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THE PERFORMANCE OF PARAPROFESSIONALS IN MENTAL HEALTH FIELDS

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THE PERFORMANCE OF PARAPROFESSIONALS IN MENTAL HEALTH FIELDS

Our major concern in this chapter is to document the role of paraprofessionals[1] in promoting service for clients in the mental health and psychiatric fields; that is, we are mainly interested in the practice of the paraprofessional as it relates to the functioning of the patient or consumer.[2] Although he plays other roles (for example, social change agent), our focus is on his input to service delivery. As we shall see, a number of major studies provide considerable evidence that the paraprofessional does indeed play a role in contributing to improved mental health of clients and patients both in hospitals and community settings.

Unlike public schools, where paraprofessionals are relatively new (although a significant minority of the staff), in the mental health programs they are of long standing and comprise a large majority of the employees.

Consideration of the role of paraprofessionals in mental health must begin first with an identification of just who it is one is discussing. If one defines as professionals those holding post-baccalaureate professional degrees and excludes those engaged in only maintenance and housekeeping activities, one can suggest three types of paraprofessionals.

1. The “old” hospital-based worker is typified by the psychiatric aide

working in a hospital setting, engaged in supportive therapeutic work. He usually does not have a college degree and is not indigenous to the community in which he is working, though he generally comes from a low-income background and is frequently black or Puerto Rican.

2. The new middle-class paraprofessional is typically a woman with a degree who has received special training in mental health skills and is generally engaged in substantive therapeutic work. Margaret Rioch's program is perhaps best known in this area. The women she trained were middle class, mainly white, and held previous college degrees.

3. The indigenous paraprofessional is recruited from the community where he works. He is usually employed, although not exclusively, in mental health centers, does not hold a college degree, and is engaged in therapeutically relevant work.

The first type, the old paraprofessional, is, of course, the most common and the heart of the staff of mental health hospital facilities. The new paraprofessional is seen in the various efforts of the late 1950s and 1960s to meet professional manpower shortages, while the indigenous paraprofessional is largely the child of the antipoverty and community mental health efforts. It is the last two to which we will give special attention.

The Old Paraprofessional

A highly significant well-controlled experiment conducted by Ellsworth indicates that the old type of paraprofessional could play a powerful role in the improved treatment outcome for hospitalized male schizophrenics. “A demonstration project in which the focus on treatment was the development of the psychiatric aide as the rehabilitation agent” was conducted at the Fort Meade, South Dakota,

Veterans Administration Hospital. Fort Meade has a 600-bed hospital; for the purposes of the demonstration, patients of one building were used as an experimental group (N= 122) and patients of two other buildings were used as a control group (N=214). For patients in both groups, the program was similar in use of medication, use of activity group therapy, the process of reaching decisions regarding discharge, assignment of new admissions, and patient characteristics.

The demonstration program was designed to raise the level of aide-patient interaction. To do this effectively, the aide’s role in the hospital had to be altered, particularly as it related to participation in decision-making. It was found that a higher percentage of experimental group patients were released to the community during the thirty-month demonstration period, and a lower percentage of them had to return to the hospital.

Post-discharge outcomes were based on six indices: (1) level of

behavioral adjustment; (2) median days subsequently hospitalized; (3) released versus not released; (4) percentage achieving twelve consecutive months in the community; (5) good social adjustment; and (6) discharge status six years later.

Both experimental and control groups were divided into three subgroups, each based on degree of schizophrenia. There were twenty- one pairs of comparisons, and the experimental group did better on all twenty-one, in thirteen of them at a substantial level of significance. “Although the chronically hospitalized patients group profited most by the approach used in the experimental program, the acute group of patients also responded significantly.

Key factors in the aides’ role seemed to be the increased interaction with patients and their new active participation in decisions regarding patients. The two factors were interconnected “as the active involvement of the aide in the decision-making process was found to be a necessary condition in sustaining aide- patient interaction.

