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ABSTRACT

To respond to the need for a coordinated system of training and training resources for West Virginia mental health personnel, the West Virginia Training Resources Center was established in 1979. Hospital and community mental health center administrators and staffs were surveyed to obtain program planning input, i.e., selection of trainee groups, assignment of priority to training areas and topics, and choice of format models for the training programs. Job-title, training and experience levels, and job analyses data were obtained from respondents. A return rate of 50% or 901 valid responses provided a representative cross-section of mental health personnel. Analyses of results indicated that while a need for training was identified the area of greatest need was not suited to traditional continuing education. Non-credentialed personnel, most notably state hospital psychiatric aides, were cited as needing most training, and a skill-oriented training format conducted at the work setting was suggested by the greatest percentage of all groups. To the extent that the results are capable of being generalized, the findings suggest that openness to the needs of training consumers is essential as the most effective means of ensuring that inservice training and continuing education programs continue to exist at necessary levels. (JAC)

Training Needs of Mental Health Personnel: A Statewide Survey

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Training Needs for Mental Health Personnel: A Statewide Survey

This paper describes a survey of training needs and interests of mental health personnel in West Virginia. The survey was conducted as part of the planning process for a multidisciplinary training system developed as a cooperative venture between the West Virginia Department of Health and West Virginina University (Ellis, Greenwood, Stevenson, and Linton, in press). Data was obtained from over 900 members of the state's community mental health and state psychiatric hospital workforce and produced information with important implications for the structure and function of the training program.

Background

In 1978, planning began for an innovative system to provide basic training and continuing education for the West Virginia mental health workforce. Here, as elsewhere, mental health centers and state hospitals were largely responsible for operating their own staff development programs. This produced a somewhat duplicative system of training which lacked coordination and which operated at relatively minimal levels, due both to the scarcity of funds and to the low priority assigned to staff development relative to service programs. Quality of care was thought to suffer as a result.

Negotiations resulted in the signing in 1979 of a contract between the West Virginia Department of Health and the Department of Behavioral Medicine and Psychiatry at the Charleston Division of the West Virginia University Medical Center. This contract provided for the creation of the West Virginia Training Resources Center (TRC), a program to provide a coordinated system of training and training resources to West Virginia mental health personnel (Ellis, 1981).

In planning the training program, we sought to obtain input, not only from administrative and academic sectors (i.e., the Department of Health and the University), but also from service providers themselves. Experience had shown that such "front-line personnel" often were overlooked during the planning phases of staff development programs; we were aware of several reasons for obtaining their input.

First, and perhaps most obvious, was the need for relevance: to design a program of training without thorough familiarity with the needs and interests of potential trainees would be to defeat our intent of creating a high-impact program and might also lend credence to the stereotype of the prestigious-but-ever-irrelevant university. Second was the somewhat humbling acknowledgement that we "university types" did not know-it-all when it came to mental health service delivery. Becoming thoroughly acquainted with the realities of working in the "real world" was important in terms of both curriculum design and the logistics of program delivery. A final reason for promoting consumer participation related to the matter

of acceptability. The idea of a central, state-financed training center immediately (and understandably) gave rise to local control issues and concerns about Big Brotherism, especially among the locally controlled community mental health centers. It was clear that having support from those concerned would be tremendously helpful, whereas having opposition would at best hamper the project and at worst defeat it. A survey was agreed upon as the most desirable means of gathering the needed information.

Method

The questionnaire was constructed in three phases. First, in order to identify appropriate questions and variables and to ensure relevance to a broad spectrum of respondents, loosely structured interviews were conducted onsite with representatives from each state hospital and community mental health center in the state. This information was drafted into the preliminary questionnaire. Next, this draft was distributed to staff members from a nearby community mental health center; 114 completed the questionnaire and provided structured feedback on clarity, time required for completion, item difficulty, and so forth. The questionnaire also was distributed to state Department of Health representatives for the same feedback, as well as their reactions regarding its comprehensiveness. This feedback was then compiled and used for construction of the final version.

Finally, the questionnaire was divided into parallel forms for each of four subgroups: hospital staff, hospital administrators, cmhc staff, and cmhc administrators. The difference between staff and administration forms was primarily one of point of view. Staff were asked for perceptions regarding their own needs, while administrators were asked for opinions on training needs of their facilities' entire staffs. The criterion used for distinguishing between administrator and staff was percent of time at these respective duties: to be eligible to complete the administrator form required that at least twenty percent time be devoted to administrative functions. The same twenty percent rule applied for the staff form and service duties. The situation occasionally occurred in which a person devoting the criterion amount of time to each area of activity was eligible to complete both forms.

