of how little is known about generating the desire for such communication in the first place, in that there is a large percentage of physicians who cannot be enticed into any kind of training in psychiatry. But several factors can be identified as discouraging the generalist from approaching his colleague:

The image or role-model adopted by the psychiatrist is frequently incompatible with the medical model (cf. the psychiatrist's disregard for specificity in diagnosis, his specialized jargon, his eschewal of active or directive transactions with patients, his frequent lack of conformity to community standards in his ways of relating in social situations, and his lack of knowledge of other areas of medicine). The psychiatrist is often inaccessible, fails to feed back essential information to the referring physician, or cannot modify his treatment tactics to conform to the needs of patients who are



radically different from the person usually rated as "suitable for analysis." He also is often woefully ignorant of what general medical practice entails.

Despite such formidable barriers, contact between psychiatrists and other physicians is sometimes made, at which point still other factors may begin to hamper communications. The psychiatrist may confine himself to imparting what he considers information (but which the generalist perceives as speculation) without trying to change attitudes or improve skills in his "students." At the other extreme, he may try to mold the generalist into his own image rather than provide a range of models in a search for the best fit with the personality and established practice style of the generalist, or he may try to teach the generalist everything that a psychiatric resident is supposed to learn in three years of training. He is too quick to label as pathology (that requires treatment) any approach to patients that is different from his own. He may reject a style of intervention that works because it cannot be explained by the theory he espouses (thus mere symptom removal is "bad" even though only the psychiatrist is disturbed by its disappearance).

It is easy, of course, to list an extensive number of criticisms that at one time or another have been directed to certain courses or specific instructors, but it would be a gross distortion to claim that such criticisms are generally valid. At the most, such a list can be considered suggestive of areas that have proved to be sore spots with one or another group of physicians.

Perhaps the most important point to be made is that if the teacher-student relationship is meaningful and effective, almost any of the teaching approaches outlined earlier will work. If it is not, almost any method will fail. When the participant feels he knows the instructor and has some kind of positive relationship with him, almost any kind of course can be set in motion; but when the students do not have a positive relationship with the instructor they will not attend the course, regardless of the inducement.

### *Role of the Psychiatrist*

It is equally true that there are differences in the way a psychiatrist collects information, how he handles it, and what he does with it; and his capacity to teach will be limited if he pretends that such differences do not exist. In working with other physicians, the psychiatrist must be prepared to function in the more traditional medical model without abandoning the psychodynamic-psychotherapeutic frame of reference. The medical model is important as the bond of

identification that the psychiatrist shares with other physicians. Thus the psychiatrist-teacher should have an active interest in major medical developments, be interested in the work of his colleagues, and be prepared to learn from them as well as to teach them.

Identification with that medical model, however, does not mean that the psychiatrist will abrogate psychiatric principles, even if in a particular case that may engender opposition or doubt. It is the psychiatrist's task to bring to the attention of the others in his group those psychiatric principles that are applicable to the problems of medical practice, and it is rare that some way cannot be found to do this in an atmosphere of cooperation and acceptance.

The psychiatrist-teacher may be chiefly a listener who is wary of taking directive action too early with his patients; but with colleagues who are primarily action-oriented he may find it appropriate to intervene more actively than is his custom and/or to define the differences in approach as a legitimate subject for discussion within his group. The psychiatrist tries to stimulate growth in the group by letting his medical colleagues find their own solutions; but in response to a direct request for information he can become didactic and tutorial.

He can discuss the accomplishments of psychiatry realistically, but he is not defensive about the fact that there are still gaps in psychiatric knowledge and that not every problem is amenable to psychiatric intervention. At the same time, he will take care to show that there is a body of knowledge in psychiatry, including some words and definitions that — because they are not in everyday use — require some effort to learn and to apply.

### *Difficulties in Group Communication*

The criticisms that have been made of some past programs (e.g., the lectures were too superficial with not enough practical information; the content was not pertinent to the problems of general practice; live patients were not used for case study; the course was more concerned with developing a small number of pseudo-psychiatrists than reaching a large number of physicians who needed help in their current practices) do not explain the failure of other programs that carefully avoided such errors. It is probable that the failure of the latter group is related to unidentified and unrecognized difficulties in the student-teacher relationship. Some of those difficulties and their manifestations can be listed as follows:

1. In almost any group there is an early positive, giving relationship; this is often followed by rebellion of the group or some of its



members. If the second stage is handled appropriately, there is finally a relaxation to a competitive-creative process within the group.

2. A group with more than six to ten members is often too unwieldy to establish an effective working relationship.

3. The appropriate focus of the group is on the problems and feeling and thinking about patients that almost all doctors have in common and on the patient that the physician brings up for discussion in the session. Group pressure and/or guidance by the psychiatrist-instructor are used to identify the resistances that hinder the doctor's work with his patient. But the dynamics of the physician himself are avoided, and the multiple transference relationships within the group — between leader, associates, and physicians — are not dealt with as such unless they clearly begin to interfere with the doctor's understanding of his relationship to his patient.

The leader should hold back as much as possible, allowing group members to teach each other. The private, inner life of the doctor is deliberately avoided; thus the group will not discuss what motivates a physician to choose or select particular patients, but rather how he treats them once they have been selected. While the psychiatrist's function in the training program is not to meet all the personal and professional needs of the participants, he does have some obligation to respect and protect their defenses.

4. Repeated or episodic absences should be discussed openly in the group as manifestations of resistance.

5. In the beginning or basic training programs, one is generally dealing with relatively uncommitted physicians who are conscientiously trying to find some way to relieve themselves and their patients of problems that they find perplexing or irritating. Such physicians are most comfortable with definitive, unambiguous, testable theoretical formulations, with tangible, concrete evidence for making clinical judgments, and with active, definitive techniques for therapeutic intervention.

6. Individual differences must be accepted, and the psychiatrist-instructor must be careful not to label as neurotic everything that differs from his point of view. The physician's response of anxiety to destructive impulses within his patient is no more neurotic than is the anxiety of a psychiatrist when the master of ceremonies in a supper club asks if there is a doctor in the house.

7. Often a participant will show major transference problems from the beginning. His lengthy polemics about differential diagnosis and his quarrelsome arguments that challenge the instructor at every step are evasive maneuvers that may hide his low expectation and skepticism about the course and his inability to accept new ideas or

learn different techniques. In handling such outbursts, it is best to avoid the role of therapist and instead help the student to see that the instructor is aware of his dilemma and reassure him that it is not a surprising one. In demonstrating ego defenses, one is on potentially dangerous ground since the student has had to use those same defenses to attain professional objectivity and detachment.

8. Early eagerness or stormy enthusiasm often betrays underlying opposition and resentment.

9. Some students hide behind a mountain of historical data in order to avoid what the patient is trying to communicate.

10. Faced with the doomed or dying patient, the student often wants to do something and is unable to accept the patient's denial of his condition as a protective defense against the crushing impact of the truth.

11. Some students are disappointed that they are not being taught to handle everything and that they are expected to be supportive rather than analytic; their disappointment is all the more acute if early in the course they have been led to believe that training will transform them into skilled psychiatrists.

#### *The Balint Approach (Teacher-Student Relationship)*

The "Balint seminars" — named after Michael and Enid Balint's seminars on psychological problems in medical practice — provide an example of an approach that focuses primarily on the teacher-student relationship and attempts consciously to avoid the kind of relationship that is fostered by the usual postgraduate seminar. The tacit assumptions of the latter are that the psychiatrist knows what kind of training the primary physician needs, that he knows what sort of psychiatric problems occur in their practice, that he knows what type of psychotherapy is possible and desirable for their patients, that he himself is skillful in practicing that type of therapy, and that he can successfully train his students in those techniques in the time available.

Experience suggests that there may be some truth in one or more of these assumptions, but not very much. General practice is fundamentally different from hospital practice, and the general practitioner is likely to know much more than the psychiatrist about the events and problems with which he deals. Hence the psychiatrist must be willing to admit that he too is a learner in the seminars and not an omniscient, omnipotent specialist.

The seminars aim to discover what the psychological problems



of everyday practice are, how to recognize and understand them, and how to use that knowledge and understanding so that it has a therapeutic effect on the patient. Meetings are held weekly, usually for about two hours each time, and continue for two, three, or more years. Rather than taking the doctors out of their practices, the Balint seminars use only the doctors' observations from their own practices, and any case brought up is generally followed by the group for as long as the doctor remains in the seminar. Obviously, there can be no prearranged timetable in such an arrangement, but the group process can generally be seen to develop in three phases:

Phase 1 — Learning: This phase starts at about the second or third month of the meetings and continues throughout the lifetime of the group.

Phase 2 — Unlearning: This stage begins about the end of the first year, and once it has begun may never end.

Phase 3 — Relearning: This phase usually starts in the second or third year of training (and since not all participants continue for that long, some physicians never reach this stage).

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In the learning or discovering phase the participant comes to recognize that the most frequently prescribed drug in medical practice is the doctor himself. He also sees that there is no literature on the indications for that drug, on its curative and maintenance dosage, its toxicity, its avoidable and unavoidable side effects, or its contraindications. In this phase the participant also learns that the practice of medicine consists of an interplay between doctor and patient, and in the case of problem patients the result of the interaction is an agreement on "what the trouble is about."

Once it is discovered that the agreement is determined partly by the patient's illness (the patient cannot solve the problems he has in human relationships within his own environment and so must transfer those problems onto his doctor) but also partly by the physician's way of practicing medicine, many important discoveries will follow, some pertaining to the doctor himself. The doctor becomes more sensitive to his own contributions to that relationship and especially to his "apostolic function" — his conviction that not only is his way of practicing medicine the only right way, but that he has a sacred duty to preach it and convert both his patients and his colleagues to his ways. The doctor also learns that patients have their own methods of forcing certain kinds of relationships with their physicians.

By becoming aware of the force of his own apostolic function, the doctor gradually frees himself from its compulsive power. He can then begin to recognize the interplay between his responses and the patient's behavior patterns, and he is able to control his otherwise

automatic reactions. This enables him to reduce the extent of his own emotional involvement in the relationship and thereby provides more opportunities for planned therapeutic interventions. His way of practicing medicine becomes more patient-oriented and less illness-oriented.

In the unlearning phase the doctor begins to curb his unlimited beliefs in traditional diagnosis, laboratory examinations, and specialized workups. Instead of asking more and more questions and collecting the disjointed answers into a medical history, the doctor has to listen and understand the meaning of what the patient is trying to communicate to him. This leads to the introduction of long (45 to 60 minutes) interviews, which may break up his accustomed routine.

In the relearning phase the task is to discover how the practicing physician can avoid a split in himself — being a general practitioner to some of his patients and a competent psychotherapist to others, practicing illness-oriented medicine with some and person-oriented medicine with others. The physician does not want to lose his identity as a general practitioner and yet wants at least at certain times, with certain patients, to identify with the psychiatrist.

Not every patient is responsive to a person-oriented approach, and some patients are responsive at certain times and not at others. In general practice, where patients are seen over long periods, there may be opportunities for the physician to notice changes in the patient that signal a desire to communicate. The doctor must be alert to such shifts and search for ways in which he can allow the patient to use him in a way that will be beneficial.