Ellsworth concluded: “Our project has shown clearly that the role of a non- professionally trained person can be modified extensively in a psychiatric rehabilitation setting. When this modification takes the form of actively involving the nonprofessional in all phases of patient rehabilitation

the treatment outcome for hospitalized male schizophrenics is highly significant."

The New Paraprofessional

Perhaps best known in this area is the early work of Margaret Rioch and the studies of Robert R. Carkhuff and Charles B. Truax. These investigators, as well as a number of others reported in this section, provide evidence regarding the effectiveness of paraprofessionals as treatment agents.

In i960, the adult psychiatry branch of the National Institute of Mental Health funded Rioch's Mental Health Counselors program. It was designed to fill the need for staff to provide low-cost psychotherapy and at the same time to provide useful work for women with grown children. The value of these women was seen in their successful child-rearing experience and maturity. There were eight women chosen from eighty applications. Their median age was forty-two; seven were married, and one was widowed; they had an average of 2.4 children. All were college graduates, and three had post-baccalaureate degrees; six had held professional jobs; four had been psychoanalyzed. All their husbands held executive or professional positions. Their upper-class status is further shown by their ability to participate in a two-year training program without pay and with no guarantee of a job at the end of the program. All eight women completed the four semesters of

training, which emphasized professional breadth, not technician specificity. It was limited to psychotherapy and emphasized on-the- job training. Most of the patients of the trainees were adolescents.

Blind evaluations were made by outside experts of trainees' taped interviews with clients, and trainees were not identified as such. On a scale from 1 (poor) to 5 (excellent), the rating of the interviews on eight factors ranged from 2.7 (beginning of interview) to 4.2 (professional attitude), with an overall global impression mean score of 3.4. Evaluation of patient progress (N=4q) showed that none changed for the worse, 19 percent showed no change; and 61 percent showed some change. Of these, 35 percent showed slight improvement, 20 percent showed moderate improvement, and 6 percent showed marked improvement. As to the counselors' faults, the director reported "they pleasantly reassure, protect and sympathize when it would be better to question more deeply and seriously. A second fault is a tendency to try to deal on a surface, common sense level with problems that are soluble only by eliciting unconscious conflicts."

Similar to the Mental Health Counselors program, in terms of the background of the women trained as counselors, the Child Development Counselors program at the Washington, D.C. Children's Hospital differed from Rioch's program in that the counselors worked with patients of a different class background. A similar cross-class effort was involved in the Albert

Einstein College of Medicine mental health rehabilitation workers project, which also used mature women, as did a Rochester, N.Y., program where housewives worked with emotionally disturbed young school children. The many programs using college students as therapeutic agents crossed both class and age lines. Still other programs used peers as therapeutic agents.

In Australia, paraprofessional part-time volunteers (mature adults, successfully married) provided marriage counseling service. Some 270 persons served approximately 15,000 persons per year. The volunteers received weekly training for about a year and a half, primarily in a nondirective client-centered Rogerian approach. In about 15 percent of the cases, the problem was solved, and in another 35 percent of the cases marital relations were noticeably improved, according to Harvey.

Aides trained in Rogerian play therapy worked with six Head Start children diagnosed by a psychologist as in need of psychotherapy, owing to uncontrollable, withdrawn, and inhibited behavior. “All six children treated by the aide showed signs of improvement during the treatment period,” as reported by Androvic and Guerney.

Similar to these efforts was the work of the Arkansas Rehabilitation Research and Training Center led by Charles Truax. Here the effort has been to identify those characteristics that make for more effective counseling and

for the use of lay counselors. Two major experiments are of interest. The first compared the work of lay therapists, clinical psychology graduate students, and experienced therapists. It involved 150 chronic hospitalized patients. "The variety of current diagnoses included manic depressive reactions, psychotic depressive reactions, and schizophrenic. . . ." Patients were randomly assigned to lay persons who had 100 hours of training, clinical psychology graduate students, and experienced counselors. "The lay mental health counselors were able to provide a level of therapeutic conditions only slightly below that of the experienced therapists and considerably above that of graduate student trainees."

