An Exploratory Study of Associate Degree Programs for Mental Health Workers

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THE FIRST ASSOCIATE DEGREE program in mental health was established at Purdue University in 1965 (*1*); since then, the growth of similar programs has been extremely rapid. Simon (*2*) has traced some of the early history of these programs. The most recent survey indicated that there were about 150 throughout the country (*3*). The National Institute of Mental Health (NIMH), which has been instrumental in stimulating the growth of these programs, funded the first one at Purdue and has since provided grant support for more than 40 others across the country. This Institute has also funded two regional education groups, the Western Interstate Commission for Higher Education (WICHE) and the Southern Regional Education Board (SREB), which have in turn provided stimulation and consultation to colleges and to the field of mental health regarding the training and utilization of workers with associate degrees.

These associate degree programs are concerned with preparing a mental health generalist, that is, a worker who after 2 years of academic and fieldwork experience would be prepared to enter a variety of job roles in mental hospitals, community mental health centers, retardation facilities, geriatric settings, and other community agencies that need additional manpower. Those persons engaged in the early planning of these programs had hoped that new jobs would be established for many of the graduates and that

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these new jobs would help alleviate some of the traditional problems of mental health delivery systems.

One traditional problem was inadequate coordination between the helping agencies and the highly specialized professionals within a single facility, which often resulted in treatment programs that were fragmented and confusing to those seeking help. Insufficient attention was given to the total situation and needs of the individual patient. The highly specialized professionals often tended to view a patient from their own idiosyncratic perspective (that is, as a diagnostic label, a testing case, or the like) and to ignore the total or whole person. And prospective patients frequently had difficulty either to hook into the appropriate starting place in the service delivery system or to maintain a satisfactory continuity once the treatment process began. Because of their pathological condition, lack of information, and lack of influence in the system, prospective patients were often unable to be effective spokesmen for themselves.

One job model for the mental health worker (MHW), which was designed to alleviate problems such as these, provides for assigning the worker 6 to 10 patients for whom he has primary treatment responsibility (*4*). The mental health worker would serve as advocate, broker, mobilizer, teacher, and coordinator for the patients, using the various professionals as consultants and supervisors in the planning and implementation of the patients' treatment and followup. This model and other related new roles for MHS graduates would logically lead also to new work roles for the professionals and permit more effective use of their skills in program planning, consultation, and research and evaluation.

The need for research to evaluate the effectiveness of these MHW educational programs and to study the impact of this new type of worker on the mental health service delivery system was urgent. To this end, the National Institute of Mental Health in 1971 funded an evaluation project at the Department of Psychiatry and Behavioral Sciences of Johns Hopkins University. The staff of this project, which is called the Center for Human Services Research, has been conducting studies at the national level to clarify the scope and significance of this new source of manpower—a source that has taken on the appearance of a major movement in the development of mental health manpower. As of June 1972, there were an estimated 2,700 MHW graduates, and such graduates are expected to exceed 17,000 by June 1976 (*3*).

We describe an exploratory study of MHW programs that was conducted by the Center for Human Services Research in the fall of 1971. At that time seven interviewers each visited an active MHW program that had graduated several classes of mental health workers and sought to obtain firsthand information on the state of the programs and the work activities and success of the graduates. This information was used by the center to determine salient issues for future research and to formulate preliminary job models based on the graduates' work experiences.

Study Sample and Methods

The seven colleges surveyed in the study were located in Alabama, Colorado, Florida, Indiana, Maryland, and Ohio. (Two of the colleges were in Maryland and the others in each of the other five States.) They were among the institutions having the most mature MHW programs.

Three of the seven interviewers were from the staff of the Center for Human Services Research and four were outside consultants selected to provide a range of viewpoints. The consultants included an MHW graduate, a program director, a sociologist, and a social psychologist.

Open-ended questions were included in the interview forms to generate rich and diverse data, and the results are reported in narrative form. We realize that these results are not representative of all mental health programs or all mental health worker graduates. Nevertheless, they do represent models to which newer programs can turn and from whose experience newer programs may benefit.

Interviews were carried out at each college with the program director, the dean of academic affairs, three program graduates, the graduates' supervisors, and one co-worker of each graduate. When a graduate had more than one supervisor, the one with whom the graduate had spent the most time was interviewed. "Co-worker" was defined as that person in the organization (professional or nonprofessional) who had worked most closely with the graduate since his or her employment began.

After each visit to a program site, the interviewer summarized his observations and evalua-

tive comments in a written report, which was later sent to the appropriate program director for the director's use in further development of his program.