Results

Response Rates

After elimination of invalid questionnaires, the number completed and returned totaled 901. Response rates, based upon our knowledge of statewide staffing patterns, were as follows: hospital administrators, 70.3%; hospital staff, 50.3%; cmhc administrators, 48.1%; cmhc staff, 49.5%. Overall response rate was 48.7%. Responses were obtained from administrators and staff at all four state psychiatric hospitals and 13 of 14 community mental health centers.

Sample Characterisitics

Job title. A broad cross-section of personnel from various programs and services was obtained, though it was impossible to determine whether all groups were represented in equal proportions, since staffing statistics were not available. A summary of respondents' job titles appears in Table I.

Training/experience. To determine levels of training and experience of service providers, the two staff groups were asked to report their education, number of years since completing school, and number of years in their current positions. Results are summarized in Tables II, III, and IV, and reveal considerable differences between the two groups. While 70% of cmhc staff reported having received a bachelor's or more advanced degree, only 9.5% of hospital staff had advanced this far and 85% reported only a high school education or less. However, this imbalance was reversed with respect to experience; over half (54.6%) of hospital staff reported having been in their current positions for over 5 years, while only 15.2% of cmhc staff reported more than 5 years experience in their current jobs.

Job analysis. In anticipation of possible correlations between respondents' main duties and their training priorities, participants were asked to estimate in percentages the amount of time they devoted to various job functions. Results are summarized in Table V, and show predictable differences between administration and staff groups and between hospital and cmhc groups.

As expected, administrators reported devoting considerably more (more than double) time to administrative compared to direct service duties, while the reverse was true for staff groups. Striking similarities were noted between job divisions of hospital and cmhc administrators; less similarity was observed between hospital and cmhc staff, whose time was more evenly divided among other areas, notably administrative duties.

Training Priorities

Issues regarding the program planning process were addressed in the following order: trainee group priorities, training area priorities, and format preferences.

Trainee groups. Since the "staff" forms of the questionnaire sought to measure self perceptions of individual respondents' needs (rather than needs of entire staffs as measured in the "administrator" forms), only the administrator group was questioned about trainee group priorities. Administrators from hospitals and cmhc's were given slightly differing lists of personnel groups (reflecting differences in staffing patterns) and asked to rank them "according to what you feel should be priority groups for training." Results, reported in mean rankings, are summarized in Table VI.

Similarities between rankings of the two groups are readily apparent; in both groups, paraprofessionals are considered highest, and professional and executive staff lowest, in need for training.

In addition, middle manager and professional groups obtained identical rankings, third and fourth respectively, from the two groups. The considerable gap between rankings for paraprofessionals and the next highest priority group is particularly noteworthy. The separation of cmhc paraprofessionals into "community" (residential, aftercare, etc.) and "other" (crisis, out-patient, etc.) resulted in an insignificant difference in mean rankings, suggesting that cmhc administrators generally did not distinguish between these subgroups in terms of need for training.

Differences in rankings of hospital and cmhc administrators are minimal, and seem related to a higher centrality of medical staff in the hospitals. (Although a specific "medical staff" item was not offered on the cmhc form, the failure of cmhc administrators to utilize the "Other" item for this purpose suggests that training for medical staff is not as high among their priorities for training as in the priorities of hospital administrators, who ranked this group second.)

Content areas. All four respondent groups were asked to rank in order of importance a list of general areas for training. (Items for this list had been derived from earlier interviews with hospital and cmhc personnel.) Results are summarized in Table VII. Most obvious is the agreement along all four groups that clinical skills (defined as such skills as interviewing tecniques, behavior modification, and group therapy) is the area

of training considered most essential to mental health personnel. The relatively large differences between first and second place mean rankings are especially noteworthy. The opinion that training in administration (program planning and management, budgeting, legal issues, etc.) should be assigned lowest priority is also relatively uniform. Although the mean ranking of the hospital staff group placed this area third (as compared to fourth, fifth, or sixth by the other groups), the difference between third and fourth place for this group was negligible.

In the middle area between highest and lowest priorities, differences of opinion regarding areas for training became apparent. Most noteworthy is the disagreement between administrators and staff regarding the Personal Development category (preventing "burnout," managing stress, optimizing relationships with co-workers, etc.). Whereas the mean rankings for both hospital and cmhc staff placed this item second on the list of priorities, hospital and cmhc administrators ranked it fourth and fifth overall, respectively.