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This phase involves a change in emphasis from the doctor as a detective searching for clues to the doctor who allows his relationship to the patient to be used in a therapeutically meaningful way. The doctor's new psychological understanding and his traditional prescribing of drugs can thus be integrated into a united, better aimed, and more reliable therapeutic action.

An example of person-oriented medicine is the approach to the patient in the terminal phases of an illness. The usual approach is to "spare the patient" and keep him ignorant of the nature of his condition; almost invariably there is increasing strain between doctor and patient amounting in certain cases to suspicion and mistrust and a general atmosphere of deception. The Balint seminars experimented with sincerity, and the doctor was enjoined to be absolutely honest with his terminal patient. In most cases the result was the disappearance of mistrust and suspicion and the development of a peaceful, friendly, and grateful atmosphere. The amount of sedatives,



tranquilizers, and painkillers needed after the honest discussions was incomparably lower than usual.

The major drawbacks to such a seminar technique are the amount of time involved in training a relatively small group of physicians and the intensity of the group relationships. The Balints have estimated that probably 60 percent of physicians can not tolerate such an approach.

## FINANCES

Most programs can be described in terms of three financial crisis stages. The first crisis is the need for a relatively small sum of money to support initial tentative organizational and planning efforts. Ordinarily, the participating organizations themselves absorb the cost of such planning.

The intermediate crisis occurs when the program planners find they must launch an initial or pilot course to maintain the planning group's enthusiasm. The program thus begins to accumulate operational experience as it begins to enlist permanent financial support for the program as a whole. Funds at this stage may be obtained from several sources: registration fees (e.g., a fee of five dollars per session, collected at the time of registration), special grants (e.g., from pharmaceutical firms), and donation of their own time and of secretarial assistance by the faculty and program administrators.

The final crisis arises when it is necessary to finance firmly (usually for at least five years) the main educational program. To meet this crisis most programs have sought a training grant from the National Institute of Mental Health.<sup>1</sup>

Such grants originated in 1959, when Congress appropriated 1.3 million dollars for psychiatric training for primary physicians. From fiscal year 1959 through fiscal year 1963, 239 grants were awarded to 70 training institutions for a total sum of \$3,446,419. The program was increased from 25 grants totaling about \$300,000 in 1959 to 73 grants totaling \$1,114,832 in fiscal year 1963.

With the assistance of the APA, the AAGP obtained a grant from NIMH, commencing in 1963, for the purpose of stimulating local groups to initiate courses and train teachers and course organizers. The intent of this program is not to teach psychiatry to primary physicians, but rather to emphasize ways and means of achieving such goals.

<sup>1</sup>To apply for a grant, write: Chief, Continuing Education Branch, Division of Manpower and Training Programs, NIMH, 5454 Wisconsin Ave., Chevy Chase, Md. 20015. Filing dates for applications are October 1, February 1, and June 1 each year for grants to begin the following July 1, September 1, and January 1 respectively, if approved and funds are sufficient for payment. Also see pages 52-57 for suggested outline of a draft proposal and a list of NIMH priority considerations. NIMH staff recommend that potential applicants submit a preliminary proposal for informal evaluation and suggestions prior to submitting a formal grant application. Consultation via letter, phone, or visit to NIMH offices is available.



The 50 states and Puerto Rico were divided into seven regions with the intent of holding a regional workshop in each of the regions at some time during the grant period. In addition to such workshops, the program initiated the formation of state mental health steering committees to advise and counsel those people interested in starting continuing education programs in psychiatry, to assist programs already under way, to plan and produce programs for future presentation, and to coordinate such activity within the state.

Fees paid to instructors or consultants to training programs vary from area to area and may be fixed by the terms of the grant. One typical fee schedule is \$50 per session (one and a half to two hours); but if the instructor must travel 50 to 150 miles the fee is \$100 plus travel expenses, and if more than 150 miles, \$150 plus travel expenses.

## EVALUATION

Ideally, an evaluation apparatus should be built into every level of the training program to assess the effects of the program and of the teaching process itself; in fact, few programs have attempted anything but the most simple measurement of results. As already mentioned, this may be related to the failure of most programs to define specific objectives in the first place.

Popularity of a course is a questionable measure of its effectiveness; indeed, many of the most popular programs seem to be those that produce minimal changes in the attitudes of the participants. Enrollment in more advanced courses by physicians who have already participated in a basic program is at best suggestive of the latter's effectiveness, since it gives no indication of whether there has been any change in the physician-student's way of practicing medicine.

Results of the training programs depend upon many interrelated variables, such as the quality of the staff, the quality of intake, the methods of training, and group leadership. Experience gained thus far suggests that the physician who will show any change as a result of his course will begin to show it early in the training program. Most workers also agree that even participants who do not appear to change need not always be counted as failures.

Indexes of change in the participants may be garnered from many areas: The physician consciously modifies his techniques as a result of increased awareness of how his own feelings affect his professional activity; he changes his style of relating to patients (e.g., Is he chiefly directive or chiefly interrogative? How authoritative is he?); he changes his attitude toward patients and/or his self-concept in the patient-physician relationship; colleagues, friends, or spouses note changes in the physician, changes in the physical organization in his office, in his intake procedure, or in his office management; there are changes in the number and type of drugs dispensed; there are changes in case load in regard to numbers or types of patients; he uses different ways of presenting patients in case conferences and seminars; there are changes in the number of referrals to psychiatrists and in comments by the physician's patients or their families; there is greater acceptance of difficult, "hard-core" patients; he



shows more consideration of psychological and social factors; there is improvement in diagnostic discriminations; there is greater utilization of community and social resources; and he has an increased ability to do reality-oriented psychotherapy.

Any measurement of change, obviously, must start from the baseline of how the participant functioned before he entered the training program, but obtaining such data before the physician is actually involved in a course has been as difficult as gathering valid data on his attitudes and approach to patients after he has completed the course.

None of the assessment techniques thus far devised is without drawbacks. Questionnaires are easiest to use but run the risk of being superficial. Studying tape-recordings of the training sessions may provide a great deal of information about the course, but it can only suggest what changes, if any, are taking place in the student-physician. Further, such tapes soon grow into an indigestible mass. Attitude scales can be helpful in providing indirect indicators of change, but they do not really tell what goes on in the consulting room.

Interviewing students can also provide many clues to their attitudes, but often they will necessarily be focused on attitudes to the program rather than on changes in student knowledge and skills. Direct observation of students in the training program and in their daily practices offers perhaps the greatest hope for assessment of actual changes; but the method runs the risk of distorting the physician's practice and in addition demands a great deal of time from both the observer and the observed.

#### Evaluation Methods

The following are some of the evaluation methods that have been reported.

##### *Adler and Enelow Studies*

Adler and Enelow (University of Southern California) conducted three studies of students in a 16-week course.

The student's formulations were compared with those of the instructor. In the second session the patient was interviewed by the instructor, and both students and instructor then described the patient, suggested a diagnosis, and formulated a treatment plan. The same procedure was repeated in a final session. Learning achievement was measured as an increase in agreement between students and instructor.

At the beginning of the course both students and instructor were

shown a film of a psychiatric interview and were asked to summarize everything they observed relevant to diagnosis and management. A film of a different patient was shown at the end of the course.

The summaries were then analyzed for psychiatric content, i.e., patient's behavior and appearance, psychiatric social history and complaints, interpretive, evaluative, and prognostic statements, diagnosis, and treatment, and (for medical content) medical history and complaints, medical diagnosis, and medical management.

Each student statement was then rated as agreeing, disagreeing, or not comparable to the instructor's statement. The investigators found, as predicted, that after the training experience there was a marked increase in the number of statements concerning the patient's behavior and appearance, a decrease in highly inferential and interpretive statements, and increased agreement in statements concerning psychiatric content and management.

Each student was given a short questionnaire (three pages, three minutes) to complete for each of five of his patients at the beginning of the course and again at the end of the course. One predicted change occurred: After taking the course, physicians spend more time taking personal history and discussing the patient's personal problems. But the following predicted changes did not occur: More histories would be taken in the consulting room; more time would be spent in activities other than physical examinations; more presenting problems would be seen as psychiatric complaints; and more things of a psychiatric nature would be done for the patient.

##### *WICHE Study*

The WICHE study, described by J. B. Pearson, used questionnaires that were given to the student and the instructor both before and after the training experience. The questionnaires were designed to gather background and status characteristics of the physicians, their attitudes toward the physician's role in a variety of behavioral situations, and their attitudes toward physician-patient relationships.

Answers were scored in such a way as to measure attitudinal movement toward or away from an ideal state, which included: *role tolerance* (the physician is more tolerant of himself in his immediate environment), and *psychiatric orientation* (less discomfort in dealing with emotional variables). Psychiatric orientation encompasses the *apostolic function* (the physician expresses willingness to utilize his personality along psychiatrically meaningful lines), and *social distance* (the physician expresses a minimum of social distance between himself and psychiatry and is more accepting of the latter).

Results of the study suggest that the "successful" short-term



seminar participant is comparatively young, has been practicing in the community a relatively short time, is in individual private practice, maintains an inflexible appointment schedule, and is conservative in political orientation. His personality structure corresponds to the descriptions of "anal character," and he has a high level of professional aspiration and well-developed work habits.

The successful short-term seminar in psychiatry is characterized by nondirective pedagogy, minimal professional disagreement between co-instructors, and a significant amount of professional dialectic between co-instructors and participants. (Popular seminars, in contrast, tend to emphasize didactic pedagogy.)

#### *Staunton Project*

The Staunton Evaluation Project included investigations of seminars in psychotherapeutic medicine given at the Staunton Clinic Unit of Western Psychiatric Institute, University of Pittsburgh Medical School, and their effects on medical practice.

The question of how best to study complex continuous phenomena like those involved in medical practice has been vexing enough to prod behavioral scientists in many fields to a flurry of activity. One school favors small time slices as samples and instruments that record precise behavior categories; but such methods invite circularity and discourage serendipitous observations. What appears to be reliability may really be no more than a measure of how quickly and how well the observer has learned the classification scheme.

Another method is the case history approach, but here the volume of data collected poses severe problems in evaluation and processing.

The Staunton Project's methods did not fall neatly into either of the other approaches but borrowed something from each of them. Direct observations of physicians in their offices were made repeatedly and were systematically varied over the course of the project so as to include all hours of the day, days of the week, weeks of the month, and months of the year. Each observation lasted for one hour and focused on the physician-patient transaction ("medical style").

At least four areas of observation offered clues to medical style: the volume and pace of work; the response to research intrusion; clustering of kinds of physician-patient transactions; and a group of spontaneous physician responses that were found to be clearly psychotherapeutic.

With regard to work load, for example, six of the physicians observed fell within a range of 6,800 to 7,900 patient visits per year; but a seventh physician had 4,159 visits, and an eighth 10,400.

Five physician-patient transaction styles were identified:

1. *The screening transaction:* The physician quickly and accurately zeros in on a working diagnosis and a preliminary treatment plan.
2. *The crisis transaction:* The physician intervenes promptly in a crisis situation with well-defined treatment methods and often with tangible results (suturing a wound is an example).
3. *The Procrustean transaction:* This occurs in cases where physician and patient have reached agreement that a chronic condition exists and the physician carries out an obviously routine treatment in a rigid, stereotyped way (examples are weight reduction and allergy treatment).
4. *The adynamic transaction:* The observer reports that nothing has happened, but both physician and patient appear satisfied.
5. *The faltering transaction:* Physician or patient or both give evidence of frustration.

