A STUDY OF NURSING IN COMMUNITY MENTAL HEALTH CENTERS IN NORTH CAROLINA IN 1973

by

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VIRGINIA JOHNSON MICHAUX. A Study of Nursing in Community Mental Health Centers in North Carolina in 1973 (Under the Direction of DR. BETTY SUE JOHNSON.)

All nurses working in community mental health centers in North Carolina in 1973 were sent a written questionnaire surveying their education and experience, job activities, work setting, and job satisfactions. Results were analyzed by descriptive statistical methods. Out of sixty-eight nurses, sixty-five responded. Conclusions from the data were presented, with some patterns descriptive of nursing in CMHC's in North Carolina emerging. Nurses were found to be working in all CMHC activities, but predominantly in direct services. Some interpretations concerning salary, satisfactions, educational needs, status, functions, and the CMHC system vis-a-vis nurses were presented. Recommendations were made based on the data.

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CHAPTER I

INTRODUCTION TO THE STUDY

Problem and Purpose of the Study

The purpose of this study was to describe nursing in community mental health centers (CMHC's) in North Carolina in 1973. In that year manpower needs in mental health were great and roles were largely unstructured in North Carolina's mental health centers. Manpower needs and roles remain much the same today, and less money is available to meet the needs for mental health services.[1] The results of this study are consistent with Glasscote's 1969 finding that nurses prefer direct work with people more than any other health professionals. Also, this study found that the nurses working in North Carolina's CMHC's in 1973 performed what was surely the largest range of mental health activities of any professional group.

DeYoung and Tower state:

> . . . a prime source of professional manpower being underutilized in the mental health setting, with the exception of the inpatient setting, is nurses. The full potential of the nurse is rarely realized because she is boxed in by a stereotype perpetuated

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[1]Interview with Dr. Betty Sue Johnson, University of North Carolina School of Nursing, Chapel Hill, North Carolina, July 16, 1976.

> by herself and others. One of the ways that this stereotype is perpetuated is by mental health nurses not giving mental health planners enough data so that they can be included in planning.[2]

This study provides descriptive information which can be used in planning the procurement, utilization, education, and retention of nurses in community mental health in North Carolina. Data on the activities of nurses in North Carolina's CMHC's, as well as data on their backgrounds, work settings, and job satisfaction are presented.

Overview of Methods

A ten page written questionnaire was developed to collect data on nurses' activities, backgrounds, work settings, and job satisfaction. Questions to be answered by the data from the questionnaire included the following:

1. How was a nurse working in a CMHC in North Carolina in 1973 prepared for her job?
2. What were the things she was doing?
3. What was the setting in which she worked?
4. What were her sources of, and obstacles to, job satisfaction?

The questionnaire was mailed to all nurses listed by the state of North Carolina as employed in a community mental

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[2]Carol D. DeYoung, Margaret Tower, et al., The Nurse's Role in Community Mental Health Centers--Out of Uniform and into Trouble (St. Louis: C. V. Mosby Co., 1971), p. 1.

health center. Anonymity of response was assured. Descriptive statistical analysis of the data was done by computer.

Scope and Limitations

The population surveyed included all nurses working in CMHC's in North Carolina in 1973, and was limited to the geographical borders and personnel numbers in that state at that time. The data included both subjective and objective conclusions on the part of the respondents. The analysis of the data was done by descriptive statistical methods. (The existing data from this study could be cross-tabulated by inferential statistical methods, for inferential use.) Since the entire population of the group in the setting to be studied was polled, generalizability of conclusions is probably limited to other areas with needs and circumstances similar to those of North Carolina.

CHAPTER II

REVIEW OF THE LITERATURE

The triad of psychiatrist, psychologist, and social worker formed the professional staff of the first psychiatric outpatient clinics, the child guidance clinics.[1] Adult outpatient psychiatric services were patterned after this model, with the psychiatrist identified as the primary therapist, the psychologist engaged to do testing, and the social worker added for liaison and casework.[2] Many community mental health centers, some of which developed from child guidance clinics and adult outpatient psychiatric clinics, have continued to use this model of staffing, even though the demands for services are now different.