In addition to being asked to indicate specific topics of interest by underlining any of several topics which were listed as examples following each topic area (for example, the "clinical methods" item was followed by "interviewing techniques, behavior modification, group process, etc."). Ranking the five topics most frequently chosen by each group reveals two clear-cut common

topics of interests. As shown in Table VIII, stress management was among the top five choices of all four groups, and preventing burnout was ranked among the top five by all groups except hospital staff, which ranked it seventh overall.

Differences in interests between hospital and cmhc personnel can also be seen; improving relationships with co-workers and behavior modification were ranked high by hospital administrators and staff, while community resource development and group process were common areas of interest among cmhc administrators and staff.

Format preferences. All groups also were surveyed for preferences regarding specific modes (formats) in which training programs might be conducted. Four "models" were described in the questionnaire as follows:

Model A: Visiting Lecture Series. Once per month programs, one hour lecture, one hour discussion, at your facility.

Model B: One-day workshops once a month at yours or a nearby facility, with lectures, discussion, learning exercises, etc.

Model C: Two-day workshops offered every two months in Charleston with lecture, exercises, etc. Follow-up consultation at your facility as requested.

Model D: Five days in Charleston for "core material, followed by two weeks supervised placement experience (placement may be home-based or elsewhere).

The models were designed to vary along several dimensions of training experience: frequency, duration, location (on-site or requiring travel), and with or without placement experience.

Respondents were asked to indicate which of the four models they most preferred and which they least preferred.

Results are summarized in Figures 1 and 2. Striking agreement is evident in the uniformity of "votes" for most preferred (B) and least preferred (D) models. Less agreement is present regarding the second most preferred model, which suggests a tendency for hospital administrators and staff to select a briefer, home-based model and for cmhc administrators and staff to opt for a more extended work-shop model which would require some travel. One may speculate that differences in manpower and possibly travel budgets are operative here. There is some indication that hospital staff are less willing to travel than their superiors are willing to permit, as suggested by differences between these groups in numbers marking Models A and C, respectively, as most preferred.

Summary and Discussion

To assist with the design of a statewide program for training mental health personnel, 901 individuals in four groups (hospital administrators, hospital staff, cmhc administrators, and cmhc staff), were surveyed by questionnaire. Input was solicited regarding selection of trainee groups, prioritization of training areas and topics, and choice of format models for the training programs. The rate of return of questionnaires approached 50% for each of the four respondent groups, and a representative cross-section of mental health personnel was obtained.

Perhaps the strongest impression gained from the survey was that a need for training indeed existed, but that the "market" was clearly not one suited to the traditional model of continuing education, i.e., a professional orientation, didactic delivery, and centralized location. Rather, the call was for the bulk of training to be with "front line," non-credentialed personnel (most notably, state hospital psychiatric aides), in a skill-oriented format, conducted at the worksite so as to minimize problems created by personnel shortages and limited travel funds.

To the extent that these results are generalizable beyond the borders of West Virginia, the need for a new and innovative approach to training clearly exists. Even where these results cannot be generalized, openness to the needs of training consumers appears to be essential. For, despite the crucial importance of ongoing training to ensure high quality services, in many cases budget cuts are eliminating training programs in favor of the very service programs which they support. A consumer-oriented approach characterized by relevance and openness to innovation may be the most effective steps to ensure that inservice training and continuing education programs continue to exist at necessary levels.

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	Hosp. Admin. (N=89)	Hosp. Staff (N=419)	CMHC Admin. (N=95)	CMHC Staff (N=396)	TOTALS (N=999)
Job Title	Frequency	Frequency	Frequency	Frequency	Frequency
Psychiatric/ Case Aide	1 (1.1%)	337 (80.4%)	0 (0%)	74 (18.7%)	412 (41.2%)
Case mgr./ Therapist (Paraprof.)	4 (4.5%)	30 (7.2%)	1 (1.0%)	110 (27.8%)	145 (14.5%)
Service Prof.(MA+)	0 (0%)	6 (1.4%)	0 (0%)	97 (24.5%)	47 (4.7%)
Facility or Program Director	47 (52.8%)	2 (.5%)	82 (86.3%)	53 (13.4%)	171 (17.1%)
Medical (M.D. or Nurse)	11 (12.4%)	22 (5.2%)	0 (0%)	14 (3.5%)	47 (4.7%)
Other	23 (25.8%)	20 (4.8%)	9 (9.5%)	44 (11.1%)	109 (10.9%)
No Response	3 (3.4%)	2 (.5%)	3 (3.2%)	4 (1.0%)	12 (1.2%)