Earlier work of the Arkansas group isolated three factors as critical to therapist's effect on patient: his communicating a high level of (1) accurate empathy, (2) non-possessive warmth, and (3) genuineness to the patients. There were no significant differences between the three groups of counselors as related to communicating accurate empathy or non-possessive warmth. On the third factor, communicating genuineness to the patient, the experienced therapists showed significantly higher performance.

Summarizing the effect on patients of the work of the lay therapists, Truax, the project director, wrote, "Research evaluation indicated highly significant patient outcomes in *overall improvement, improvement in interpersonal relations, improvement in self-care, and self-concern, and*

improvement in emotional disturbance."

The second study conducted at the Arkansas center addressed more closely the effect of paraprofessional counselors. Some 400 patients at the Hot Springs Rehabilitation Center, a large residential center, were randomly assigned in three different groups: (1) to experienced professional (master's degree) counselors; (2) to experienced counselors assisted by an aide under maximum supervision; and (3) to aides (former secretaries with little if any college but 100 hours of training) working alone under supervision. Within each of the three patterns, caseload was varied at either thirty or sixty; thus, there was a 3 X 2 experimental design. Two-thirds of the patients were male; two-thirds, white; all had personality or behavioral problems, and a sizable number had speech and hearing defects or were mentally retarded.

Performance under the three patterns of staffing was based on client work quantity, cooperativeness, work attitude, quality of work, dependability, ability to learn, and overall progress. On all measures, "The best results were obtained by the aides working alone under the daily supervision of professional counselors. The professional counselors working alone had the second best results, while the counselor plus the aide had the poorest effects upon clients."

The greater positive effects on client rehabilitation by the aides with

their own caseload appeared to be "due both to the somewhat higher levels of warmth and empathy communicated to the clients by the aides and the greater motivation and enthusiasm of the aides."[3] Carrying their conclusions beyond this project, the authors stated that "The findings presented here are consistent with a growing body of research which indicates that the effectiveness of counseling and psychotherapy, as measured by constructive changes in client functioning, is largely independent of the counselor's level of training and theoretical orientation."

Summarizing his review of many of the programs described above, Garfield concluded, "The implication of all the programs ... is that counselors can be trained in a clinical setting, in a reasonably short time, to perform a variety of functions."

The broadest examination of the work of paraprofessionals in mental health was Sobey's study of over 10,000 paraprofessionals in 185 National Institute of Mental Health (NIMH) sponsored programs. As the data were presented in gross categories, one cannot, for the most part, distinguish the particular type of paraprofessional being employed, although it would seem that the category includes persons from all three of the groups we have delineated above—the old paraprofessional, the new middle-class paraprofessional, and the indigenous paraprofessional.

The major finding related to the reason for the use of paraprofessionals is that

> Nonprofessionals are utilized not simply because professional manpower is unavailable but rather to provide new services in innovative ways. Nonprofessionals are providing such therapeutic functions as individual counseling, activity group therapy, milieu therapy; they are doing case finding; they are playing screening roles of non-clerical nature; they are helping people to adjust to community life; they are providing special skills such as tutoring; they are promoting client self-help through involving clients in helping others having similar problems.

The basis for the use of paraprofessionals illustrated in Table 56-1 by the responses of project directors to the question of whether, given a choice of hiring professionals, project directors would prefer to utilize paraprofessionals for those functions that professionals had previously performed. In short, 53 percent preferred to use paraprofessionals over professionals for tasks previously performed by professionals, or to put it another way, only 32 percent preferred to use professionals.

As could be anticipated from the above, "overwhelmingly the project directors felt that the service performed by nonprofessionals justified the expense of training, supervision and general agency overhead." The directors saw paraprofessionals contributing across a broad spectrum of program activities including servicing more people, offering new services, and providing the project staff with new viewpoints in regard to the project population. Table 56-2 displays the directors' sense of these contributions.