#### *Miscellaneous Evaluation Methods*

Miscellaneous instruments for evaluation include:

1. Opinions on Mental Illness (OMI) questionnaire, given at the beginning and at the end of the program.
2. Interviewing participants in their own offices during the seminar and again six or seven months after completion of the course.
3. Interactional analysis of the course as it is being given.
4. Analysis of admissions to local and state mental hospitals from geographic areas served by physicians who have taken a course. It is difficult to interpret any changes observed unless many of the variables are controlled or can be subjected to elaborate statistical analysis. Sometimes admissions will rise as a result of increased diagnostic acumen; at other times they might fall because of the development of greater skill in treating the emotionally disturbed. One such study, for example, reported that in the project area first admissions decreased nearly 30 percent; in the area with a mental health clinic they increased 42 percent; and in the area without psychiatric resources they increased 15 percent. Readmissions increased in all three areas, but only 13 percent in the project area, compared with 22 percent in the clinic area and 50 percent in the area with no resources.



## COMMITTEE ON PSYCHIATRY AND MEDICAL PRACTICE

Adequate and appropriate evaluation of programs is receiving increasing emphasis by the Committee on Psychiatry and Medical Practice of the American Psychiatric Association, which currently considers its major functions to be 1) improving the distribution, efficacy, and quality of training programs; 2) developing techniques of evaluation; and 3) establishing a network of educational institutes for planners and directors of programs and for regional consultant groups to assist with program development in their areas. The following official statement by the Committee, titled "Training of Non-psychiatrist Physicians: Some Criteria," indicates the focus of its activities in the coming years.<sup>2</sup>

Training programs in psychiatry for nonpsychiatrist physicians are an established and significant part of continuing postgraduate medical education. According to American Medical Association figures, of a total of 1,264 courses offered in 1963-64, 124 were in psychiatry; by 1965-66 that number had climbed to 253, and courses in psychiatry thus constituted 15 percent of all medical postgraduate courses. Even those figures, however, tell only half the story, for a survey by the National Institute of Mental Health in 1964 revealed that the actual number of courses in psychiatry was 248 rather than the 124 reported by the AMA survey.

NIMH training grants have provided the major support for such courses. During the past decade approximately 11,000 physicians (55 percent of whom are general practitioners) have participated in NIMH-sponsored programs. What have these programs accomplished? What effects have such courses had on the participants? And what benefits have patients derived from such training of their physicians? These and related questions press insistently for answers, particularly since grant support for future programs is likely to expand less rapidly, even though proposals to initiate new programs increase. It is clear that new directions must be found and that more effective use must be made of available education resources for physicians. In order

to accomplish this, greater attention will have to be paid to program planning at all levels — national, regional, state, and local — and to special training for program directors in program planning and administration.

Efforts along this line have been made in the past by a variety of groups: the annual colloquia for postgraduate teaching of psychiatry to nonpsychiatrist physicians sponsored by the American Psychiatric Association; annual teacher training institutes under the auspices of the Western Interstate Commission for Higher Education, the University of Oregon, and others; the APA Physician Education Project; the American Academy of General Practice; the American College of Physicians; and the NIMH Continuing Education Branch.

However, results, at least as judged by measured effectiveness of current programs, have been uneven, and special problems have emerged. Many different training models have evolved, but none of them has been predictably successful or universally appealing to potential applicants. Some programs have tended to become static, others have gradually exhausted themselves and died out, while others have required extensive revision in order to survive at all. In many, an overburdened faculty with minimal background in program planning and educational methods has taught practitioners too busy to devote more than small amounts of time to the program. And in few programs has it been possible to assess the worth of the learning experience.

It seems clear that the program most likely to survive and flourish will be the one that satisfies the following minimal criteria.

1. Determination of the needs and lacks on the part of the prospective student population.
2. Formulation of educational objectives in terms of what the successful participant will be able to do, or will be able to do better, once he has completed the program.
3. Selection of teaching methods appropriate to the stated educational objectives.
4. Integration of the training program with other developing comprehensive health efforts, such as community mental health centers, regional medical programs, comprehensive health planning, Model Cities programs, and Office of Economic Opportunity programs.
5. Evaluation of results in terms of the degree to which specific achievement goals have been attained.

The Psychiatry and Medical Practice Committee and the Physician Education Project of the APA consider it part of their responsibility to assist those operating and planning programs

<sup>2</sup>American Journal of Psychiatry, Vol. 125, pp. 1110-1111, 1969.



in continuing education in psychiatry for nonpsychiatrist physicians to meet these minimal criteria. Our proposed methods of doing this are through expanded consultation services to program operators and intensive teacher training sessions for those who wish assistance in planning and improving programs.

## STATE MENTAL HEALTH STEERING COMMITTEES

The largest single activity of the Committee on Psychiatry and Medical Practice is liaison and consultation with the American Academy of General Practice. Indeed, when the Committee was first created it was called the Committee in Liaison with the American Academy of General Practice, and its only function was to work with the Mental Health Committee of the Academy. The APA Committee is currently engaged in a large-scale effort designed to implement the NIMH grant to the AAGP for developing mental health programs in continuing education for physicians throughout the country.

The AAGP has divided the United States into seven regions, and one member of the Mental Health Committee is assigned to each region as coordinator. Similarly, the APA Committee on Psychiatry and Medical Practice has seven members, each of whom is assigned to one of the regions as APA Regional Coordinator.

The seven regions are as follows:

Region 1: Maine, Vermont, New Hampshire, Massachusetts, Connecticut, Rhode Island, New York, New Jersey

Region 2: Washington, Oregon, Montana, Wyoming, Alaska, Idaho

Region 3: Mississippi, Alabama, Georgia, Florida, North and South Carolina, Puerto Rico, Tennessee

Region 4: North and South Dakota, Nebraska, Iowa, Minnesota, Wisconsin, Michigan, Illinois

Region 5: Kansas, Oklahoma, Missouri, Arkansas, Texas, Louisiana

Region 6: Indiana, Ohio, Pennsylvania, Kentucky, West Virginia, Maryland, Delaware, District of Columbia, Virginia

Region 7: Colorado, California, Nevada, Utah, Arizona, New Mexico, Hawaii

A crucial emphasis of the AAGP in recent years has been on the development of State Steering Committees for Mental Health, whose organization and development are ordinarily the responsibility of the AAGP regional chairman, working in close association with his corresponding regional representative from the PMP Committee.

### Goals

The major objectives of the State Steering Committee are to stimulate and guide postgraduate education programs in psychiatry, to determine the needs of the state for such programs, and to encourage county medical societies, medical schools, etc., to give appropriate courses. Their achievement goals include the following: coordination of existing courses in order to minimize duplication and overlapping; centralization of the registration of students in order to avoid confusion in recruitment; development of new courses in geographic areas not already served; development of new educational approaches for the state; promotion of more effective communication among various professional groups; introduction of psychiatry into general hospitals that do not have psychiatric services, in the belief that every general hospital should have a written mental health service plan for acute and ongoing emotional problems; promotion and improvement of consultation between psychiatrists and other physicians; and any other relevant and appropriate activity that will facilitate formal and informal psychiatric education of primary physicians.

### Functions of APA Committeeman

The functions of the APA committeeman related to the work of the AAGP specifically include the following: to serve on the National Planning Committee, i.e., the joint meetings of the AAGP Committee on Mental Health and the APA Committee on Psychiatry and Medical Practice; to serve as co-chairman (with the AAGP regional chairman) of the regional workshops; to advise and consult with the AAGP committeeman from his region; when necessary and authorized by the project training director, to travel with the AAGP committeeman to a state in his region for consultation on problems concerning implementation of the Academy's objectives in the area of mental health; and to assist in the development of evaluation procedures and processes.

The APA committeeman also provides direct consultation to the steering committees themselves and obtains outside consultation when needed. Such consultation will typically be in the following areas: 1) to assist in the formation of the steering committee by approaching and effecting liaison with the various medical organizations that might be represented on the steering committee: state medical associations and their mental health committees, state departments of mental health, medical schools' departments of psy-

chiatry, universities' departments of continuing education, district branches of the APA, state mental health associations, etc.; 2) to assist in appraisal of the states' interests, needs, special problems, and unique opportunities; 3) to demonstrate the value of an active educational program and ways in which such programs may be initiated and conducted through the use of regular meetings or organizations such as the state's medical society; 4) and to publicize the steering committee throughout the medical community.

Formation of a state steering committee depends in part upon active participation by the state's medical leaders. Among the key people to be approached are the president of the state's chapter of the AAGP, chairman of the state medical association's committee on mental health, president of the district branch of the APA, the state's commissioner of mental health, the chairmen of departments of psychiatry in the state's medical schools, and directors of postgraduate education in the state's hospitals.



## OUTLINE OF STEPWISE PROGRAM DEVELOPMENT

The following is a suggested step-by-step procedure to develop a program for postgraduate training in psychiatry. The rationale for many of the steps has been discussed in the foregoing sections; the procedure itself has been modeled in large part after that employed in a notably successful state education program administered by the Connecticut Academy of General Practice (as described by Mr. Lee Isenberg in the Fifth Colloquium).

1. Select a target group of potential students.
2. Do a "problem census" on that target group — what are their needs as they see them, as the AAGP (or American College of Physicians, American Academy of Pediatrics, etc.) sees them, and as organized psychiatry sees them (See Appendix A).
3. Using the "problems" thus uncovered as a guide, devise a tentative curriculum for the course.
4. Select a nucleus faculty, and with that group decide if any modifications of the tentative curriculum are indicated; the "core curriculum" chosen must mobilize the enthusiasm of the nucleus faculty, or the program will almost certainly fail.
5. Select one member of the nucleus faculty as continuing coordinating chairman for the program.
6. Identify and determine availability of additional faculty, both from local sources and possible consultants from other areas.
7. Plan for funding of the program. If this will include application for an NIMH grant, see Appendix B for a guide for continuing education in mental health.
8. Write up a tentative outline of the course — with curriculum and faculty — for presentation to the education committee of the state chapter of the AAGP. The outline should be submitted at least three months prior to the anticipated opening of the course.
9. In collaboration with the AAGP Education Committee and appropriate local community leaders (depending on the target group that has been selected), develop a firm curriculum. It must include a format that is geared to the abilities and desires of the faculty, to the nature of the material being taught, and to the expressed wishes and assumed needs of the target group.

10. Determine what other courses have been given or are being given to the same target group or in the same area; the point is to avoid destructive competition between courses, as well as fruitless repetition of something that has already proven a failure.

11. Contact medical schools in the area for assistance in obtaining guest speakers and outside consultants if these are needed.

12. At this point, the course plan is essentially in final form. The next step is to formulate, in concrete terms, the educational objectives of the course: What will the successful participant be able to do, or be able to do better, once he has completed the program?

13. Devise evaluation procedures to measure the changes anticipated in the students; such an evaluation must be a part of the program from the very beginning.