Table I: Frequency of Job Titles

	Hospital Staff (N=419)		CMHC Staff (N=396)	
Education	Frequency	% of Total	Frequency	% of Total
<12 years	94	22.4	6	1.5
Hgh.Schl./GED	258	61.6	73	18.4
Associate	14	3.3	32	8.1
Bachelor's	24	5.2	120	30.3
Master's	11	2.6	138	34.8
Doctorate	5	1.2	19	4.8
Other	8	1.9	3	0.8
No response	5	1.2	5	1.2

Table II: Education of Staff Respondents

	Hospital Staff (N=419)		CMHC Staff (N=396)	
Years	Frequency	% of Total	Frequency	% of Total
1-5	63	15.0	185	46.7
6-10	48	11.4	88	22.2
11-20	65	15.5	57	14.4
21-30	72	17.1	22	5.6
31-40	72	17.1	8	2.0
41-50	22	5.2	1	.2
Missing	77	18.4	35	8.8

Table III: Years Since School (Staff Respondents)

	Hospital Staff (N=419)		CMHC Staff (N=396)	
Years	Frequency	% of Total	Frequency	% of Total
1-5	174	41.5	336	84.8
6-10	111	26.5	40	10.1
11-20	101	24.3	10	2.5
21-30	12	3.0	1	0.2
31-40	3	0.8	9	2.2
Missing	18	4.3	0	0

Table IV: Years in Current Position (Staff Respondents)

Job Function	Hosp. Admin. (N=89)	Hosp. Staff (N=419)	CMHC Admin. (N=95)	CMHC Staff (N=396)
Direct Services	21.1	75.0	22.4	54.7
Administration	51.3	16.4	50.4	25.8
Consult. & Educ.	6.2	—	6.8	8.8
Supervising	16.2	5.2	19.3	3.7
Being Supervised	—	3.9	—	3.8
Other	4.9	2.5	1.3	2.0

Table V: Job Analyses (Mean Percentages*)

*Since these figures are group means, column sums may not total 100%.

	Hospital Administrators (N=89)		CMHC Administrators (N=95)	
Overall Rank	Trainee* Group	Mean Ranking	Trainee* Group	Mean Ranking
1	Paraprofessionals: aides, attendants, etc.	1.62	Paraprofessionals: crisis, outpatient, etc.	2.28
2	Medical staff	2.53	Paraprofessionals: community workers	2.35
3	Middle Mgrs., Program Directors	2.94	Middle Mgrs., Program Directors	3.19**
4	Non-medical Professionals	3.71	Professional staff	3.36
5	Executive staff	4.35**	Clerical staff	4.58**
6	---	---	Executive staff	5.21

*An "Other (please specify)" category was also listed. However, this item was utilized by only 13 (14.6%) of hospital administrators and 11 (11.6%) of CMHC administrators, and therefore was not included for comparison purposes. Mean rankings for the "Other" category were 4.38 and 4.18 for hospital and CMHC administrators, respectively.

**Significant between-group (facility) differences ($p \leq .03$)

Table VI: Administrators' Trainee Group Priorities

Topic Area	Respondent Group: Hospital Administrators (N=103)	Hospital Staff (N=419)	CMHC Administrators (N=105)	CMHC Staff (N=396)	Overall (N=1023)
Clinical Methods	2.48 (1)	2.08 (1)	2.29 (1)	1.93 (1)	2.20 (1)
Personal Development	3.36 (4)	2.54 (2)	3.83 (5)	3.22 (2)	3.24 (2)
Supervisor Skills	3.20 (2)	3.23 (4)	3.51 (3)	4.08 (5)	3.50 (3)
Community Skills	4.80 (6)	3.65 (5)	3.40 (2)	3.54 (4)	3.85 (4)
Administration	4.41 (5)	3.21 (3)	3.76 (4)	4.52 (6)	3.98 (5)
Consultation & Education	N.A.	N.A.	4.04 (6)	3.45 (3)	---
Other(s)	---	4.31 (6)	5.00 (7)	4.59 (7)	---