Among the four major professions dealing with patients in community mental health centers, nurses, by a far higher percentage than others, have been found to derive their chief job satisfaction from working with patients.[3]

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[1]Willa D. Abelson, A Clinic in the Community: 1913-1963 Half Century of Psychiatric Service (New Haven: Clifford Beers Guidance Clinic, 1966), p. 4.

[2]Characteristics and Professional Staff of Outpatient Psychiatric Clinics (U.S. Department of HEW, Public Health Monograph No. 49, 1957), p. 2-3.

[3]Raymond N. Glasscote, John E. Gudeman, et al., The Staff of the Mental Health Center (Washington, D.C.: The

Even though close to 88% of the people with health problems are to be found in the community rather than in institutions, nurses have always been numerically low in outpatient psychiatry.[4]

This paradox ". . . derives historically from the traditional ties of the psychiatric nurse to the psychiatric hospital setting, and currently from the relative unclarity concerning the role of the psychiatric nurse in a community program."[5]

In 1973, ten years after the funding of the Community Mental Health Centers Act, and eight years after the NIMH special project (grant #MH-08229) "The Psychiatric Nurse in Community Psychiatry,"[6] was undertaken at Maimonides Community Mental Health Center, only two percent of the money allocated to staff salaries of mental health centers went to the category of staff in which nurses were usually included, that is, ". . . other staff."[7]

Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, 1969), p. 25.

[4]Jerome P. Lysaught, lecture delivered at "Symposium 1973--Dyadic Dilemma: Doctor-Nurse Roles and Relationships," Durham, North Carolina, February 1973.

[5]Gertrude A. Stokes, ed., A Giant Step: The Roles of Psychiatric Nurses in Community Mental Health Practice (Brooklyn, New York: Faculty Press, Inc., 1969), p. 20.

[6]Stokes, p. 20.

[7]Franklin D. Chu and Sharland Trotter, Nadar Report on Community Mental Health Centers, Volume I (1973), Chapter II, p. 13.

Some reasons why nurses were not employed in CMHC's in any numbers may have included Huber's finding that ". . . many nurses signified a willingness that their functions be defined by other disciplines or that they be gradually evolved."[8] Similarly, Saunders wrote of the changing role of the nurse that ". . . the rate and direction of change are possibly largely outside the control of nurses themselves."[9]

Since the landmark document Action for Mental Health urged an expanded program of mental health services and expenditures in 1961,[10] and since the passage of the Community Mental Health Centers Act (P.L. 88-164) in 1963, several studies of mental health center personnel have been undertaken. These studies were from several different perspectives: an in-depth study of a few centers;[11] a study

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[8]Helen Huber, "Defining the Role of the Psychiatric Nurse," Journal of the Fort Logan Mental Health Center 1 (Winter 1963): 99.

[9]Lyle Saunders, "The Changing Role of Nursing," in Bonnie Bullough and Vern Bullough, eds., Issues in Nursing (New York: Springer Publishing Co., Inc., 1966),p. 118. Reprinted with permission from The American Journal of Nursing 54 (1954): 1094-98.

[10]Action for Mental Health: Final Report of the Joint Commission on Mental Illness and Health (New York: John Wiley & Sons, 1961).

[11]Chu and Trotter, p. 13.

of one profession in one center;[12] or a study in which another professional supplies information about nursing.[13] Glasscote's The Staff of the Mental Health Center is a detailed study of facts about and attitudes of mental health center personnel including nurses. The present paper describes a study in which all of the nurses working in CMHC's in one state supplied objective and subjective information about themselves and their work.