The response to the last item in Table 56-2, relating to new viewpoints, suggests that a significant number of the paraprofessionals were indigenous workers. Also, in sixty-nine projects, the directors reported expanding the professional's understanding of the client group through association with the paraprofessionals. The same thrust is to be seen in the comment that "the introduction of nonprofessionals was perceived as infusing the projects with a new vitality, and forcing a self- evaluation which although painful, led to beneficial changes for the field of mental health." The work style and personal attributes of the paraprofessionals were important, as they brought,

> a change in atmosphere within the agency, and more lively and vital relationships among staff and between patients and staff. . . . Improved morale, better attitudes toward patients, definite improvement in over-all quality of service were other improvements reported. The addition of youthful, untrained personnel within several hospitals makes the older trained personnel re-examine their own roles and the role, structure and function of the entire hospital.

Table 56-1. Utilization Preference in NIMH-Funded Projects: Professionals or Nonprofessionals

UTILIZATION PREFERENCE	NUMBER OF PROJECTS RESPONDING
Would clearly utilize professional staff	17
Would probably utilize professional staff	38
Uncertain	29
Would probably not utilize profession staff	36
Would clearly not utilize professional staff	55

Table 56-2. Contributions by Nonprofessionals to Improvements in Service

IMPROVEMENTS IN SERVICE	Projects Reporting Degree of Nonprofessional Contribution (percentages)			
	SUBSTANTIAL	MODERATE	SLIGHT OR NOT AT ALL	TOTAL NUMBER OF PROJECT RESPONSES
Service initiated/ completed faster	54	31	15	80
Able to serve more people	59	32	9	127
New services provided	57	27	l6	141
More professional time made available for treatment	45	31	24	106
New viewpoints gained by project staff regarding population served	53	31	16	135

In summary, "Nonprofessionals were viewed as contributing to mental health in two unique ways: (1) *filling new roles based on patient needs* which were previously unfilled by any staff; and (2) performing parts of tasks previously performed by professionals, but *tailoring the task to the nonprofessionals' unique and special abilities."*[4]

The value of the use of new paraprofessionals is summarized by Carkhuff, a former staff member of the Arkansas center: "In directly comparable studies, selected lay persons with or without training and/or supervision have patients who demonstrate changes as great or greater than

the patients of professional practitioners."

The Indigenous Paraprofessional

The characteristics of the lay counselor, as described by Carkhuff, appear to apply as well to the indigenous worker.

1. The increased ability to enter the milieu of the distressed.
2. The ability to establish peer-like relationships with the needy.
3. The ability to take an active part in the client's total life situation.
4. The ability to empathize more fully with the client's style of life.
5. The ability to teach the client, from within the client's frame of reference, more successful actions.
6. The ability to provide clients with a more effective transition to more effective levels of functioning within the social system.

One of the earliest uses of indigenous paraprofessionals was at Howard University in the Baker's Dozen project of Jacob Fishman, Lonnie Mitchell, and colleagues. The Howard team's work has continued both there and at the University Research Corporation, whose many reports include consideration of mental health programs, primarily as part of new careers efforts.

A 1969 survey of eighty community mental health centers found that 42

percent of all fulltime positions were filled by indigenous workers. The figures were higher in drug-abuse treatment (60 percent) and geriatric services (70 percent). A study in the same year, of paraprofessionals in ten community mental health centers in New York City, reported their "actual work as described by administrators varied from unskilled to highly skilled but more often is of the highly skilled variety." The work included interviewing, escort service, home visits, manning storefront offices, receiving complaints, collecting information, acting as translators, performing individual and group counseling, organizing community meetings, leading therapy groups, assisting patients in self-care, acting as patients' advocates with other agencies, case-finding, screening applicants, making case conference presentations, doing casework, giving speeches, planning after care services, and giving supportive psychotherapy to ex-patients.

Reiff and Riessman made the point that the use of the indigenous paraprofessional was part of the new concern for service to the poor. If the concern was only to meet professional manpower shortages, indigenity is unnecessary. However, if there was a concern to reach and serve those unreached and unserved, in short, if the propelling motive grew out of a critique of service performance, then the indigenous worker may be needed. The ability of the indigenous paraprofessionals is "rooted in their background. It is not based on things they have been taught, but on what they *are."* They are poor, from the neighborhood, minority group members, their

family is poor, they are a peer of the client with common language, background, ethnic origin, style, and interests.[5] They can establish special relations with clients: The paraprofessional belongs; he is a significant other; he is one of us. His life style is similar to that of the client, especially "the tendency to externalize causes rather than look for internal ones."