14. Submit the complete course outline to the regional director of the AAGP for postgraduate education approval.

15. Obtain sponsorship for the program, and at the same time integrate it with other comprehensive health efforts within the community (e.g., community mental health center, regional medical programs, comprehensive health planning, Model Cities program, Office of Economic Opportunity programs). It is generally advisable to focus on organizations that the community is accustomed to using for educational programs; these will obviously vary according to local conditions. Such organizations can be grouped broadly within three categories: a. psychiatric organizations (APA district branch, state mental hospital, state or local mental health authority, etc.); b. other medical groups (state and county medical societies, hospitals, county health department, local chapter of American College of Physicians or American Academy of Pediatrics, etc.); c. nonprofessional organizations (mental health association, lay boards of hospitals, Junior League, Chamber of Commerce, education and welfare agencies, etc.).

16. Arrange a workshop for faculty members and the local arrangements committee in order to select a site for the presentation of the training program, to set the date for the beginning of the program, and for a final check to be certain that the originally proposed training program is suitable for the desires, needs, and characteristics of the target population.

17. Prepare an announcement of the program for mailing to the target population approximately 30 days prior to the start of the program. The announcement should include a description of the course, date and site of the meetings, biographical background information on the instructors or group leaders, the fee for the course if the participants are to be charged, and an advance registration form. If an



entire medical community in an area has been selected as the target group, it can be anticipated that about five percent of those invited will respond to the first announcement; if the target population has been limited to a specific subgroup of the medical community and the program has been geared specifically to their desires and needs, the proportion of first responders should be higher.

18. Prepare posters describing the course for display in appropriate locations (e.g., in the physicians' room in the hospital where the course is to be given).

19. Send a reminder notice and a second advance registration form two weeks before the course begins.

20. Prepare a news release, with picture(s) if possible, for placement in appropriate newspapers or journals approximately one week before the course begins.

21. At the same time, confirm arrangements concerning faculty and speakers, equipment (including rental agencies if outside equipment is used), and keys, lighting, etc., for site of course.

22. During the week before the first meeting, telephone all the physicians who have received announcements of the course; remind those who have registered in advance of the time and date of the first meeting, and try to get all the others to attend the first meeting. It is most effective if the physician can be reached directly (and not his nurse or his answering service); experience suggests that the best time to telephone is right after lunch. Registration need be closed only if there are approximately 40 percent more advance registrants than course openings, for generally 30 to 40 percent of those pre-registered will not appear for the first session.

23. Arrange for a photographer to take press pictures at the opening session.

24. Arrange for a registration desk to be manned throughout the first session, and during that session be sure that all participants fill out the necessary forms so they will receive AAGP credit. Fees charged should be collected at the first session.

25. Depending upon the kind of evaluation included in the program, have participants complete the necessary forms for a "pre-training" baseline.

26. After the first session, contact all advance registrants who did not appear, and recruit additional physicians for the remainder of the course to offset the usual 20 percent drop-out rate in the second-session enrollment.

27. Thereafter, contact each physician who is absent for any session; contact all participants by telephone if there is a change in

schedule; call guest speakers on the day scheduled for their appearance.

28. Throughout the course, complete whatever questionnaires, interviews, etc., are required by the evaluation portion of the program.

29. As soon as possible after the end of the course, another workshop should be arranged for an evaluation of how the course might be improved if it is to be repeated. For most courses, an optimal form is rarely reached before the third time they are given.



## SUMMARY

The foregoing outline has attempted to summarize the experience gained thus far by those involved in continuing education in psychiatry — program planners, faculty, participants, and evaluators. Insofar as possible, theory and speculation have been avoided, and emphasis has been placed instead on describing alternative approaches that have been useful in past and current programs.

Because it is a summary of findings, this guide is a cross-sectional view of current approaches, rather than a longitudinal-historical review of the field. Such an overview has served to pinpoint certain areas that seem to warrant special attention in future programs. Among these are explicit definition of the goals and specific achievement tasks of training programs, involvement of participants in planning, understanding of group process in learning, evaluation and assessment of results, more effective regional coordination of ongoing programs, and continuing education of the psychiatrist himself — not only within his own specialty but in other areas of medicine as well.

It is believed that the expanded consultation services proposed by the Psychiatry and Medical Practice Committee and the Physician Education Project of the APA can provide the directive and focus requisite for further advancement in this important and significant area of postgraduate education.

## APPENDICES

### *Appendix A: Excerpts From Report of a Survey of Colorado Medical Society Membership Initiated by the Colorado Mental Health Steering Committee<sup>1</sup>*

The survey was initiated with a letter to members of the Society on its official stationery, and over the signature of the Mental Health Liaison Committee of the Colorado Academy of General Practice and the American Psychiatric Association, and with the signed endorsements of the presidents of the Colorado Medical Society, the Colorado Psychiatric Association, and the Colorado Academy of General Practice. The letter, quoted following, illustrates the value of multiple endorsement.

Dear Doctor:

We hate questionnaires just as much as you do! Hopefully, however, you will accept the challenge of this intrusion on your time (five to ten minutes by actual trial) and respond as fully as possible.

The enclosed questionnaire was prepared by representatives from the Colorado Academy of General Practice, the Colorado Psychiatric Association, the University of Colorado Medical Center, WICHE, and the Division of Mental Health of the State Department of Institutions.

Certain questions may appear irrelevant or superficial to some of you (in Pathology, Radiology, Psychiatry, for example) — please deal with these questions as you wish. Please, however, respond to some degree. This is your opportunity to participate actively in the planning phases of your postgraduate education programs.

The following is a summary of questionnaire responses regarding mental health activities received from Colorado physicians. The original idea for querying these physicians was developed by the Colorado Mental Health Steering Committee. This is an independent group made up of representatives from the following organizations: Colorado Medical Society,

<sup>1</sup>Prepared by Judson B. Pearson, Ph.D., Professor, Department of Sociology, University of Colorado, and William R. Morris, M.D. (Ph.D. Candidate), Department of Political Science, University of Colorado, with Bernard L. Bloom, Ph.D., Consultant, Mental Health Programs, Western Interstate Commission for Higher Education (WICHE), and Professor of Psychology, University of Colorado, and Raymond Feldman, M.D., Director, Mental Health Programs, WICHE. Published by WICHE, Boulder, Colorado, August 1969.



Colorado Academy of General Practice, Colorado Psychiatric Association, University of Colorado Medical Center, Colorado Division of Mental Health, and Western Interstate Commission for Higher Education. The common bond of interest of the Colorado Mental Health Steering Committee is a mutual concern of all members in the continuing education of physicians concerning the emotional and mental health aspects of medical practice.

The Western Interstate Commission for Higher Education, in cooperation with the office of the Colorado Medical Society, took on the task of distributing and receiving the questionnaires on completion. In November, 1968, they were mailed to all 2,500 Colorado physicians in the state. A total of 1,256 usable questionnaires were returned, representing a response rate slightly in excess of 50 percent. Undoubtedly, such a high percentage of responses is a positive reflection upon the respondents and their interest in the subject. Moreover, considerable pre-questionnaire publicity in various state medical publications was employed. Also, the president of each county medical society was contacted and was requested to urge the cooperation of all physicians in the county. All these factors unquestionably counted for such a high response rate.

A comparison was made of the feedback from rural and urban physicians, and of the physicians who did and did not identify themselves on the questionnaire. In addition, 78 questionnaire items were studied by means of a cluster analysis. In contrast with physicians who did not identify themselves, physicians who did appeared to treat more patients with emotional problems, felt more at ease with them, referred them more often, had attended postgraduate courses in psychiatry, and most often found that their patients were improving.

Similarly, in contrast with urban physicians, those from rural areas tended to treat more emotionally ill patients, referred these patients to specialists more often, felt the need for more training in psychiatry and emotional problems, and more actively followed up their patients after hospitalization.

When asked the type of emotional condition most often encountered in their practices, the Colorado physicians said, "psychosomatic reactions, anxiety neuroses, and depressive reactions." Doctors also claimed these conditions were the most difficult to treat, along with alcoholism and marital problems. Physicians practicing in the state's poverty pockets disproportionately checked alcoholism as a condition they frequently saw in their offices.

The questionnaire also revealed a communications gap. Private mental hospitals do a much better job of informing physicians of the status and progress of discharged patients than either public or Veterans Administration mental hospitals.

The following are some of the interrelationships disclosed by a study of the cluster analyses:

It appears that the greatest interest in improving psychiatric skills is to be found among physicians who are active and comfortable with psy-

chiatric patients. Physicians who are anxious to improve psychiatric skills have a significant number of patients with marital disorders; physicians busy with psychiatric patients are generally busy with all kinds of patients; and physicians who frequently consider the psychological aspects of physical disorders often tend to make referrals to psychiatrists in the community.

The report also revealed that doctors in two specific adjoining geographic regions were particularly receptive to psychiatric continuation education programs. These regions were an expanding affluent population area in metropolitan Denver and an adjoining area which is sparsely populated and mountainous.

General practitioners and physicians, specializing in obstetrics, gynecology, and pediatrics, a total of 500 respondents, generally expressed high readiness to improve psychiatric skills and thus may be well suited for continuation education efforts.

On the other hand, a second group of 450 respondents, including physicians specializing in surgery, dermatology, and diseases of the eye, ear, nose and throat, indicated very little readiness to improve psychiatric skills and may not be a very good group for continuing education offerings.

In all, these observations are considered to be of interest and are being brought to the attention of all physicians.

#### Gross Percentage Response Breakdowns of Questionnaire Responses on the Management of Mentally Ill Persons in Colorado

Please note that, although 1,256 complete and usable questionnaires were returned (out of approximately 2,500), not all physicians responded to each item in the questionnaire. Throughout the ensuing analysis, the letter NA refers to "not answered" and "not applicable."

1. Age at last birthday: 11.15—under 35; 56.45—35-50; 32.17—over 50; 0.24—NA
2. Type of practice:
 

27.95 GP	4.94 Eye, Ear, Nose and/or Throat
11.31 Ob., Gyn., or Ped.	5.97 Psychiatry
11.94 Surgery	2.87 Public Health or Urology
12.10 Internal Medicine	15.37 Other
2.47 Orthopedics	3.98 NA
1.11 Dermatology	
3. How is your medical practice set up?
 

51.99 Individual private practice	2.95 Private institution
17.99 Non-clinical partnership	6.85 Public institution
13.22 Medical clinic	6.45 Other
	0.56 NA



## 4. How long have you been practicing in your present community?

27.86 5 years or less	15.92 16-20 years
18.24 6-10 years	20.77 21-plus years
16.81 11-15 years	0.40 NA

## 5. In which county do you practice?

County breakdowns not included here.