Regional and State Activities

Four of the colleges whose programs were studied were served by the Southern Regional Education Board. This board helped these colleges (which were located in Alabama, Florida, and Maryland) with program development by providing individual consultations with the SREB staff, by arranging for the college staff's attendance at SREB planning conferences, and by supplying SREB publications. The three programs outside the South also benefited from SREB conferences and literature. In the West, the Western Interstate Commissioner for Higher Education was playing a major role in program development by the time of our study. The WICHE project has focused on establishing programs for minority groups, primarily Chicanos and Indians.

Interestingly, a certain person or certain persons provided a coalescing force for the inception of each of the seven programs, but during the initial planning they did not know of each others' activities. The events leading to the inception and development of this new movement merit more documentation and study.

State departments of mental health participated to some degree in the early development of each of the programs. In some cases personnel of the State mental health department had been a driving force behind program development, while in other cases the State personnel had acted as more passive onlookers. At the time of our study, four of the six States had developed entry job specifications for graduates. Three of the States had at least a two-step classification (career ladder). There were plans for, and talk of setting up, more extensive career ladders in all six States to allow graduates vertical and lateral mobility. Nevertheless, extensive development and implementation of such ladders were still needed at the time of our study.

By the time of the study, three States (Alabama, Maryland, and Ohio) had held meetings of mental health personnel, college personnel, or both, to exchange information. These States were establishing more MHW programs than the others, but the persons who were interviewed differed as to whether this development was desirable. Many expressed concern that with too many programs MHW graduates would saturate the job market. There appeared to be little agreement at any of the seven colleges as to the appropriate number of programs for their State or region or the best size for these programs. Most deans and program directors expressed a need for State and regional coordination to help resolve such issues.

Results

Numerous unresolved issues were uncovered at each of the seven sites of the programs. Our report, however, focuses primarily on those generic issues that were common to most, or all, of the programs visited.

Characteristics of programs. The programs were located in both urban and small-city colleges. The primary objective of these institutions was to serve the needs of their community or geographic region. The programs varied in size from 16 to 158 students; they had from 2 to 4 full-time faculty members. All were regarded as successful by the deans of the colleges where they were located and by the programs' directors. Five of the seven colleges had received NIMH grants to aid in the initial establishment of their programs. The other two had received supporting grants from the States in which they were located. One objective index of success was that five of the colleges had assumed financial support for their programs upon the termination of Federal funding. The other two were still receiving outside grant support at the time of the study.

Although the programs had succeeded in placing most of their graduates in mental health settings, their most pressing need still was to obtain more jobs for graduates. The program staffs at each setting clearly articulated this concern, but organized efforts at finding more jobs usually were not being made. What was done was frequently considered by the interviewers to be piecemeal; usually the program director or a faculty person aided individual students in their job seeking. The interviewers saw a need for more continuous information from community agencies about manpower requirements.

Program goals. Each program was primarily concerned with the goal mentioned earlier—preparing students to be mental health generalists, that is, workers with a broad background in the

behavioral sciences and mental health who could move into a wide variety of jobs in the field. The program directors hoped that the jobs filled by the MHW graduates would add coordination, continuity, and speed to the treatment programs of individual patients. They also anticipated that some graduates would work as assistants to mental health professionals, taking on part of the work previously performed by the professionals.

The seven programs varied in the degree to which they were affiliated with, and trained their graduates for jobs within, a single mental health setting. Two programs were closely affiliated with a State mental hospital; one was affiliated with a community mental health center and another, with a large State residential treatment center for habilitation of the mentally retarded. There was a general consensus among the persons interviewed that students should have fieldwork experience in more than one setting before they graduated so that they could apply their skills in different ways and thus become more generic.

The staffs of the seven programs were also concerned with providing the student with an educational base that could be transferred to baccalaureate programs in related areas. These very broad, and sometimes conflicting, goals (for example, meeting course requirements for transferability versus having a more job-oriented focus in the curriculum) were usually not spelled out in detail. As a result, there was some uncertainty among faculty and students, which was reflected in the ambivalence of students about whether to seek a job immediately after graduation or to enter a baccalaureate program and in faculty uncertainty about decision making in respect to curriculum revision. In addition, students were frequently not prepared for the role of seeking out and obtaining new jobs. Since the roles or jobs for which they were trained did not exist, the MHW graduates frequently had to convince those already employed in the mental health setting of their potential usefulness. Specialized training within the MHW training programs to prepare students for such "lobbying" was reported by staff members of several of the programs.