Hallowitz, the co-director of the pioneering Lincoln Hospital Mental Health Services Neighborhood Service Center program, described a range of activities for the indigenous worker in such a setting. These included expediting, being a friend in need, sociotherapy, supervised work, services to post-hospital patients, services to the disturbed in the community, and self-help. The Lincoln Hospital Mental Health Services Neighborhood Service Center program began with an Office of Economic Opportunity grant, January 1, 1965. Three centers were established, each staffed with five to ten aides. They were seen as bridges between the professionals and the community. They are expediters, advocates, and counselors. Something of the power of their impact and the need for services in a community such as the South Bronx is shown by the service figure of 6,500 persons seen at two of the centers during the first nine months. The program offered services to the client's whole family, and it was estimated that more than 25,000 persons were affected during that period.

Harlem Hospital employed indigenous workers in a variety of roles.

Harlem residents interested in working with the aged provided outpatient geriatric psychiatric services. They made home visits, provided escort services, observed and reported on patient behavior, provided social services. About half of the study group of sixty cases were successfully managed.

Especially innovative was June Christmas's Harlem Hospital group therapy program, which uses indigenous aides. The aides worked in a half-day treatment program for a small group of chronic psychotic post-hospital patients. The aides participated as co-therapists in weekly group psychotherapy sessions,

acted as participants and expediters in the monthly medication group meetings, were members of the weekly therapeutic community meetings, and led the weekly client discussion groups. In addition, they performed case services, family services, and home interviews; surveyed patient needs; and provided community mental health education. The program was expected to hold one-third of the patients; it has held two-thirds. A four-step career ladder—trainee, worker, technician, specialist—is in effect, gained, in part, through the efforts of union Local 1199 of the Drug and Hospital Workers Union.

The Temple University Community Mental Health Center has trained indigenous workers as mental health assistants, workers whom they describe

as “helpers first, then therapists.” Over time a work pattern developed where the mental health assistants “function as a ‘primary therapist’ providing on-going treatment and continuity of care which would include the procurement of ancillary (professional) services whenever appropriate.” The assistant, a title the workers themselves preferred to “aide,” worked with 96 percent of the patients in the clinic’s first year. Two key factors in their work involved holding patients and by their availability preventing hospitalization.

While the percentage of patients’ attrition between initial contact and first appointment is still high, it is a lower rate than that presented for comparable patient aggregates in usual clinic settings. The need to hospitalize patients contacting the crisis center and clinic has decreased by 50% due to the Assistants’ availability for immediate outpatient care.

The Central City Community Mental Health Center in Los Angeles used community workers in a program designed to develop additional mental health manpower, train new workers, improve understanding between the disadvantaged and mental health personnel, increase the available services, and create new services appropriate to the disadvantaged. The community workers are used in the mental health facility itself, at a family service center, in various social welfare agencies, in a public health project, in a public housing program, and to provide crisis intervention therapy in a suicide prevention program. Among the other uses of indigenous paraprofessionals

in mental health programs was as alcoholism counselors in a program of the Baltimore County health department; as paramedic technicians at a state residential school for the mentally retarded in Hawaii; as part of a home treatment team at the Veterans Administration Hospital in Tuscaloosa, Alabama; in a child guidance clinic component of a comprehensive mental health center in Rochester, N.Y.

Formal Education and Performance

In a far-reaching study of seventeen state rehabilitation agencies, involving 209 counselors, 50 supervisors and 1,502 patients, the ratings of supervisors and patients were correlated with four levels of worker education: post M.A., M.A., B.A., less than B.A.

[H]igher levels of academic training of rehabilitation counselors do not result in higher supervisor ratings on the dimension of overall effectiveness of the counselor. . . .