## 6. To what extent do you try to adhere to your appointment schedule?

39.33 Very closely	12.74 Moderately
38.22 Closely	6.45 Quite flexibly
	3.26 NA

## 7. About how many patients do you see in your practice in a typical day?

19.27 Under 10	10.36 31-40
32.49 10-20	4.99 41 or more
26.68 21-30	6.21 NA

## 8. For about how many of them, on the average, do you prescribe psychoactive drugs?

27.07 None	5.33 4
15.21 1	9.71 5
15.21 2	8.27 6-10
9.63 3	3.52 11 or more
	6.05 NA

## 9. How often do you treat mental and emotional conditions in your practice?

25.88 Frequently	40.21 Infrequently or never
31.61 Moderately	3.31 NA

## 10. In general, how comfortable do you feel when a patient presents his emotional problems to you?

47.85 Quite comfortable	8.68 Uncomfortable
39.41 Moderately so	4.06 NA

## 11. In general, how comfortable do you feel when you attempt to confront a patient with his own disturbing behavior?

31.37 Quite comfortable	15.84 Uncomfortable
47.45 Moderately so	5.25 NA

## 12. What are the emotional or mental conditions which are the most frequently encountered in your practice?

60.35 Psychosomatic reactions	7.56 Other sexual problems
72.53 Anxiety neuroses	11.78 Problems of childhood
54.70 Depressive reactions	14.01 Problems of adolescence
9.47 Conversion reactions	6.61 Involutional problems
1.04 Dissociative reactions	22.37 Problems of old age

5.97 Psychoses  
34.47 Marital problems  
1.67 Homosexuality

15.37 Alcoholism  
5.73 Drug abuse  
2.47 Other

## 13. Which of these conditions have you found the most difficult to treat in your practice?

33.04 Psychosomatic reactions	4.94 Other sexual problems
32.64 Anxiety neuroses	5.73 Problems of childhood
31.37 Depressive reactions	8.52 Problems of adolescence
10.75 Conversion reactions	3.82 Involutional problems
3.58 Dissociative reactions	14.01 Problems of old age
15.29 Psychoses	33.44 Alcoholism
25.40 Marital problems	12.98 Drug abuse
9.08 Homosexuality	3.82 Other

## 14. From what one or two sources have you acquired most of your knowledge of psychiatry?

60.83 Reading	17.20 Consultation with psychiatrists
60.35 Clinical experience	5.41 Internship
37.90 Medical school	13.14 Residency
13.22 Postgraduate lectures or courses	

## 15. How useful in your practice have you found articles on psychiatry?

11.62 Very useful	34.08 Almost useless
47.37 Moderately useful	6.93 NA

## 16. How could they be made more useful?

56.53 NA. Of the remainder, the respondents expressed desires for less "jargon" and theory, and for articles which were more directly tied into medical practice.

## 17. Do you feel a need to learn more about the management of emotional problems?

57.48 Yes	19.43 No
19.59 Undecided or no opinion	3.50 NA

## 18. Have you ever attended a postgraduate course, seminar, or workshop in psychiatry?

38.46 Yes	58.68 No	2.87 NA
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## 18a. If so, has the knowledge you gained been useful in your practice?

14.09 Very useful	3.66 Almost useless
23.01 Moderately useful	59.24 NA

## 18b. How could these courses be made more useful?

79.30 NA. Most respondents to this question expressed needs for more didactic and more practical courses. Some felt that they could be increased in number.



19. If you have not attended a postgraduate course in psychiatry, what are your reasons?

15.92 Not interested	15.45 Topics not sufficiently useful
14.89 None at convenient time or place	1.67 Never knew courses existed
11.39 Too busy	40.68 NA

20. On the average, how many times per month would you estimate that you refer patients to psychiatrists in private practice?

26.67 0	5.02 4
23.65 1	3.90 5
18.31 2	4.70 6 or more
9.00 3	8.76 NA

21. Would you like to refer more than you do?

36.15 Yes	36.78 No
17.52 Undecided or no opinion	9.55 NA

21a. If so, what are your reasons for not referring more than you do?

33.36 Patients can't afford it	7.48 No capable psychiatrist nearby
30.02 Resistance of patients	9.71 Psychiatrist not been useful
19.11 Capable psychiatrist too busy	12.42 Other

22. To what extent do you participate in the patient's treatment after he has been seen by a psychiatrist?

16.80 Frequently	39.97 Seldom or never
30.73 Moderately	12.42 NA

23. To what extent do your patients usually show satisfactory improvement after treatment by a psychiatrist?

17.99 Frequently	13.69 Seldom or never
51.04 Moderately	17.28 NA

24a. To what extent are you kept informed of your patient's discharge and told of his treatment, progress, etc., when he is discharged from a state or county mental hospital?

7.56 Frequently	50.00 Seldom or never
16.00 Moderately	26.43 NA

24b. To what extent are you kept informed of your patient's discharge and told of his treatment, progress, etc., when he is discharged from a V.A. mental hospital?

4.38 Frequently	44.11 Seldom or never
12.26 Moderately	39.25 NA

24c. To what extent are you kept informed of your patient's discharge and told of his treatment, progress, etc., when he is discharged from a private mental hospital?

15.76 Frequently	32.32 Seldom or never
20.62 Moderately	31.29 NA

25. Do you provide follow-up treatment for discharged mental patients for their emotional problems?

43.31 Yes	38.85 No	17.83 NA
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25a. If not, are there any particular reasons?

78.90 N.A. No discernible patterns were ascertained.

26. How are psychiatrists of the greatest help to you in your practice?

40.84 NA. Generally speaking, the respondents felt that psychiatrists were of greatest help as consultants and advisers and in handling acute psychotic disorders.

27. How could they be of more help?

63.22 NA. Among those who did respond, there was substantial consensus that psychiatrists should make themselves more readily available, and also that they should communicate more readily with them.

28. When one of your patients does have a difficult mental or emotional problem, what community resources are ordinarily available to you?

71.89 Private psychiatric help	59.79 State or public mental hospital
56.69 Community mental health center	28.50 Private mental hospital
26.04 Social agency	26.75 College or university facility

29. What is needed most in your community to improve the treatment of the mentally ill?

44.19 NA. In order of frequency of answer: "more psychiatrists"; "don't know"; "more mental health centers"; and "less costly psychiatric facilities."

30. Would you be interested in receiving further training in the emotional aspects of medical practice?

37.82 Yes	35.67 No
19.75 Undecided	6.77 NA

30a. If yes, what type(s) of training would you prefer? Please rank in order of preference.

25.80 A short lecture course  
25.64 Continuing course or seminar over a period of weeks  
19.98 An opportunity to discuss emotional topics at length with a psychiatrist

31. Would you be interested in attending a continuing course or seminar taught by one or two psychiatrists?

30.18 Yes	38.06 No
20.46 Uncertain	11.30 NA

31a. If yes, would you be willing to serve as coordinator or registrar of such a course?

6.29 Yes	40.53 No
11.07 Uncertain	42.12 NA

32. Would you be willing to discuss the mental health needs of your community with professional colleagues who may be in a position to render advice and assistance?

38.93 Yes	30.65 No
15.29 Uncertain	15.13 NA

33. If you have responded to any of the "yes" or "uncertain" categories in the three preceding questions, please include your name and office address below. Your identity will be kept in complete professional confidence.

62.18 Included name and address	37.66 Did not include name and address
	0.16 NA

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#### Appendix B: Guide for Program Planning and Grant Project Proposals Continuing Education in Mental Health<sup>1</sup>

Prepared by the Continuing Education Branch,  
Division of Manpower and Training,  
National Institute of Mental Health

##### A. Description of Training Program or Project:

1. *Historic background and developments* leading to the proposal, e.g., nature of sponsoring institution or agency, or persons or division responsible for continuing education, previous continuing education activities, relevant needs and resources for continuing education in geographic and subject areas, participation by other agencies, professional associations or employee groups engaged in planning present proposal, relation of continuing education proposal to state or community mental health plans.
2. *Students.* Basis for decision as to which types of students will be given highest priority in your continuing education efforts. Nature of

<sup>1</sup>This outline is a brief modified version of grant application instructions designed as a guide for potential grant applicants, for rough draft proposals, or simply for local use in program planning.

student or consumer involvement in planning educational program. Type(s) of students and estimated number to be taught. If program is multidisciplinary, approximate number of each type. Nature and approximate number of all potential students (i.e., universe from which actual students will be drawn), plans for recruiting and selecting students, evidence of expressed interest by potential students, plans for follow-up and diversification of education according to different student backgrounds and needs.

3. *Objectives.* Describe briefly the goal-setting process as well as objectives arrived at, e.g., what information and perspectives were considered, what persons or groups participated in defining the objectives and setting priorities. *General objectives* include overall continuing education objectives, e.g., to help prepare staff for a developing community mental health program, to increase the effectiveness of physicians or clergy in dealing with the mental health aspects of their practices, to meet a high priority manpower need in child mental health, etc. *Specific objectives*, preferably stated in terms of measurable knowledge, demonstrable skills or behavioral change, should be tailored to specified needs of trainee target groups and mental health service priorities, e.g., to change specific behavior of public health nurses in Smith County for helping families cope with crises in which a parent has a terminal illness. Specific objectives may also be stated in terms of measurable changes in patients or in mental health indices of the population served by the trainees, e.g., reduction in the rate of arrests for alcoholism in the population served by trainees.

4. *Methods and Content.* Describe *methods* to be used in each training activity. Indicate rationale for choice of methods as they pertain to specific training objective content, available faculty and learning process. Describe the *time sequence* and total course hours for each training activity. Include a breakdown as to hours per day, days per month, etc., and relate the duration to the content and objectives. Describe the *specific content* to be included in the proposed program and indicate the relation of the content to the objectives.

5. *Available data and future plans for analysis of program development and evaluation of education.* Describe any plans for teacher training and critique.

B. *Budget items.* Give sufficient budget breakdown or formulae used in calculations to make nature of budget clear. List figures in two columns: current year and first year of proposed grant support.

1. Total budget of department, agency, or school (exclusive of PHS grants).

a. Total budget.

b. Estimate of that part of the total budget which is for continuing education.

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- c. Estimate of that part of the budget which comes from continuing education student registration fees.
- d. Estimate of total direct or indirect employer's contribution to the continuing education program in the form of time off, travel, registration fees, etc.

## 2. Project budget.

- a. NIMH support contemplated for the initial budget period (usually 12 months).
- b. NIMH support contemplated for the proposed project period (the maximum period for which support may be requested for a new grant is five years).

## C. Key staff in continuing education.

- 1. Personnel and their approximate hours per week or per year already devoted to continuing education.
- 2. Personnel and their approximate hours per week or per year in proposed project:  
Beginning with the program director list names and qualifications of key personnel in the project regardless of expected source of support. For unnamed positions list type of personnel desired.

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The above outline is meant to suggest comprehensive program planning but not necessarily extensive NIMH grant support. Contributions from students and employers may most easily be gained for support of direct teaching activities. NIMH support may be most strongly indicated for support of program planning and program administration which the sponsoring institution cannot yet provide. Nonetheless, NIMH support may be requested for any phase of the continuing education program as indicated by local circumstances.

March 1969

## Appendix C: Consideration of Priorities for NIMH Continuing Education Grants Programs

Prepared by the Continuing Education Branch,  
Division of Manpower and Training,  
National Institute of Mental Health

The basis for future NIMH programming in relation to the training of Mental Health Personnel will be determined by the nine priority areas listed below. These will be considered in rating the overall priority of individual grant projects within the total Continuing Education Grants Program. The first three criteria weigh most heavily in determining priorities for funding, assuming minimum criteria have been met in items 4 through 9.

