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The plight of the nurse in community mental health centers

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The extensive utilization of paraprofessionals as therapeutic agents in National Institute of Mental Health (N.I.M.H.) funded community mental health centers (Gottesfeld, Rhee and Parker, 1970; Levenson and Reff, 1970; Sobey, 1970), has brought much attention to the need for inservice staff development (Joint Commission on Mental Illness and Health, 1961; Riessman, 1967; Sobey, 1970). The importance of inservice training or supervision, especially for the partially trained staff person, has been indicated in terms of its beneficial effects for both caregiver (Rosenkrantz and Holmes, 1974; Taynor, Perry and Frederick, 1976) and carereceiver (Goodman, 1972; Karlsruher, 1974, 1976).

Professionally trained, experienced staff are typically called upon to function, in part, as clinical supervisors. The role of clinical supervisor could be conceptualized, in its simplest form, as a two-fold process: the identification of staff in need of additional training or supervision, and the implementation of a training program. According to this model, one of the first questions to answer is: which staff are in need of inservice training? An obvious target for this intervention are those individuals who, because of their lack of formal training, are designated as paraprofessionals. Are paraprofessionals the only group functioning as therapeutic agents who are in need of further training? Preliminary evidence suggests that the community mental health nurse may also be in desperate need of additional training (Reres, 1969; Zahourek, 1972). The evidence suggests that community mental health nurses lack adequate previous training as mental health caregivers and have limited confidence in their clinical skills. Are supervisors aware of this situation and do they then in turn provide additional 'on-the-job' training? It is entirely possible that nurses are given considerable 'professional autonomy' even though they may have received little adequate preparation prior to job performance. It is conceivable that because of their professional status, medical education and training, nurses' need for inservice training and supervision are overlooked as attention is directed towards the less prestigious paraprofessional.

The present study examines how nurses compare with paraprofessionals and non-

nursing mental health professionals in terms of: the extent of their previous training, self-confidence in performing clinical services, and frequency of current formal supervision.

Method

Subjects

Subjects were the direct service (non-supervisory) clinical staff employed throughout 19 different community mental health programs situated within 3 counties located in southeastern Michigan. Six programs were located in predominantly urban areas; 3 rural; and the rest suburban. Of the 19 programs, 9 were counseling agencies, 2 adult day treatment, 2 child day treatment, 1 drug abuse, 2 emergency services, 1 program for the mentally retarded, 1 inpatient, and 1 program was connected with a probate court. Initially, 174 staff were asked to participate, and 164 eventually agreed to do so. This constituted a response rate of 94%. Of the 164 staff responding to the survey, 94 (57.3%) were full time direct service line staff. This study focuses on these 94 staff divided into 3 groups based on their professional identity: 46 (49%) paraprofessionals, 8 (8%) nurses, and 40 (42%) professionally trained non-nursing mental health staff (8 M.A. level psychologists, 24 master's of social work (M.S.W.) and 8 Ph.D. clinical psychologists).

Instrument

Participating staff completed a questionnaire-type survey which requested background information and included the following measures.

Adequacy and similarity of previous training experience to current work. Staff were asked to evaluate on two separate 7-point Likert-type scales their perceptions of the adequacy and similarity of their previous training experience in terms of their current work.

Previously supervised clinical experience. Respondents were asked to indicate whether or not they had received supervised clinical experience prior to their current employment in each of the following areas: crisis intervention, individual adult, group, family, adolescent, and child therapy or counseling.

Clinical self-confidence. One set of items asked staff to indicate how confident they felt while engaging in: crisis intervention, individual adult, family, group, child, and couples therapy or counseling. A 4-point Likert-type scale was employed for these ratings.

Frequency of current formal supervision. Staff were asked to indicate the frequency of their current formal supervision.

Procedure

For the initial data collection, all staff employed at least half time were asked to participate in the study. Staff filled out the questionnaire at their respective agencies during regular staff meetings. The average staff member required about 40 min to complete the survey.

Results

Adequacy and similarity of previous training experience

As indicated in Table 1, nurses rated their previous training experience as least adequate and similar in terms of their current work role.

Table 1. Adequacy and similarity of previous training experience in terms of current work by professional identity

	Professional identity			
	Paraprofessionals	Nurses	Non-nursing professionals	All groups
		Adequacy		
χ	5.28	4.12	5.70	5.36*
(*N*)	(46)	(8)	(40)	(94)
		Similarity		
χ	4.56	4.37	5.50	4.96§
(*N*)	(46)	(8)	(40)	(94)

Note. 1 = very inadequate or not similar; 7 = very adequate or very similar.
*$F(2, 93) = 3.49, P < 0.03$.
§$F(2, 93) = 3.57, P < 0.03$.