A term used frequently to describe what nurses do in their clinical practice is "role." Sarbin defined "role" as ". . . the organized actions of a person coordinate with a given position."[14] Parsons defined role similarly.[15] Saunders defined role as ". . . collective expectations."[16] Given the classic definitions of role, not to mention its chronic defiance of definition in nursing, this investigator decided to use other parameters. These were, broadly speaking, the skill and special preparation of the nurse, the setting in which she worked, the activities in which she engaged, and her motivation/satisfaction determinants.

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[12]Stokes, p. 3.

[13]Glasscote, et al., p. 178.

[14]Theodore R. Sarbin, "Role Theory," Chapter 6 in Gardner Lindzey, ed., Handbook of Social Psychology (Cambridge, Massachusetts: Addison-Wesley Publishing Co., Inc., 1954), p. 225.

[15]Talcott Parsons, The Social System (Glencoe: The Free Press, 1951).

[16]Saunders, p. 118.

These general parameters, were fairly consistently found in the literature to be influential in the nature and quality of work done. Brophy's research, studying nurses specifically ("Self, Role, and Satisfaction"), found a positive relationship among expected functions, actual functions, and satisfaction.[17] Haynes and Massie discounted the monistic theory of motivation and adopted the pluralistic hierarchy of needs theory to explain job satisfaction.[18] Saunders discussed the characteristics for which nurses are usually rewarded or not rewarded, leading to the interpretation of satisfaction as both a motivator and an outcome.[19] Slocum, et al., tested Maslow's need theory and found that, "Job performance was significantly correlated with the fulfillment of self-actualization needs for professional employees."[20]

Ullman named skills and special training of individuals, and the social structure of the system as two of the three factors which he believed influence the nature

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[17]Alfred L. Brophy, "Self, Role and Satisfaction," Genetic Psychology Monographs 59 (1959): 263-308.

[18]Warren W. Haynes and Joseph L. Massie, Management--Analysis, Concepts, and Cases (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1969), pp. 102-141.

[19]Saunders, pp. 121-122.

[20]John W. Slocum, et al., "An Analysis of Need Satisfaction and Job Performance Among Professional and Paraprofessional Hospital Personnel," Nursing Research 21 (July 1972) 4: 338-342.

of work accomplished.[21] Alutto, et al., found support for the concept of "side bets," i.e., investments in one's work, as important in understanding an individual's commitments to an organization or profession.[22] Lysaught concluded that "the two pervasive "facts" that surround all consideration of nursing motivation are that most nurses are women and that nursing is viewed from a context of eleemosynary thinking."[23] Lysaught's "facts" have implications in the areas of compensation for nurses and control over the professional "role." The studies of Glasscote, Chu, Stokes, and DeYoung, mentioned above, have all emphasized function as emminently descriptive of a profession's usefulness in mental health centers.[24]

After the original burst of literature documenting the activity of nurses in CMHC's in the late 1960s and early 1970s, little of note has been added to the literature relevant for this study.

From the above studies, interviews with mental health nurses, and personal experiences, the following

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[21]Stokes.

[22]Joseph A. Alutto, "On Operationalizing the Concept of Commitment," Social Forces 51 (June 1973) 4: 448.

[23]Jerome P. Lysaught, "Motivation in Nursing," in Action in Nursing--Progress in Professional Purpose (New York: McGraw-Hill Book Company, 1974), p. 316.

[24]Glasscote, Chu, Stokes and DeYoung, et al.

methodology and the specific questions for the questionnaire were derived.

CHAPTER III

METHODS

Purpose

The purpose of this study was to provide descriptive information that could be used to further a broader and more effective use of nursing professionals in CMHC's in North Carolina. This study was intended to provide planners with data on a professional group that is often thought to function in a more limited way than that which they can offer, frequently accomplish, and often want to pursue. By answering in a written questionnaire the major questions of who the CMHC nurses were, what they did, where they did it, and how they liked what they did, the respondents supplied data useful to these purposes.