Administrative housing of programs. The administrative status and housing of the MHW program was still unresolved at a number of the colleges visited. Some of the programs were regarded as separate departments, while others functioned as a section of another department (such as a department of psychology). Wherever the program functioned as part of another department, members of the mental health faculty often had received their appointments from the parent department instead of from a mental health department. Some faculty members held appointments in both kinds of departments, but controversy concerning allegiance and priorities arose as a result of these joint affiliations. The dean of one college was debating whether the mental health program should be placed with medically oriented programs (under allied health) or grouped with other human services programs.

Although the administrative personnel expressed confusion about the nature of the MHW programs, the program directors tended to disavow the medical model in mental health and to prefer alignment with a department of human services rather than one with a medical orientation. Several program directors also expressed misgivings about being part of a department of psychology, fearing that this would lead to the training of assistants to psychologists.

Each of the seven colleges studied had programs in the allied health-human services fields, but little joint activity in planning or educating has resulted. (There has been little collaboration, for example, between mental health staffs and nursing staffs in most of the colleges.) This situation may have led to some duplication in educational experiences. Such duplication is not only expensive but deprives students of the potentially rich experience of learning how other professionals carry out their work. In addition, none of the MHW programs had established collaborative relationships with graduate training programs for mental health professionals. If the two groups of mental health trainees could work together while in training, their understanding and utilization of each others' skills following graduation would likely increase.

Other program characteristics. The program directors had considerable freedom in setting up their own curriculum and selecting faculty members, although the final authority for decisions on the curriculum ordinarily rested with a curriculum committee, and decisions about the selection of faculty rested with the academic dean. The pro-

grams were all functionally similar to traditional academic departments in the degree of freedom with which their staffs could carry out their program goals; that is, the staffs reported considerable autonomy.

One rather surprising observation in our study was that some of the mental health programs were not well understood by faculty and students in other programs in the colleges. Since none of the mental health programs was new, the need for more and better communication within the colleges is apparent.

All directors of the programs reported conducting some sort of "screening"—usually interviewing prospective students and attempting to "counsel out" potentially undesirable candidates. Only one program, which had a strict quota system tied to its screening, rejected large numbers of candidates. This program also appeared to have a "high prestige" image within the college—an image not apparent at the other six locations. A more systematic study of the various types of screening used and their effectiveness seems to be indicated.

Another surprise was the observation that none of the seven colleges were trying to evaluate their programs. A majority of the programs, however, had been evaluated earlier, usually as part of their NIMH grant activities. Only one was actively using an advisory board or committee of community representatives, although several had originally formed and used such boards.

Deans. Six of the seven deans interviewed considered the further development of allied health programs (under which they included mental health) as one of their top priorities. Nevertheless, within the allied health field, the deans' responses to questions concerning allocation of funds for faculty and other program resources (such as space, secretarial support, and new faculty) suggested that mental health programs generally had a lower priority than some of the more traditional health programs such as nursing.

Although faculty members and students outside the mental health area seemed to need more information about the mental health programs, the deans interviewed were on the whole knowledgeable about, and supportive of, these programs. Several deans were concerned about the lack of visible jobs for graduates; others expressed the view that it was not the responsibility of the college to guarantee jobs and noted that graduates might have to leave the community to find mental health work. All, however, expressed optimism about the future of these training programs.

Program directors. The program director was viewed by the other persons interviewed as the key to a successful program. The disciplines represented by the program directors included psychology—5 directors; psychiatric nursing—1; and special education—1. Six program directors had their doctorates; one had a master's degree. The directors were diverse in terms of training and background, and only one had substantial training in college administration before being appointed director.

Four of the directors had initially developed their programs; three were serving as the second director. All seven seemed dedicated to the welfare of their programs. Several expressed a strong preference for a student-centered climate in which students would have significant input and the roles of faculty and students would be blurred, but no clear-cut evidence emerged as to whether their programs functioned more democratically or better than those under more traditional directors. Several of the original directors expressed a certain amount of disillusionment. Their original expectations had been that "this new type of mental health worker would help to change the custodial orientation of the field," but these expectations were still largely unmet. These directors commented that some of their graduates were beginning to sound like traditional workers in their comments about patients (that is, they were less humanistic and more cynical). One can infer that these directors did not consider their programs at fault since only one reported that he was planning major changes in his progam's goals or direction in the near future.

Changes in the programs that had occurred or that were being considered reflected a consistent tendency to broaden the progam goals toward a human services or community services focus (for example, to include special education, work in the corrections field, and so forth). The reasons given for this broadening included: (*a*) pressure to enlarge the job market, (*b*) a belief that such broadening was the general trend in the mental health field, and (*c*) some graduates had found

jobs and were performing effectively in related fields of helping people.