A one-way analysis of variance indicated that a significant difference among groups exists in rating of adequacy ($P<0.03$) and similarity ($P<0.03$) of previous experience to current work.

Multiple comparisons of means (Scheffe, 1959) indicated that nurses rated their previous training experience as significantly less adequate than both paraprofessionals ($P<0.05$) and non-nursing professionals ($P<0.01$). Although nurses rated the similarity of their previous experience lowest of the 3 groups, pairwise comparisons did not indicate that the difference was statistically significant. The difference between paraprofessionals and non-nursing professionals on similarity of previous experience did reach statistical significance ($P<0.01$), primarily due to the larger *N*.

Previously supervised experience

The most striking trend to emerge is that both nurses and paraprofessionals were consistently less likely to have received supervised experience in each of the 6 areas surveyed (see Table 2).

Table 2. Per cent and frequency of staff with previously supervised experience by type and professional identity

	Type of experience					
	Crisis intervention	Individual adult	Group	Family	Adolescent	Child
		Paraprofessionals				
%	29.5	34.1	36.4	20.5	45.5	34.1
(*N*)	(13)	(15)	(16)	(9)	(20)	(15)
		Nurses				
%	37.5	75.0	37.5	37.5	12.5	12.5
(*N*)	(3)	(6)	(3)	(3)	(1)	(1)
		Non-nursing professionals				
%	75.0	90.0	70.0	67.5	82.5	67.5
(*N*)	(30)	(36)	(28)	(27)	(33)	(27)
		All groups				
%	50.0	62.0	51.1	42.4	58.7	46.7
(*N*)	(46)	(57)	(47)	(39)	(54)	(43)

Note. Number of respondents on which percentage is based is indicated in parenthesis. Two paraprofessionals did not respond.

A chi-square analysis indicated that nurses were significantly less likely than non-nursing professionals to have received supervised experience in 3 of the 6 areas surveyed: crisis intervention, ($P<0.03$), adolescent counseling ($P<0.0001$), and child counseling ($P<0.004$).

A similar analysis indicated that a significant difference exists between paraprofessional and non-nursing professionals in each of the 6 areas surveyed. Paraprofessionals were significantly less likely to have received previously supervised experience in crisis intervention ($P<0.0001$), individual adult counseling ($P<0.0001$), group counseling ($P<0.002$), family counseling ($P<0.0001$), adolescent counseling ($P<0.0004$), and child counseling ($P<0.002$).

Self-confidence

Two major trends in the data emerged: nurses reported the least self-confidence in 5 of 6 categories of clinical activities; and non-nursing professionals recorded the highest level of self-confidence in 5 of 6 services surveyed (see Table 3).

Table 3. Self-confidence in performing clinical services by activity and professional identity

	Professional identity			
	Paraprofessionals	Nurses	Non-nursing professionals	All groups
		Crisis intervention		
χ	1.62	1.42	1.40	1.51
(N)	(43)	(7)	(40)	(90)
		Individual adult counseling		
χ	1.76	1.83	1.79	1.49*
(N)	(38)	(6)	(39)	(83)
		Family counseling		
χ	1.96	2.50	1.83	1.94
(N)	(32)	(6)	(38)	(76)
		Child counseling		
χ	1.96	3.50	1.77	1.91§
(N)	(33)	(2)	(36)	(71)
		Group counseling		
χ	1.82	2.16	1.71	1.79
(N)	(34)	(6)	(39)	(70)
		Couples counseling		
χ	2.00	2.33	1.69	1.84
(N)	(26)	(3)	(36)	(65)
		All activities		
χ	1.85	2.29	1.70	1.94

Note. 1 = very effective and competent; 2 = satisfactory-adequate; 3 = somewhat inadequate; 4 = poor-ineffective. Missing staff in each category responded, 'no opinion'.

*$F(2, 82) = 11.47$, $P<0.0001$.

§$F(2, 70) = 3.54$, $P<0.03$).

A one-way analysis of variance indicated that a significant difference in self-confidence exists among groups in 2 services: adult counseling ($P < 0.0001$), and child counseling ($P<0.03$).

Multiple comparisons of means indicated that a significant difference between nurses and non-nursing professionals ($P<0.009$) and between paraprofessionals and non-nursing professionals ($P < 0.0001$) exists in the area of adult counseling. In the area of child counseling, a significant difference exists between nurses and paraprofessionals ($P<0.02$) and between nurses and non-nursing professionals ($P<0.01$).

Frequency of formal supervision

The data indicated that nurses tend to receive significantly less formal supervision in their current jobs than either of the other 2 groups. For example, 80% of the nurses received less than 1 hr of supervision every 2 weeks, while 27% of the paraprofessionals and 24% of the non-nursing professionals received a similar amount of supervision (see Table 4).