## A. Integral to Delivery of Mental Health Services

- 1. The project is geared to the current priorities, levels of service, resources, and capabilities of the particular area in which it is located.
- 2. The project makes use of or contributes to relevant community resources and facilities for mental health education and mental health services.
- 3. The project is integrated with state plans for mental services, manpower development and continuing education, and has appropriate contacts with mental health delivery systems, and preferably broader health and human services.
- 4. Spread effect: participants selected for their potential as change agents, e.g., key decision makers, citizen leaders, administrators, teachers, and consultants.

## B. High Priority Content Areas Consistent with National Priorities

- 1. "Department of Health, Education and Welfare Concerns"  
Violence, Delinquency, Law and Order  
Hunger and Malnutrition  
Model Cities and Neighborhood Centers  
Family Planning  
Coordinated Services for the Aged  
Center City (Ghetto Problems)  
Motivating People to Work  
Rural Poverty
- 2. Health Services and Mental Health Administration priority  
Improved health service delivery system.
- 3. National Institute of Mental Health priorities  
Programs related to Community Mental Health Services  
Children's Services  
Poverty areas, urban and rural. Minority groups.  
Drugs and Narcotic Addiction  
Alcoholism  
Suicide Prevention
- 4. "Division of Manpower and Training Programs Priority Considerations"  
Preparation of personnel for work in community mental health programs  
Focus on critical and long-neglected mental health problems  
Training of sub- and nonprofessional personnel  
Recruitment and training of minority group mental health personnel  
Training of personnel for appropriate utilization of nonprofessional mental health workers  
Shortening the duration of training programs for mental health workers

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5. Continuing Education Branch priorities

Provide for leadership development in continuing education (in addition to other priorities listed in this document)

C. High Priority Need

Geographic area

Balance and distribution of existing manpower resources and their effective utilization

Relative absence of continuing education opportunities

D. Nature of Sponsoring Organization

1. Administrative competence based on experience, size and/or quality of administrative offices. Capability of responsible business management and grants administration

2. Evidence of commitment to continuing education and to objectives of grant program, preferably demonstrated through past experience, or at least strong evidence for future commitment

3. Feasibility — likelihood of being able to carry out intent of grant

4. Existence of or potential for development of necessary collaboration between departments within the sponsoring organization and between the organization and the community

E. Educational Design

1. Consistent with principles of adult education

2. Program development emphasis as compared to isolated courses

3. Planning and evaluating in cyclical fashion

4. Objectives clear and well defined, preferably with measurable behavioral criteria

5. Methods and content consistent with objectives and realistic for the actual faculty and participants

6. Content relevant and basically sound

7. Advisory planning groups to include administrators of sponsoring and affiliated institutions, faculty, trainees, and community representatives (consumers of services)

8. Innovation and varied educational methods and design (including experiential learning)

9. Evaluation of educational aspects of program

F. Cost Effectiveness

1. Multiple sources of funding

2. Cost per trainee or per learning product. The higher the cost per trainee, the greater the premium on highly selected trainees with planned impact via their "spread effect"

3. Sound economic plan, preferably leading to independence or a self-sustaining program, e.g.

Program growth without increasing grant

Program continuation with decrease or elimination of grant

G. Participation of Consumers and/or Students

1. Selected on basis of manpower development strategy

2. Selected on basis of evidence as to desire to understand and solve problems related to their work and own career development as compared to secondary motives, such as vacation or therapy

3. Actively involved in all phases of program, from planning through evaluation

4. Self-education and mutual education emphasis

H. Quality of Personnel

1. Administrative staff, advisory boards, trustees

2. Faculty

3. Consultants

4. Evaluators

I. Evaluation and Research

1. Program evaluation. Evaluation of ultimate outcome and impact on mental health of population served (as compared to evaluation of intermediate educational objectives and methods — which is listed in item E.2.)

2. Research in continuing education including relevant basic research. (Continuing Education grant cannot be primarily for basic research, but priority would be higher for a continuing education project in which relevant research is being conducted, usually with other sources of support)

3. Continuing education of research personnel

Appendix D: Guidelines for Evaluation of Continuing Education Programs in Mental Health, March 1970

Prepared by the Continuing Education Branch,  
Manpower and Training Division, National Institute of  
Mental Health, Thomas G. Webster, M.D., Chief

Introduction

Directors of continuing education programs often express concern about evaluating the impact of their programs. Funding agencies, program participants, and other interested persons share this concern. In settings where research experts are available to participate in evaluation, the types



of methods used and knowledge gained, such as questionnaires for measurement of attitude change, sometimes have little direct utilization in changing the program. Research experts share the concern for effective useful program evaluation.

One problem related to evaluation is that training program directors and faculty often do not gather the kinds of information which could make them aware of new possibilities for improving their programs. They are sometimes unaware of information that could be fairly easily obtained and that could have a considerable impact on their programs. It has also been noted that a constant frustration for program directors is the great limitation of time available for administration, including program planning and evaluation.

These Guidelines have been written with the hope that they will be useful to training program directors and to research persons who consult and participate in program evaluation. The Guidelines can be an aid to such persons as they explore the range of information useful for planning, designing and evaluating their programs.

The emphasis of these Guidelines is on the types of information that provide a basis for program administrators to make constructive changes in their programs. Evaluation data not only includes information more customarily thought of in relation to assessment of educational methods and outcome, but information essential for program planning as well.

In order to develop the Guidelines an Ad Hoc Advisory Committee on Continuing Education Program Evaluation was convened in April, 1969, sponsored by the Continuing Education Branch, Division of Manpower and Training Programs, National Institute of Mental Health. Fifteen experts representing a variety of disciplines from universities, training organizations, and government agencies in addition to ten NIMH staff members met and discussed the many facets of evaluation.

The Guidelines are necessarily broad and designed so that training program directors may select and use the items which are most relevant to their programs. The Guidelines are not designed as a program planning guide, except for the evaluation aspects of the program. However, the principles discussed may be helpful in developing more comprehensive plans based on principles of (1) community involvement, (2) education, (3) administration and finance, and (4) the discipline(s) being taught.

It is anticipated that this initial edition of the Guidelines will later be revised on the basis of feedback from persons who have used them. Suggestions as to which portions should be retained, deleted, modified, illustrated or supplemented will be most welcome.

## WHAT IS EDUCATIONAL EVALUATION?

### *Evaluation and Program Objectives*

Well defined program objectives are crucial for purposes of program evaluation. The objectives may be defined in terms of criteria of mental health for the community or population being served, in terms of changes in the

learners or their organizations, in terms of secondary phenomena which the educational program is expected to induce via the learners, in terms of increments in demonstrable knowledge and skills or in terms of demonstrable effectiveness or the relative merits of one educational method compared to another.

Determination of objectives is a technical process in itself, and much has been written on this subject in literature on administration, research and education. For any continuing education program the objectives should be determined for a variety of levels, not all of which are necessarily incorporated into formal evaluation of outcome.

1. General institutional objectives.
2. Educational program objectives.
3. Educational activity objectives.

First, the sponsoring institution(s) should have a representative advisory committee which includes administrators, faculty, participant trainees and consumers of services. *General institutional objectives* should be clarified in terms of the uniqueness of the sponsoring organization(s) and their mission(s), in terms of the available manpower and in terms of the ultimate population being served. This may require considerable discussion and clarification based upon available data as well as philosophy and values. Since every organization has limitations in resources for accomplishing its purposes, the objectives should be translated into priorities and strategies to assure that the limited resources are employed in a feasible manner for maximal impact on high priority needs. Such a strategy naturally includes concepts of long range development as well as immediate impact, concepts of learning and change in individuals and organizational teams, concepts of spread effect and secondary impact via key catalysts within the system and concepts for initiating self-perpetuating processes based upon the motivation of persons in the system rather than leaving the program overly dependent upon the motivation of the initial planners and administrators.

Within this context and consistent with these general objectives, the *educational program objectives* should be determined in terms of what types of changes in knowledge, skills and behavior are expected in what types of personnel. The participants in the continuing education program are thus selected on the basis of their priority significance for accomplishing the general objectives of the sponsoring organization(s).

Within this context more specific *educational activity objectives* can be determined for any specific course or other educational activity. Educational objectives are preferably defined in terms of measurable behavioral change, which can thus provide a basis for evaluation of results. Educational methods are preferably selected only after the educational objectives have been determined, and the methods should be consistent with the objectives. For example, changes in skill are not usually obtained by lecture methods. Evaluation of methods is usually intermediate or secondary to evaluation of educational outcome or achievement of educational



objectives. By the same token, evaluation of a specific course is secondary to the achievement of overall program objectives.

Regardless of which aspects of a total program are selected for the most intensive evaluation, there should be an internal consistency in different levels of objectives and methods, and some type of evaluation is necessary at all levels.

In summary, the most useful evaluation is closely associated with "keeping your eye on the ball" rather than being caught up in intermediate or esoteric facets of the program. Clearly defined objectives and related evaluation of continuing education programs also enable the funding agency and other sponsoring organizations to attain their objectives, which in turn contributes to the improvement of high priority mental health services at all levels.

#### *Educational Evaluation — A Circular Process*

For the purpose of these guidelines, educational evaluation is defined as the process by which relevant information is constantly gathered and fed back into the program to be used as the basis for enlightened decision making leading to improvements in the program.

Evaluation has an important function in well-planned continuing education programs from their earliest inception, such as helping to determine the continuing education needs in a community.

Evaluation is essential in each of the following stages of program development:

1. Assessing the mental health problems of the community and the specific needs they reflect for continuing education. Depending upon the nature of the sponsoring organization, the "community" may be local, state, regional or national.
2. Defining the educational objectives in specific behavioral terms.
3. Defining the target audience for the program and developing methods for selection of the desired trainees.
4. Determining the educational content and methods to be used.
5. Developing plans for gathering evaluation data and feeding relevant results back into the program to accomplish constructive change.

Educational evaluation for continuing education is thus conceived as a continuous, circular process. The cumulative evaluation at the end of one year of a program should provide a basis for the planning and evaluation process during the second year. This continuous, circular process helps integrate evaluation into program planning and implementation. Assessment of the outcome and effectiveness of a specific educational activity or program for a particular year is only one phase in the total evaluation process.

#### *Educational Evaluation and Educational Research*

Evaluation and research have many similarities. In a broad sense research includes evaluation, and evaluation may use research procedures and fact finding methods. However, educational evaluation and educational research differ in several significant dimensions.

The purpose of research is to discover and verify principles and to develop new knowledge, which may or may not be immediately applied. The purpose of evaluation is to provide information for enlightened decision making and application to improve the ongoing program.

Elaborate methods are generally devised to make it possible for scientific investigators to divorce themselves as much as possible from value judgments. Findings in specific basic research projects are not ordinarily fed back into the project to accomplish immediate change. Rather, the program is kept constant for the period of the research so that one or more elements of induced, controlled change can be precisely measured.

Research principles and methods are often used in evaluation. However, the capacity of a continuing education program to apply highly sophisticated educational research methods in their program evaluation will depend upon the resources available. Most continuing education programs have neither the need nor the capacity to utilize highly technical research methods, let alone perform basic research.

Educational program administrators view both the methods and the purpose of evaluation from a wide variety of perspectives. These range from views that equate evaluation with formal research procedures to very informal views of evaluation that are more akin to the opinions, judgments and intuition of administrators.