Certain common elements were noted among the program directors. Most did not have a significant amount of contact with other program directors. Most were also not so closely in touch with students on a day-to-day basis as they had been earlier. (Both of these elements suggest that the program directors are isolated and need interaction with their peers.) Several directors seemed to feel that there were fewer rewards from working in the program than there had been originally. Although much community work needed to be done in the areas of job development, inservice training for new graduates, and general education related to mental health workers, the directors reported that they were spending relatively little time in these areas. They partially attributed this situation to an increased workload and insufficient release time from the college to attend to activities other than teaching. Another related factor mentioned was that the stimulation and challenge of establishing a new vocation had partially worn off with time. The program directors generally divided their work time among interviewing prospective students, counseling students, general administrative work, teaching, special projects (such as preparing publications and developing syllabuses), and community development. Further job analysis would be necessary to determine accurate percentages for the time devoted to each activity.

Faculty. Each of the seven faculties studied was interdisciplinary; psychiatry, social work, activity therapies, and so forth, were represented. The faculties of two colleges included program graduates who were working either as volunteer instructors or as full-time faculty members. Most of the programs used one or two part-time faculty members who were professionals from local agencies. Some part-time staff members had been awarded faculty status and pay; others had not. The field work supervisors usually provided supervision of the students without pay or faculty appointment.

Most of the program directors and members of the faculty had entered the program with experience in clinical work, but with little or no background in teaching. Although they did not designate this lack as a problem, it apparently led to some difficulty in certain educational activities—for example, in preparing course syllabuses, delivering lectures, devising grading systems, and the like.

Students. The majority of the students in the programs were young white women of middle-class background. The program directors reported that initially a significant number had been older women whose families were partially or completely raised, but in most programs the percentage in this category had reportedly decreased. None of the programs had difficulty in attracting prospective students, although few were males or members of minority groups. One college did report that about 60 percent of its students were black. The students in all seven programs appeared involved and enthusiastic about them, but they shared general feelings of uncertainty about their professional futures in view of the job market.

Graduates. The seven colleges had a total of 225 graduates from the MHW programs, with a range of 13 to 58 (median 31). Data were collected on 27 graduates in interviews. The graduates tended to be older than the national average age for MHW graduates—30 years. A majority had no direct mental health experience before entering the program. Taken as a group, the graduates viewed themselves, and were viewed by their supervisors and co-workers, as performing effectively on the job. Some were described as making outstanding contributions to their work.

The graduates' work settings were diverse—State mental hospitals, community mental health centers, outpatient clinics, State homes for the mentally retarded, a Veterans Administration hospital, day care facilities, an alcoholism and drug abuse treatment center, and others. All the settings were clearly mental health (or mental retardation) facilities.

Most of the graduates interviewed were employed in the agencies where they had done their fieldwork. As students they had made a positive impression on the professional workers in these settings, which had led to their employment after graduation.

In general, there was little, if any, formal preparation at the setting for the graduate's entry into the job, and as a result, many of the graduates

were initially given a great deal of freedom in developing their own jobs. Indeed, some expressed dissatisfaction because they had been left too much on their own during this period.

All of the graduates worked directly with patients to a significant degree. Their job activities included psychotherapy, group therapy, psychological testing, behavior modification, teaching, interviewing, behavioral observation and recording, family therapy, outreach work, and the supervision and inservice training of aides and attendants. One graduate was the head of a mental health workers' department in a mental hospital. One was on the faculty of a mental health program.

An examination of the graduates' jobs from the standpoint of the schema formulated by the Southern Regional Education Board in 1967 (*4*) reveals that the graduates performed most often in the roles of behavior changer, evaluator, teacher-educator, care-giver, and data manager (keeper of patients' records); the roles of advocate, broker, administrator, and mobilizer received less emphasis. The roles of outreach worker, community planner, and assistant to a specialist were also filled by a few graduates. Most graduates filled multiple roles, an observation suggesting that this aspect of the "generalist" goal was being met. A few graduates were working in more limited (specialist) roles (for example, as a low-level assistant to an occupational therapist).

The levels of functioning of the graduates varied considerably, but most were performing at an "appropriate level" (SREB 1967: Level II—apprentice, technician, or assistant—associate degree or somewhat higher; Level III—journeyman, associate, or technological—bachelor or arts). Some were filling roles (mainly that of "behavior changer") that are at the beginning professional level.