Population

The population included all nurses, defined as R.N.s or L.P.N.s, working either full or part time in North Carolina community mental health centers in 1973. A list of all nurses was provided by the North Carolina Department of Mental Health, and numbered 68. Only one was an L.P.N. At times it was difficult to tell exactly which agency some of the nurses worked for; for example, a nurse on the state

list wrote that she was really employed by the Department of Public Health, although she spent part of her time with mental health cases. She and any others who were not direct employees of the Department of Mental Health were not included in the population.

Setting

The setting was the state of North Carolina. Located in the south Atlantic coast region, North Carolina has a land mass of 48,798 square miles. In 1970 North Carolina had a population of 5,082,059 with a median family income of $7,770, and a median educational level of 10.6 years. The median age of North Carolina residents was 26.6 years. Over one-third of the jobs in the state were in manufacturing.[1]

North Carolina had four state-run mental hospitals, four state centers for the mentally retarded, and five alcoholic rehabilitation centers in 1973. Also, there were eighty-five other state community mental health programs, administered by about 63 mental health centers. (Some CMHC's had outreach and children's clinics under the CMHC umbrellas, but with distinct names of their own.) Of these community mental health programs, 36 employed nurses under the

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[1]County and City Data Book, 1972, A Statistical Abstract, William Lerner, Director (Washington, D.C.: U.S. Department of Commerce, Bureau of Census, 1973), pp. 2, 3, and 5.

Department of Mental Health.[2]

Development of Tools

A questionnaire (Appendix 1) was developed to gather information on the following four questions:

1. How was the nurse working in a CMHC in North Carolina prepared for her job?
2. What were the things she was doing?
3. What was the setting in which she worked?
4. What were her sources of, and obstacles to, job satisfaction?

Questions were developed from readings, interviews, experience, and interest. Questions relevant to the four main areas of inquiry were mixed in the questionnaire, because this arrangement seemed more readable and interesting.[3] The format of questions varied considerably, including fill-in-the-blanks, rankings, selection of one answer, selection of all answers that applied, and "yes/no" choices. Lists of choices given in the questions were arranged

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[2]"Institutions of North Carolina Department of Mental Health," list provided by the North Carolina Department of Mental Health, Raleigh, North Carolina, April 1973.

[3]For reference, it may be noted that: questions 1-10, 49, 52-55 and 57-61 are demographic/educational; questions 12, 14-26, 28, 29, 39-41, and 48 concern setting; questions 13, 27, 34-38, and 43 concern functions; and questions 21-23, 30-33, 40, 42, 44-46, 48, 50, 51, and 56 concern satisfaction. Several questions concern both setting and satisfaction.

alphabetically in an attempt to downplay bias; and words were defined or underlined whenever this was presumed to be helpful to the reader. Some data not immediately useful were requested in anticipation of a future cross tabulation of the results of this study.

The next to last draft of the questionnaire was pretested on five selected individuals who had recently functioned as nurses in CMHC settings, but who were not part of the population (Appendix II, Pretest Worksheet). The pretesters were asked to comment on the format, content, and method of presentation of the questionnaire. All of them returned the Pretest Worksheet, and some of their comments were incorporated into the final questionnaire.

The questionnaire ran to ten pages, comprising 238 variables. Since long questionnaires are often considerable obstacles to getting responses, and since the original population was only 68 nurses, the cover letter for the questionnaire was carefully planned. Ideas in the cover letter intended to motivate a response included the following: identification of the population as a special group; identification of the surveyors as colleagues; use of a direct request for help; use of North Carolina Nurses' Association Psychiatric/Mental Health Conference Group sanction of the study; use of anticipatory reward; and use of explicit time directions. Yellow envelopes were used to help the questionnaire stand out on a crowded desk (Appendix

III, Cover Letter).

The four Regional Mental Health Commissioners were informed of the study by Ms. Helen Tighe of the State Mental Health Department. The North Carolina Nurses' Association Psychiatric/Mental Health Conference Group agreed to the use of their name in the cover letter as proponents of the study. Also they lent their support in the form of a title for the return address of correspondence, "Conference Group Study."