[H]igher levels of academic training for rehabilitation counselors do not result in higher client reports of satisfaction with his counselor.

The lack of correlation between formal education and work performance has been cited in many of the reports described above. It may be that the type of formal education presently offered does not lead to improved

paraprofessional performance because, as we have seen, training of untrained people has led to improved performance. New training approaches are beginning to develop at the college level.

Something of a new approach was developed in the new mental health college programs. A 1965 NIMH grant inaugurated at Purdue University the first two-year training program for mental health workers. This was followed in 1966 by a Southern Regional

Education Board conference on the role of community colleges in mental health training. In 1967, two Maryland community colleges began such programs, and by September 1968, twenty-six community colleges were offering similar programs, and fifty-seven by 1970. The programs emphasized practicum, interviewing skills, counseling, use of community resources, and techniques of behavior modification.

In evaluating the Purdue program, various effects have been noted as regards changes in patient care—"humanizing" the hospital, opening closed wards, establishment of patient government, more use of recreation and work facilities, use of new treatment modalities such as milieu therapy and sociotherapy.

These developments offer some countervailing tendencies to the finding of the survey of New York City community mental health centers, described

above, that despite the fact that 70 percent of the center administrators rated the paraprofessional contribution as essential and another 22 percent rated him highly desirable, there is "little thought given toward developing the paraprofessional job into a worthwhile one."

And, perhaps encouraging is the fact that the graduates of the new Purdue program while working in mental health programs have chosen not to do so in traditional mental health facilities. It may be, as the authors suggest, that these new workers are disillusioned with the traditional medical model of mental health services.

The tensions involved between new personnel, new training, and traditional mental health practices have been well captured in a far-reaching article by Minuchin. He pointed out that initially the use of paraprofessionals in mental health grew out of the manpower shortage.

For many professionals, a very important major assumption was implicit in this strategy, that we could maintain intact the traditional conceptualizations of mental illness and treatment, simply fitting the nonprofessional into the already existing structure of delivery of service. But the inclusion of paraprofessionals in the existing structure of delivery of service brought to a head a bipolarity of approaches to mental illness which was already incipient in the field.

At the one pole, where sociological thinking dominated, where pathology is seen as coming from the outside in, paraprofessionals have had less difficulty in fitting in. At the other pole, where the individual is very much a separate human being, the problem of fitting in has been very much greater. The paraprofessionals are seen as doing little more than "implementing the professional's recommendations and their supervision."

Minuchin's answer is that the field itself must be changed, indeed the very relationship of individual and society reconceptualized. As we have seen, the paraprofessional, initially introduced in a narrow framework, has in one way or another become a force for and focus around changes of a basic nature in the field. It is these changes, rather than minor tinkering within the present structure, that may be the shapers of the paraprofessionals' future role in mental health.

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Notes

1 Many terms have been used for the noncreden- tialed worker: "nonprofessional," "subprofessional," "new professional," "paraprofessional," "auxiliary," "aide," "allied worker," "community professional," "community worker," "new careerist," and so on. Recently, the term "paraprofessional" seems to be most widely accepted and is the one we shall use, although many of the workers themselves are beginning to prefer "new professional."2

2There is a huge and rapidly growing literature concerning paraprofessional programs in general, as well as mental health programs in particular. Illustrative is the recent publication of a bibliography on paraprofessional programs, which contains well over a thousand items.26

3 The aides spent more time with clients, especially when they had high caseloads. The professionals, when they had high caseloads, spent less time with clients. The aides, in effect, appeared to feel that it was necessary to work hard to get to all the cases, while the professionals seemed to feel that with so many clients to see, it was impossible to get to all. However, "Overall, neither the total number of minutes spent in contact with individual clients nor the frequency of client contacts was related to the client's vocational progress."

4 Editors' italics.

5 Perhaps the ultimate in the use of the indigenous worker is an NIMH-funded project to train twelve Navajo males as medicine men. They are to learn the fifty ceremonies of tribal traditions for treating illness and to work with the Public Health Service doctors regarding referrals and assistance.