Naturally, in a long range perspective research program development operates by much the same principles as educational or service program development. Basic principles of program evaluation and program development apply to all. The above distinctions between research and evaluation are valid in the context of these Guidelines and are too often overlooked in program evaluation. However, this discussion is not intended to overlook the importance of value judgments, application of findings and program development in research work. By the same token, an educational program will at times hold certain variables constant and keep value judgments to a minimum in the interests of evaluation.

#### *Other Dimensions of Evaluation*

Evaluation may be regarded in several dimensions, such as (1) ultimate vs immediate vs intermediate outcome (2) broad vs focused impact (3) long range vs short term (4) process vs outcome and (5) cost effectiveness vs educational effectiveness.

In terms of ultimate objectives each program can be judged for its contribution in the effort to solve mental health problems. In terms of intermediate objectives a program may be evaluated for its effect on the



functioning of the learners. How did the educational program change them, and how will this in turn affect mental health in their communities? In terms of *immediate objectives* a program may be evaluated for the effectiveness of the educational methods in fostering learning and behavioral change in the learners.

Assessment of ultimate objectives, that is, changes in the population served by the trainees, is highly desirable but can be difficult and expensive. When expert resources are available for such things as epidemiologic studies these may provide a means for assessing the effectiveness of the continuing education program in terms of improved indices of mental health. Such evaluation would usually be accomplished by integrating the educational program within existing programs for planning and delivery of services, as compared to supporting such evaluation as part of the educational program.

Another dimension of evaluation is the difficulty assessing *broadly dispersed ripple effects* as compared to *focused impact* of the educational program.

Often educational program administrators would see the ultimate outcome on the mental health of a population as too broad and indefinite for assessment compared to their focus on the intermediate outcome of changes in trainees or immediate satisfaction with teaching methods. However, ultimate vs intermediate objectives need not be synonymous with broad vs fine focus. Selection of a limited specific population can make the assessment of both ultimate and intermediate impact an easier task. For example, a measurable ultimate objective might be the reduction in rate of arrests for alcoholism in a population of 200,000. In this context the design and evaluation of impact of a continuing education program (impact on both trainees and the population at risk) could be more focused and feasible than assessing the impact on 200 participants of a weekend symposium on alcoholism, let alone assessing the impact on their clients. Naturally, not all continuing education programs can or should provide such a fine focus on the ultimate objectives. However, problems of educational evaluation are compounded by the tendency for educators to focus on immediate and intermediate objectives — or on "satisfaction" rather than any more specific educational objective.

Evaluation of long range objectives, such as a five year program, is obviously a different task than evaluation of short term objectives, such as the effects of a specific course. Program development may remain static or deteriorate if evaluation is concentrated only on short term objectives. Not infrequently a "successful" continuing education project in the first two years can flounder on "recruitment problems" by the fifth year.

Evaluation of educational methods and process cannot remain divorced from educational outcome. A continuing education program may rely so heavily on a process of demonstrated value, such as supervised clinical work or small group methods, that the program becomes characterized by "riding a hobby horse." Ultimate and intermediate objectives may be lost from view, only a special self-selected group of trainees may

be reached, and the satisfaction of faculty and trainees with the process may obscure an abortion in program development. On the other hand, evaluation of outcome in terms of ultimate and intermediate objectives may be an empty exercise if the educational process and methods are demonstrably unsatisfactory. "Happiness data" is not a substitute for assessment of outcome, but student satisfaction is obviously an important ingredient for the educational process. In a related dimension, evaluation of methods and outcome should include assessment of *efficiency* as well as *effectiveness* of the methods and process.

The director of an educational program cannot be oblivious of *cost effectiveness*, no matter how convincing the evidence of *educational effectiveness*. Generally speaking, the more costly the education per trainee-hour (or per unit of assessed outcome) the greater the need to demonstrate the spread effect or ultimate impact of the program. High cost may conceivably be justified by virtue of assured secondary influences or activities of the key persons being trained or by virtue of initiating a self-sustaining process that requires relatively small cost for the ultimate outcome. Cost effectiveness thus becomes related to motivation of trainees and their employers, their willingness to contribute to financial support of the educational program and their potential for accomplishing the ultimate objectives of the program. Assessment of cost effectiveness is important to program planners to assure optimal utilization of limited resources. It is also important for attracting further support from trustees and other funding resources.

#### Evaluation and Vested Interests

Any continuing education program can and probably will be evaluated from a variety of points of view. A well-constructed evaluation plan will make provisions for obtaining feed-back from as many of the following as possible:

1. *The Community:* How does the program help the total community? Does it fit into the community health priorities picture? Does it fit into the community organization and leadership situation? Have the trainees been selected on the basis of their strategic impact for the community? How well does the program fit with activities of related and/or conflicting interest groups? What changes have occurred in the community and the target population as a result of the continuing education program?

2. *The Trainees:* Do the overall training goals and objectives of the program meet the needs of the target population? How valuable was the training experience to the trainee group? Did the program contribute any fringe benefits such as career advancement, academic credit, enhancement of role?

3. *The Sponsoring Organization:* How well does the program fit into the structure and contribute to the identity of the training institution? How does it contribute to the aims and services provided by the institu-



tion? Does the program involve organizational changes which would enhance the institution's capacity for achieving its objectives?

4. *The Program Director and Staff:* How do they see their roles in the project? Are their activities viewed as professionally helpful and appropriate? How do their activities affect their careers? Do their roles carry high or low status?

5. *The Funding Organization:* Does the application reflect a carefully planned program based on need? Is the program feasible? Is the program strategic in its impact for purposes of accomplishing the objectives of the funding organization? Are potential participants involved in program planning? Do plans call for efficient administration and financial effectiveness? Is the program integrated into other community efforts relating to the same problem? Are educational objectives identified? Are provisions made for effective instruction? Is the subject matter relevant and adequate in quality as well as quantity? Does the program design incorporate evaluation based on the objectives of the planned training program? Are the accomplishments consistent with the priorities of the funding organization? Are the administrative policies and procedures consistent with those of the funding organization? Will the program assessment provide data appropriate for progress reports and/or final reports?

With the possible exception of the sponsoring institution, the funding agency, the training director, and the trainees, very few individuals in the opinion-forming groups described in the previous section will be asked to make formal judgments about a continuing education program which comes to their attention. Even fewer will engage in scientific measurements, but all will have ideas about the program's values and weaknesses.

By being aware of these vested interests and by involving representatives of these groups in both planning and evaluation, a program director may attract more resources and build a stronger program.

Representatives of such groups will use various sets of principles or criteria in making their judgments, depending upon their backgrounds.

Example: An administrator will use principles of administration.

Example: A community leader will use principles of community involvement, community development, public relations, and politics.

Example: A colleague will evaluate the quality, quantity and organization of the selected content according to the nature of the discipline involved.

Example: An educator will pass judgments based upon principles and practices of education.

Example: The program director and faculty measure the program's success against its stated goals and their own professional satisfaction.

Example: The funding agency will assess a continuing education project on the basis of principles of cost effectiveness and relevance to the mission of the funding agency.

Example: The trainee will pass judgment on the educational experience based on principles relative to his career development and learning relevant to problems encountered in his work.

### *Borrowing Expertise*

How then can a program director who is rarely expert in more than one or two areas assure sound evaluation of a program? BY UTILIZING THE EXPERTISE OF OTHERS AND INVOLVING REPRESENTATIVES FROM RELATED DISCIPLINES FIRST IN THE PLANNING, AND THEN IN THE EVALUATING PROCESS. A program director may call upon experts in the staff or consultants from groups such as those discussed above.

In planning as in evaluating, it is particularly helpful to keep in mind the definition of evaluation as a process of gathering data for purposes of enlightened decision making.

(Specific suggestions for utilizing expertise of persons in related areas and organizations are found in final sections of the guidelines.)

### USE OF THE ACCOMPANYING CHARTS

The three charts in the following section are designed to help in developing a workable and continuous evaluation process usable from the earliest planning stages through final evaluation and writing of a report.

The charts illustrate an approach to evaluation planning. They are not intended to be detailed checklists. Not all items will apply to every program. Program directors may find it worthwhile to go over each question and make a decision as to whether it is applicable and practical to include in his evaluation process. While each question may be worth review, it is expected that for any given program only a portion will be used.

There is a separate chart on three of the four evaluation areas mentioned in the introduction: (1) Community Involvement, (2) Education, (3) Administration and Finance.

The term Community Involvement is used in a broad sense to mean not only how the program relates to other programs and organizations in the community, and how they participate in it, but how the program contributes to the solution of local, state and national mental health problems.

Each of the above evaluation areas is broken down on the following pages from three standpoints: (1) principles, (2) planning, data gathering, decision-making, (3) suggested evaluation questions. (These may be used as follow-up questions but in many instances they are also questions to which the review committees seek answers prior to making grants.)

The fourth area mentioned in the introduction — that of evaluation from the standpoint of the specialized knowledge and skills of the discipline(s) being taught — is not developed in a separate chart. Criteria unique to each specialty area are beyond the scope of these guidelines. Each program should assure relevance and soundness of specialized knowledge and utilize consultants when the expertise is not available on the faculty. Evaluation would usually be by expert judgment, standardized examinations, critical incident studies and increments in demonstrable skills acquired by trainees. Some general consideration of the quality, quantity and organization of the content is covered under Principles of Education, Chart 2-A.



### 1. Community Involvement: How Does The Program Fit Into The Larger Community Framework?

#### 1-A Principles

A continuing education program should be an integral part of the efforts of the community, state, and nation to solve mental health problems and consistent with the mental health plans and priorities for the specific geographic area involved. It should also be consistent with existing and potential manpower resources and include a strategy for effective utilization of limited manpower to meet high priority needs.

The continuing education program should be an integral part of, or at least compatible with, the nature of the sponsoring institution. The sponsoring organization(s) should have a history of commitment to education and to the objectives of the proposed continuing education program — or at least provide firm evidence of intent to develop such a history.

Community agencies and consumers with interests related to the training program area should be involved in the planning and development, and where appropriate, the operation of the program.

The impact of the proposed program on the power structures, mutual interests, competitive positions, economics and politics of related agencies and persons should be taken into consideration during the planning.

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#### 1-B Planning, Data Gathering, Decision Making

Review literature relating to mental health manpower and training needs. (See appendix for sources.)

Study state and community mental health plan and regional health plans.

Review available epidemiologic and manpower information and other surveys.

Include informed citizens and professionals as sources of information for program planning.

Make formal or informal survey of community attitudes and needs.

Discuss program with local and regional mental health and regional health authorities.

Define program's operational identity within the sponsoring organization and within the community. Read carefully any official statements as to the nature and mission of the sponsoring institution. Become informed as to the image of the organization and its purpose in the minds of its officials and of outsiders, particularly in the minds of potential participants in the continuing education program.

Contact agencies with related interests, and become informed as to their resources and activities.

Identify the groups and their functions to be involved in the planning.

Develop relationships with community agencies which might serve as educational resources.

Establish planning and evaluation and/or advisory committee, repre-

senting key agencies' students, experts in the discipline, in education, and in administration and finance.

Involve related interest groups in evaluation plans.

Analyze what problems shared by other agencies the proposed program would help to solve.