Administration of Tools

The questionnaire was mailed to the entire population under consideration with the cover letter, and with a stamped, self-addressed return envelope. The population was informed of the anonymity procedure by means of a statement attached to the questionnaire: no center or individual was to be identified in any report resulting from this study.

The summary of results was to be sent to the whole population of nurses, thereby not singling out those who had responded. Anonymity of response was protected by coding to a master list of the population. As each response was received, the name was crossed off the master list and the code number was removed from the questionnaire. The list of participants was destroyed after the expected sample was returned.

A period of eighteen days from the date of mailing was allowed before a follow-up letter with another questionnaire was sent to those persons who had not yet responded (Appendix IV). Forty-nine out of 68 replied before the follow-up letters went out.

A telephone protocol for further follow-up was developed (Appendix V), but was not used. Sixty-five out of a population of 68 returned their questionnaires after 28 days, so more follow-up was unnecessary.

Statistical Methodology

The different types of answers in the questionnaire made it more difficult to prepare the data for computer analysis, and to interpret the data, than if questions had been all of one or two types. Fill-in-the-blank answers had to be grouped for the computer. Variable labels were derived for each of the 238 variables.

Computer analysis began six weeks after the initial mailing of the questionnaire. Since the whole population under consideration was to be used, and since the purpose was descriptive, inferential statistical methods were ruled out. A straight frequency distribution, standard deviation, mean, mode, median, relative frequency in percentages, relative adjusted frequency in percentages, and cumulative-relative adjusted frequency in percentages were obtained on each variable.

After computerization, answers that were numbers, such as percentages of time, had to be lumped into meaningful divisions in order to fit into tables for presentation. For the tables rankings were cut off after the first three, because the top three usually included most responses and meaningfulness. Some results indicated that the question involved probably contained some weakness in structure or content. These problems are indicated in the "Analysis and Interpretation of Data."

CHAPTER IV

ANALYSIS AND INTERPRETATION OF DATA

Typical Profiles from Questions to be Answered

The following four profiles of a "typical" North Carolina CMHC nurse in 1973, her work setting, nursing activities, and job satisfactions were drawn from the computerized descriptive data analysis of responses to the questionnaire. Sixty-five out of 68 nurses responded to the questionnaire, making a 96% return rate. This compared favorably with other studies employing questionnaires. For his written questionnaire, Glasscote's return rate for nurses in his study was 60%.

Profile of CMHC Nurse. The "typical" nurse working in a CMHC in North Carolina was prepared for her job by a three year diploma education in nursing. This included training in psychiatric acute and chronic in-patient care, but not outpatient care. The typical nurse had more than three years of psychiatric experience. She worked full time, and had worked in the CMHC fewer than five years. She was the newest of the four core mental health professionals to enter CMHC work.

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[1]Raymond N. Glasscote, John E. Gudeman, et al., The Staff of the Mental Health Center (Washington, D.C.: The Joint Information Service of the American Psychiatric

The CMHC nurse found her general nursing background helpful in her work, but felt that she needed more training in specific treatment modalities. She had received multi-disciplinary continuing education from the CMHC within the past six months. If opportunity were to present itself, she would seek more formal nursing education.

Profile of CMHC Setting. The typical setting for a CMHC nurse was a center employing up to 25 people, one to three of whom were nurses. The CMHC had been open for five or more years, and it provided at least four of the five "essential services" of inpatient care, outpatient care, emergency care, partial hospitalization, and consultation and education. The mental health center employed the usual range of mental health professionals and paraprofessionals. The typical administrative director came from the original triumvirate of psychiatry, psychology, or social work--three professions also typically having the most informal influence in the center. The other mental health professionals had typically been with the center for two years more than the nurse.

The nurse usually felt equal to the social worker or other nurses in her working relationships. The center staff usually formed social subgroups on the basis of friendship.