The performance of this group of graduates suggests that associate degree workers can perform many traditional mental health tasks in a relatively competent manner. It also suggests that most of them are not being used in innovative roles that focus on outreach, prevention, community planning, or broker-advocate work. Their work roles, of course, reflect the orientation of their work settings. Most of the settings in our study were moving from a traditional focus on treatment to a community mental health orientation, but they were not yet well organized in primary prevention and the coordination of diverse treatment elements. Some graduates, however, were filling innovative roles in community mental health centers, which are not so tradition-bound as the hospitals.

Only one setting had established a mental health workers' department. Most of the mental health workers were assigned to an interdisciplinary, therapeutic team, which provided the basis for their primary work group. Their professional identification as mental health workers within these teams, however, usually remained strong, and they maintained high aspirations for their work.

The majority of graduates had jobs indistinguishable, except for salary (a range of $6,000–$8,000), from those at other levels at their work settings, and many expressed dissatisfaction because although they viewed themselves as performing the same job as other professionals, they did not receive as much pay. The graduates tended to be satisfied with the content of their work but were unsure about the future because there was no long-range career ladder. The one exception was a three-level career ladder in Maryland.

Although supervisors expressed positive views about the graduates' work, most appeared to have little first-hand information about it. Supervision often appeared to be sporadic, frequently being on a demand basis rather than being regularly scheduled. Specific on-the-job training and firsthand observation and evaluation of the graduates' skills were rare.

The graduates reported that their fieldwork was the most valuable part of their training. They ranked the group dynamics component of their curriculum second, followed by their other specialized courses. General education courses were ranked last.

A number of graduates recommended better screening of prospective mental health students. The graduates made a number of other recommendations about the curriculum; most of these suggestions clustered in the skills training area (notably knowledge and skills for treatment of families and drug abuse). Several mentioned the need to know more about the interrelationships of human services delivery in a community. Some said that the programs should supply better supervision for fieldwork. Most, however, expressed a generally positive view of their educational programs.

Few graduates reported that resistance by other workers was a significant factor in their adapting

to their jobs. Several interviewers, however, inferred that such resistance existed and believed that it tended to be stronger in other workers who either knew little about the graduate's function or whose territory overlapped the graduate's (usually social workers, nurses, aides, and attendants). Further study of these and other environmental constraints probably would be enlightening.

Most graduates had already started, or were planning to continue, their education, although many were enrolled in curriculums with little or no relevance to their immediate or planned work in mental health (for example, a program leading to a bachelor's degree in psychology). Most expressed interest in continuing their education in the field of mental health, but reported that there were no feasible opportunities to do so. Although some of the graduates knew of the several new baccalaureate programs in mental health, almost all felt tied to their particular geographic region by marriage or other reasons. In Maryland some of the graduates were participating in the new bachelor's programs in mental health that had recently been initiated at Antioch College, Morgan State College, and Towson State College.

Conclusion

The seven programs studied were relatively healthy and viable, although a number of unresolved administrative issues remain. Program goals appear to need more clarification; screening and evaluation require further study. Our study of the graduates also revealed other needs—for the development of more human services jobs they can fill, preparation of the work setting for the graduate's job entry, adequate supervision, measurement of the graduate's competency, and the further development of career ladders.

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In an exploratory study of seven assoicate degree programs for mental health workers in six States, 21 graduates, their supervisors at work, and their peers were interviewed, as were the directors of the programs, academic deans of the colleges where the programs were located, and faculty of the programs. The graduates seemed to be performing well in both traditional and innovative job roles, but they complained of inadequate salaries, underdeveloped career ladders, and too little supervision in the beginning period of their work.

The college administration staffs regarded these associate degree programs as viable, although all seven deans recognized that expansion of the job market for graduates was the most pressing need. The program directors and faculty members reported a need for more release time to work in the community in order to create jobs for the graduates.

Career ladders were not adequately articulated in most States so that upward mobility of the graduates was limited, and the number of males and members of minority groups entering these programs was found to be small. The interviewers were of the opinion that the programs could benefit from more continuous information from community agencies as to their current and future manpower needs. Also, the agencies engaging these graduates apparently need to conduct training programs for them and provide them with more extensive supervision as they begin their work. The programs' directors expressed the belief that these workers can perform well in a wide variety of human service jobs in which the emphasis is on human interaction.

Further evaluative research needs to be carried out so that the competency of the graduates can be measured better, program goals can be refined, and prospective students can be adequately screened. Nevertheless, these associate degree programs appear to offer one promising approach to the alleviation of the continuing manpower shortage in the mental health field.