Table 4. Frequency of current formal supervision by professional identity

	Frequency of supervision		
	At least 1 hr/week	Less than 1 hr/2 weeks	Totals
	Paraprofessionals		
N	29	11	40
(%)	(72.5)	(27.5)	(100)
	Nurses		
N	1	4	5
(%)	(20.0)	(80.0)	(100)
	Non-nursing professionals		
N	25	8	33
(%)	(75.8)	(24.2)	(100)
	All groups		
N	55	23	78
(%)	(70.5)	(29.5)	(100)

Note. Six paraprofessionals, 3 nurses and 7 non-nursing professionals did not respond. Nurses received significantly less formal supervision than either paraprofessionals ($\chi^2 = 5.51$, $df = 1$, $P < 0.01$) or non-nursing professionals ($\chi^2 = 6.24$, $df = 1$, $P < 0.01$). No difference was indicated between paraprofessionals and non-nursing professionals ($\chi^2 = 0.009$, $df = 1$, $P < 0.75$).

A chi-square analysis indicated that while nurses receive significantly less supervision than either paraprofessionals ($P<0.01$) or non-nursing professionals ($P<0.01$), no significant difference was reported between paraprofessionals and non-nursing professionals ($P<0.75$).

Since frequency of supervision may, in part, be a function of the number of hours per week working with clients, data regarding frequency of client contact was analyzed. As indicated in Table 5, nurses actually tend to spend more time with clients per week than either of the other 2 groups, however, a chi-square analysis indicated that the difference among groups did not reach statistical significance ($P<0.06$).

Table 5. Average weekly client contact by professional identity

	Average weekly client contact			
	10 hr or less	11-20 hr	21 or more hr	Totals
		Paraprofessionals		
N	14	8	21	43
(%)	(32.6)	(18.6)	(48.8)	(100)
		Nurses		
N	1	2	5	8
(%)	(12.5)	(25.0)	(62.5)	(100)
		Non-nursing professionals		
N	3	13	23	39
(%)	(7.7)	(33.3)	(59.0)	(100)
		All groups*		
N	18	23	49	90
(%)	(20.0)	(25.6)	(54.4)	(100)

Note. Three paraprofessionals and 1 non-nursing professional did not respond.
*$\chi^2 = 8.79$, $df = 4$, $P < 0.06$.

Discussion

The findings of this exploratory study tend to indicate that nurses employed in community mental health centers may be experiencing many difficulties and problems in their professional roles as psychotherapeutic agents. The data suggests that nurses' previous mental health training is relatively poor and that despite heavy client contact, they receive little 'on-the-job' supervision. This paucity of previous and current training seems to be reflected in their relatively lower self-confidence in performing many clinical activities. This may be an important finding since there is some evidence which suggests that helping professionals' confidence in their methods and abilities is a powerful ingredient in the psychotherapeutic process (Frank, 1973; Stotland and Kobler, 1965).

The results of this study suggests that university-based training programs for nurses intent on a career in community mental health need to become more relevant in terms of the variety of professional psychotherapeutic roles they will be assuming. Additionally, community mental health supervisors need to become more aware of the limits of nurses' previous training and experience and, therefore, provide increased relevant inservice training and supervision to this most important group of mental health caregivers.

This study also suggests that supervisors may not be entirely aware of the extent of staffs' experience, training and abilities. Since the adequacy of preparation prior to job performance may well vary from staff person to staff person as well as from center to center, perhaps a comprehensive 'training needs assessment' (Dade and Strumwasser, 1977; Nguyen, Attkisson and Bottino, 1976; Siegel, Attkisson and Cohn, 1974; Warheit, Bell and Schwab, 1974) would provide supervisors with a vast amount of information to use as the basis for the planning and development of inservice training programs.

Although the results of this study are extremely suggestive, the findings are limited in generalizability because of the small number of nurses taking part in the study. In fact, very few nurses were actually found to be employed as clinical staff in the community

mental health centers surveyed. It is certainly possible that the combined effects of limited educational and inservice training opportunities both discourages nurses from entering the mental health field and creates a situation which causes them, because of continuing job performance uncertainty and anxiety, to leave mental health centers in search of employment in which they feel more knowledgeable and secure. No doubt, under such circumstances, supervisors and administrators would certainly be prone to employ non-nursing professionals or paraprofessionals because of their perceptions of nurses limited mental health clinical skills (this is sometimes known as 'catch 22').

A second problem which limits the generalizability of this study is the potential lack of reliability and validity of the measures employed. For example, it is possible that responses to the adequacy and similarity of previous training as well as those related to self-confidence were, in fact, based on different subjective criteria. More objective measures would be appropriate in future research.

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