Table VII: Training Area Priorities: Mean Rankings

Rank*	Hospital Administrators	Hospital Staff	CMHC Administrators	CMHC Staff
1	Improving Relationships With Co-workers	Behavior Modification	Community Resources Development	Preventing Burnout
2	Patient Management	Relationships With Co-workers	Fiscal Resource Development	Community Resource Development
3	Behavior Modification	Stress Management	Program Planning & Management	Group Process
4	Prevent Burnout	Relationship Building	Preventing Burnout	Stress Management
5	Stress Management	Crisis Intervention	Stress Management Group Process (tie)	Community Education

*Determined by frequency of respondent choice

Table VIII: Training Topic Choices

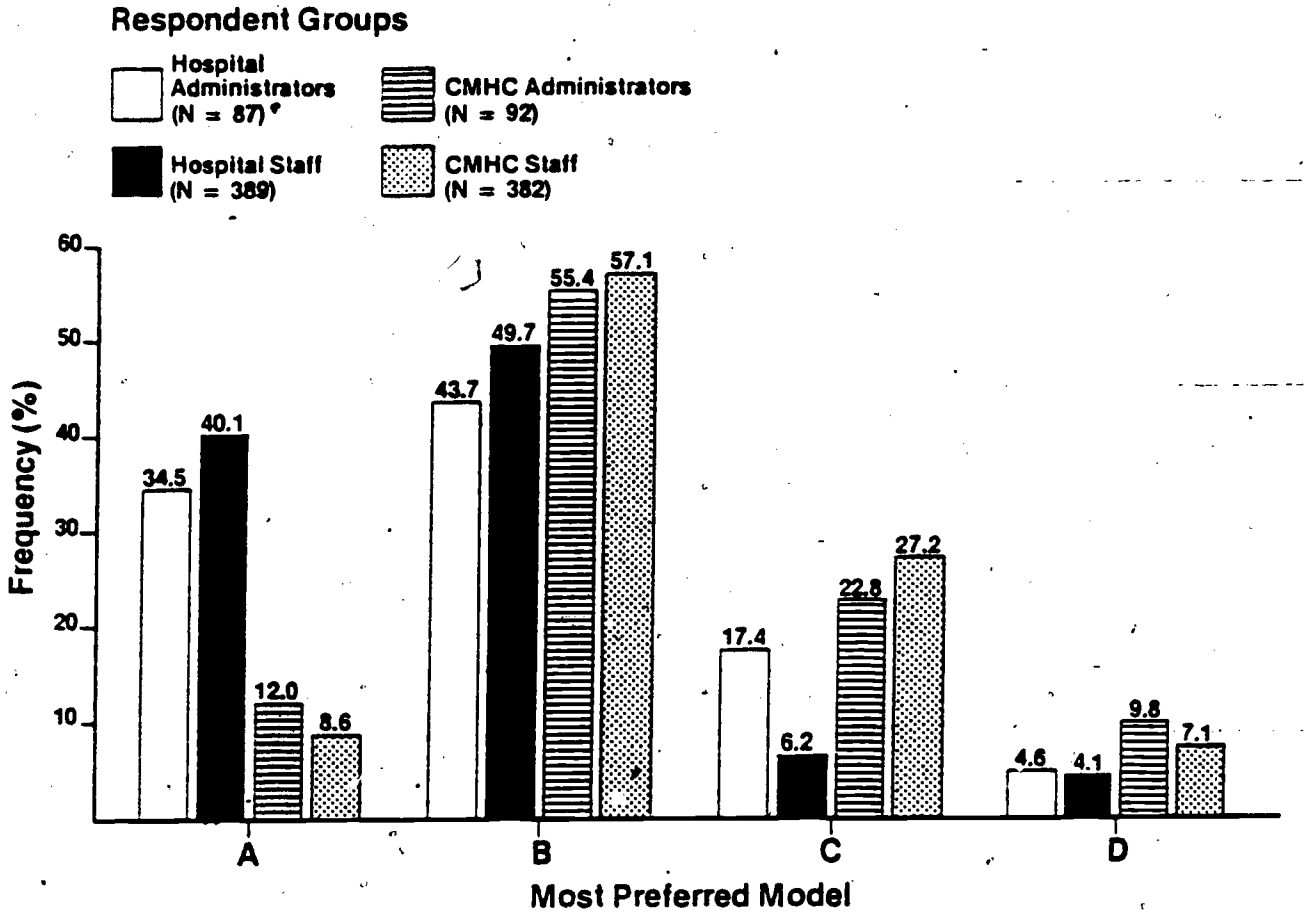

Figure 1: Percentages of four survey groups expressing preference for each of four hypothetical training formats. Models were defined respectively as follows: Model A--Visiting Lecture Series. Once per month programs, one hour lecture, one hour discussion, at your facility; Model B--One-day workshops once a month at yours or a nearby facility, with lectures, discussion, learning exercises, etc.; Model C--Two-day workshops offered every two months at a central site, with lecture, exercises, etc. Follow-up consultation at your facility as requested; Model D--Five days at central site for "core material," followed by two weeks supervised placement experience (placement may be home-based or elsewhere).

