The Community Meeting (C.M.) has different names and different meanings in different settings. It may be called patient-staff meeting, ward meeting, etc., but their structure is the same. Patient and staff participate in joint sessions to discuss issues concerning the patients, the staff and other related subjects of common interest. This form of group meeting was initiated by Maxwell Jones, the apostle of Community Psychiatry, a derivative of the social science's application to mental health. It has long been acknowledged that the environment plays a vital role in molding human behavior. As a matter of fact, the environment shapes the life and form not only of any living organism, but also of everything that exists in the universe.

We expect the hospital to be a "therapeutic community" where "team" approach is applied in a "learning-living" experience, creating a favorable "milieu" for the patients to expedite their recovery. Among the goals of the therapeutic community are the fostering of independence, responsibility, self-reliance, initiative, and leadership. Jones and many others analyzed the role of the hospital, or any other treatment facility; of the staff, who are supposed to intervene therapeutically; and of the patients, toward whom this action is directed in order to find an optimally efficient, systematized program for the benefit of the patients and staff. The role of the C.M. within the therapeutic community is not uniformly defined, and its importance in theory and practice changes from place to place. At times it is synonymous with the therapeutic community itself, and its function was a measure of the success or failure of the whole program.

The origin of the C.M. goes back probably to ancient times, when the primary family, presently referred to as "the extended family" or the tribe came together to solve problems of general interest. The old town meeting had a similar function. The format of these meetings must have been very different from one community to another, depending on the basic structure of the hierarchical organization of the respective society: democratic, autocratic-tyrannical, or a mixture of the two, since there is no pure democracy, just as there is no pure dictatorship. Jones's concept was democratic. "Daily C.M., with examination of what was going on in the community, provided an essential part of the interaction between the staff and patients and an opportunity for all to learn from the discussion of current problems." Wilmer's approach was far more authocratic. Although he declared that "... a daily joint meeting between the
staff and patients is single most important therapeutic tool available," he also
maintained that the "guiding force" should be "the doctor and the staff." He did
not see the contradiction between his approach and his goals when he wrote that
the C.M. creates "... an atmosphere in which the patients will take over, and
with minimum guidance from the therapist, will discuss their problems with
each other and with him. ... In the C.M. I consciously played the role of the
therapist, attempting by my interpretation and my summaries of the discussion,
to direct the patients to the meaningful notion of their emotional and mental
problems."

The contradiction between the advocated strong role of the staff leader and
the purported atmosphere to encourage patients' take-over prevails even today.
The literature concerned with issues related to 6 ~ the C.M. deals mostly with
purpose and theory, not with format. It is this writer's opinion that the conven-
tional setting of the C.M. is the one that prevented the set goals from being
realized, namely "flattening the power hierarchy, which results in diminished
unilateral power being exercised by this authority ..." 7 It did not prevent the
patients from regressing to the level of a dependent child and the staff from
fostering this attitude. On the other hand, it prevented the establishment of a
meaningful communication between staff and patients, which is what many
postulate as one of the most important purposes of the C.M. 6.12

Another issue is the significance of the composition of the patients in dif-
ferent settings. One of the most thorough articles dealing with the practical and
theoretical aspects of the C.M. 8 avoids this subject and discusses the topics from
the rather narrow point of view of a V.A. hospital population, where the
majority of the patients are male, the pathology is not predominantly psychosis,
and the patients are on a higher functional level. The problems in these settings
are radically different from those of the large state hospital's units, or of other
state and community clinics, which are geared toward the treatment of the
needy population.

The purpose of this article is to present a different format for the C.M.
which seems to fulfill the requirements (previously) outlined, and which can be
applied in almost any setting, regardless of the patients' composition. One of the
possible several exceptions is a facility for severely regressed, organically afflicted
patients. The C.M. in most places operates like this: the staff, at the designated
time, starts yelling at full blast, "Community Meeting! Community Meeting!"
The patients then start to shuffle slowly toward the big room, dragging chairs
with them. A few staff members join the group, which sits in total silence,
staring straight ahead. The leader is a staff person. In general, all the "suitable"
patients should attend. Different criteria are applied to determine which pa-
tients are required to be present and which should be excluded, if any. In some
places, the patient is not allowed to return, once he has left the meeting, without
the permission of the leader. The staff tries to encourage the patients to bring up
subjects that concern the whole community and discourages them from dwelling
on personal problems. In most instances, the response is deafening silence.
(Chertoff and Berger 14 regard this problem as a manifestation of resistance in
psychotic patients against group therapy.) The usual way to prod the reluctant