Analyze whether the proposed program will pose any threats or problems for agencies, or individuals with related or over-lapping or conflicting interests.

#### 1-C Suggested Evaluation Questions

How does the program fit into, and contribute to local, state and national mental health goals and priorities?

What contribution is the proposed program expected to make toward solving high priority mental health problems? How will it foster more effective utilization of existing manpower? Spread effect?

Has the preliminary investigation covered all related areas and yielded adequate information for preliminary decisions on training needs around which a program can be built?

Is there adequate baseline data by which to evaluate (at least informally) the relevance and impact of the continuing education program on high priority mental health needs and manpower?

Is the program consistent with the goals and objectives of the sponsoring organization? Has the sponsoring institution demonstrated by past performance or current investment of resources a commitment to the objectives of the continuing education program?

In what ways were community agencies with related interests and consumers of the program involved in its planning, operation, and evaluation?

Does the program fit sufficiently well into current trends and values in the community that the program "has lots of things going for it" in addition to the primary sponsorship?

What methods were used to explore and resolve potential conflicts of interest both within the sponsoring organization and among organizations with related interests and purposes. Are there distorted views of the program or its sponsors which handicap its success and that would be amenable to accurate information and communication?

### 2. Education: Is the Program Based on Sound Educational Therapy and Practice?

#### 2-A. Principles

Sound education:

— is based on trainee, community and faculty involvement in the planning and educating process.

— is based on carefully selected trainees, screened to match their

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needs to the specific training being offered and their strategic significance for effective utilization of existing manpower.

- is based on specific educational objectives, preferably stated in behavioral terms, which reflect the needs of trainees and of the community they will serve.

- is based on trainees' readiness to learn and community readiness for program.

- is based on achieving a measurable outcome consistent with the educational objectives.

- is based on a carefully planned program outline and timetable which permits ample time to accomplish goals, and for individual instruction as needed.

- utilizes a variety of methods, materials and community resources. Methods are consistent with objectives and are appropriate to the particular trainees.

- contains appropriate amounts of quality subject matter presented in keeping with the principles of the discipline(s) being taught.

- provides for flexibility in planning and carry-through so needed modifications may be made during the course.

- is designed to achieve continuous feed-back from trainees, faculty and others for the purpose of continuing and final evaluation of the program.

- is based on an optimum number of highly qualified instructors and a ratio of students based on maximum learning in relation to time, cost and educational methods used.

- is based on adequate back-up administrative and other service personnel to bring faculty to maximum efficiency.

## 2-B. Planning, Data Gathering, Decision Making

*NOTE: See Community Involvement Chart 1-B preceding for steps to take to gain educational involvement.*

Define target trainee population and their relevance to mental health manpower strategy for the area being served. Define both the total universe of potential trainees and the criteria for selecting actual trainees — such as their number and qualifications.

Devise screening measures to select trainees and to screen out inappropriate potential trainees.

Devise promotional methods to attract appropriate trainees.

Sample trainee and/or community needs (felt and unfelt) and readiness by formal or informal surveys, and interviews with key leaders and potential trainees.

Consider the "ripple effect" — how trainees will spread benefits of their learning to professionals and allied personnel to the benefit of the community.

Define program objectives in terms of trainee and community needs and readiness, using specific behavioral criteria when possible.

Develop detailed program outline and timetable which states general objectives, objectives for specific teaching-learning experiences, and suggests materials, methods and resources to be used.

Consult literature and educational experts regarding educational methodology. Provide teacher training in educational methods and materials.

Use prospective faculty, colleagues, subject specialists in developing content and organization within the framework of the program objectives.

Consult faculty and trainees periodically to determine if teaching-learning needs are being met. (Continuous evaluation by instructors and students.)

Develop a continuous and final evaluation plan which is an integral part of the program plan and timetable.

Decide which formal and informal evaluation techniques to program into the course.

Define basic data useful for evaluation which should be gathered through administrative procedures — students' background preparation, enrollment figures, attendance, preliminary enrollment questionnaire, student grades, etc.

Arrange for highly qualified instructors and needed support personnel.

Define instructors' responsibilities clearly.

Provide for adequate administrative services to the professional staff.

## 2-C. Suggested Evaluation Questions

What role is played by fellow professionals, prospective faculty members, trainees and educators in assessing training needs, defining program's purpose, developing program and evaluation plans?

What provisions are made for student participation in the active educational process?

If teaching resource organizations are used, do these cooperate and make significant contributions to the planning and educational process?

Were the methods used to select a trainee group appropriate to the proposed educational program and its objectives?

What methods for assessing needs were used?

Are needs clearly specified in the program plans and are objectives defined in terms of these needs? Are the educational objectives clearly defined in behavioral terms? What will be the criteria and methods for assessing whether the educational objectives have been accomplished?

Does a purpose statement in the program plan clearly specify the long-range objectives based on needs of various constituencies?

Does the plan reflect a program of adequate scope and emphasis oriented toward achieving stated objectives?

Are the educational methods and materials selected for effectiveness, and do they reflect variety? Are the methods consistent with the objectives?



What methods were used to assure high quality content?

Can the program adapt quickly to changing needs and conditions?

Are findings from continuing evaluation being fed back into the program to accomplish on-going improvement?

What provisions are made for formal or informal testing procedures to obtain continuous feed-back from trainees, the community, etc.?

Were follow-up questionnaires or interviews employed to gain information on how trainees passed along the benefits of their training to others and how their patients or clients benefitted?

Are criteria of staff selection clear?

Is the faculty adequate both in quality and quantity?

Are their instructional responsibilities clearly defined? Is there provision for faculty meetings and faculty development?

Are all necessary staff services provided for?

Do instructors have time to reflect on and review critically their teaching and the progress of the trainees?

### 3. Administration — Finance: Have Adequate Financing and Administration Been Provided For?

#### 3-A. Principles

##### Sound Administrative and Financial Management:

- advances the educational aims of the program through providing services to that program.
- provides adequate communications service.
- provides facilities and personnel for smooth operation of the program.
- operates on sound personnel management policies.
- provides adequate back-up services for staff.
- defines and plans in detail all costs for personnel, services, equipment, and facilities throughout the course of the program.
- projects need at all stages of program development, and makes allowances for upcoming needs, including need for follow-up evaluation studies.
- seeks to establish sound financing both for initial phases of program and for ongoing program.
- keeps accurate records, and gathers baseline data for use in program evaluation.
- prepares cost analysis and cost effectiveness studies.

#### 3-B. Planning, Data Gathering, Decision Making

Outline the kind of administrative structure needed.

Seek management and financial guidance from experts in these areas.

Consider membership of such experts on planning committee.

Provide effective promotion and public relations service.

Reserve suitable meeting rooms, laboratories, and needed equipment.

Develop contractual and/or financial arrangements with participating community organizations.

Define specific qualifications needed in the professional staff, with job descriptions.

Plan any needed orientation for staff.

Provide for adequate services to support professional staff (administrative, maintenance, clerical and service personnel.)

Plan budget in detail and project it step by step to cover the planning, operating and following through stages of the program.

Include in budget plan all costs for competitive salaries for professional, administrative and service personnel; materials, facilities, equipment and maintenance, guest lecturers, planning committee costs, etc. Salaries and fees consistent with those of comparable nature by the sponsoring organization and geographic area.

Assess increasing costs arising out of increasing involvement of related groups, and make allowances for these.

Outline various sources of support and select soundest. Develop auxiliary support. Define these in the proposed budget. Employers and trainees should participate in financial support of the educational program, thus providing an indication of its value to them for fulfilling their own objectives.

Determine basic kinds of useful data which should be gathered in the process of registration, and during the course. (attendance, student background, etc.)

Plan administrative and staff time needed to gather baseline data and keep records, handle followup mailings, or compilations of data from tests, questionnaires, etc.

Plan way of measuring cost effectiveness and cost benefit.

#### 3-C. Suggested Evaluation Questions

Are office services adequate in quantity and quality?

Are inquiries and registrations handled promptly?

Is the promotion program recruiting desired clientele? Do promotion materials accurately reflect the quality and spirit of the program? Is promotion used to help bring together unperceived needs of students with their felt needs?

Are promotional costs excessive for this project, possibly reflecting recruitment problems based on factors other than reasonable promotional measures?

Are meeting rooms adequate in number, size, flexibility, comfort, and attractiveness? Are the lighting, ventilation and storage facilities adequate? Is there adequate instructional equipment? Is the space and equipment used as close to capacity as possible? Is the instructional equipment in optimal operating capacity?



Are relationships with participating organizations businesslike? Are there contracts or letters of understanding defining mutual agreements? Is compensation adequate? Are there adequate eating and sleeping arrangements?

Is the staff fully qualified? Is compensation of professional staff competitive with other institutions?

Are new instructors and leaders given adequate orientation? Is the performance of the faculty assessed?

Do leaders and instructors receive assistance in room arrangement for maximum informality and interaction?

Are physical facilities properly safeguarded, maintained in good condition?

Is the budget detailed, realistically planned and set up on a timetable?

Have all possible expenses been considered, including planning costs, evaluation costs, etc.

Have trustees, employers and other funding sources been sufficiently informed and involved to see the long-term wisdom and efficiency of continuing education of staff as an essential component for effective utilization of manpower and delivery of services?

Has every possible source of funding been investigated?

Is the program taking advantage of more than one source of funding?

Do employers and trainees contribute?

Is it developing future sources for a continuing program?

Are records accurate, as comprehensive as necessary, as simple as practicable, and accessible? Are routine data gathered for future evaluation?

Have cost effectiveness (number reached and ultimate impact per dollar spent) and cost benefit (beneficial changes caused in students per dollar spent) been made? Has the consultation and assistance of experts in cost analysis been utilized?

#### Appendix E: Some Sources of Consultation and Information

For consultation and information regarding federal grants

National Institute of Mental Health  
Thomas Webster, M.D.  
Director, Continuing Education  
Training Branch  
Barlow Building 11A12  
5454 Wisconsin Avenue  
Chevy Chase, Md. 20015

For consultation and information nationally

American Psychiatric Association  
Physician Education Project  
Howard M. Kern, Jr., M.D., Director  
1700 18th Street, N.W.  
Washington, D.C. 20009

#### PSYCHIATRIC EDUCATION AND THE PRIMARY PHYSICIAN

For consultation and information in the states of Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming

Western Interstate Commission for Higher Education  
Raymond Feldman, M.D.  
Director, Mental Health Programs  
University East Campus—30th Street  
Boulder, Colo. 80302

For consultation and information in the states of Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia

Southern Regional Education Board  
Harold L. McPheeters, M.D.  
Associate Director for Mental Health  
130 Sixth Street, N.W.  
Atlanta, Ga. 30313

For general information regarding continuing education

American Medical Association  
C. H. William Ruhe, M.D.  
535 North Dearborn Street  
Chicago, Ill. 60610

For assistance in coordination and consultation with general practitioner groups

American Academy of General Practice  
Volker Boulevard at Brookside  
Kansas City, Mo. 64112

For assistance in coordination and consultation with internists

American College of Physicians  
Edward C. Rosenow, Jr., M.D.  
4200 Pine Street  
Philadelphia, Pa.

#### Appendix F: Useful References

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