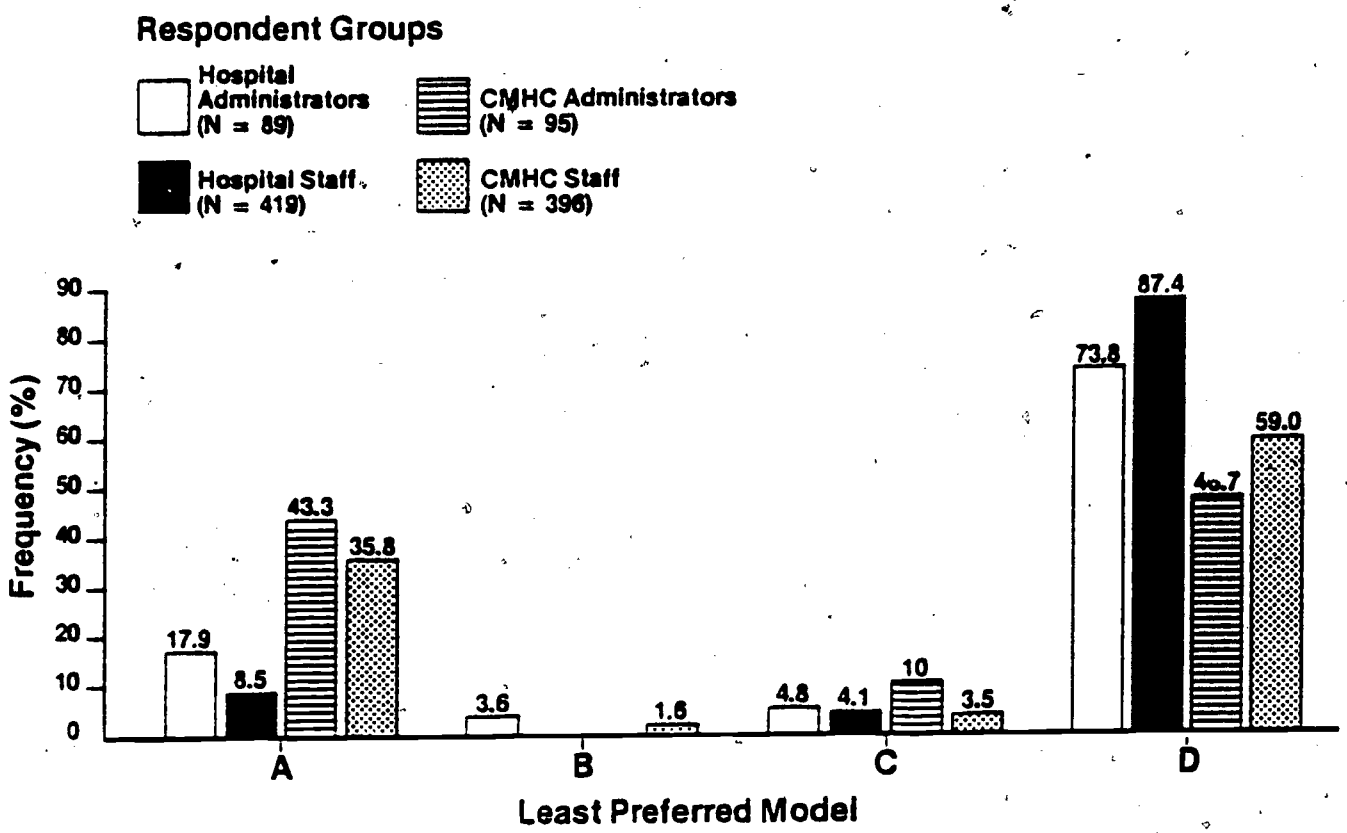

Figure 2: Percentages of four survey groups expressing lowest preference for each of four hypothetical training formats (see Figure 1 for model definitions).