Association and the National Association for Mental Health, 1969), p. 9.

Staff meetings in the typical center were held for the purpose of sharing information and discussing problems. The nurse participated in these meetings by entering the discussions spontaneously.

The typical center rewarded the nurse for her skill more than for any other trait. Poor communication in the center was the main difficulty for the usual nurse; the nurse's own ideas of what she should do and her past training were the main things that helped make her work easier.

The typical CMHC setting had clinical supervision available, although it was not required. The nurse preferred to choose her own supervisor on the basis of clinical skill. She saw her supervisor when needed, not at regular meetings. The nurse supervised non-professional people, as a rule.

The typical setting did not offer the nurse written evaluations of her job performance. However, the typical CMHC had a program expansion while the nurse worked there, and asked her to assume new responsibilities. The CMHC gave the typical nurse official permission and support for her wide range of activities, and accepted her decisions and/or recommendations about those activities. The typical center rewarded the nurse for her work by approval from other staff.

Profile of Nurse's Activities. The typical nurse

worked from a job description that was written either by or for her individually; this job description fit the work she did fairly well. If the job description differed from the nurse's actual work, it was because the nurse did more than the job description specified, her duties having broadened since she was hired.

The typical nurse's activities included the full range of mental health services offered by the CMHC, except for research and inpatient care. She spent most of her time in direct clinical practice with adult acute and chronic outpatients. She felt competent to work either independently or with supervision in all functional areas of the CMHC, except for the area of research. The typical nurse rarely felt the need to justify her activities to anyone else; however, when she did, it was to the other professionals in the center.

Profile of Nurse's Satisfactions. The typical CMHC nurse relied on her own ideas of what she should do. The support of other nurses had little positive effect on her work, (maybe because there were few other nurses around to give support), but support from other co-workers was helpful. Good communication was important to the typical nurse. She liked her work as well or better than she had expected to like it.

Clinical treatment was her most satisfying activity, and paperwork was least satisfying. She was satisfied that

her work met the needs of her patients, the center, and (lowest score) herself. The typical nurse would have preferred to be rewarded by a salary increase and more clinical authority, rather than by her typical reward of approval from others.

The typical nurse was satisfied that her salary was commensurate with her formal educational level. However, she did not think that it was commensurate with either her responsibilities or her activities. Whether or not her salary was commensurate with her experiential level was not asked of the nurses. The typical nurse was paid between $7,000 and $9,000 per year.

The typical nurse felt that her opportunities for professional growth and education were good to excellent in her present job. She planned to stay in CMHC work. She did not have a preference for other types of nursing.

Comparison of Profiles with Other Studies. The typical nurse in North Carolina's CMHC may be compared to the nurses in Glasscote's in-depth study of the staffs of eight CMHC's around the country. The North Carolina nurses had less formal education than Glasscote's nurses, but had a similar percentage of training needs once on the job, mostly in the area of specific treatment modalities. The North Carolina nurses were less mobile geographically. The North Carolina nurses were more experienced than their counterparts in Glasscote's study, and therefore they were

presumably older. Like Glasscote's nurses, the North Carolina nurses indicated that their chief satisfaction on the job was in working with patients. About 30% of the nurses were dissatisfied with the attitudes of fellow staff members and with the organization of the centers, which was very close to Glasscote's findings of dissatisfaction.[2]

The settings in which nurses in North Carolina worked differed from the centers that Glasscote and others studied, in some important ways. The North Carolina centers were considerably smaller. They were often located in rural areas, rather than in the large, urban settings which predominated in the other studies. The setting differences had implications for the type of nurses hired, persons with more formal education generally being more available in large cities. In Glasscote's study, 69% of the nurses were immigrants to their center's area, i.e., to a large city.[3] The less mobile nurses in North Carolina brought to their frequently small settings in which they worked many of the shared style and background advantages of the "indigenous worker," in addition to their professional training.

This study agreed with Glasscote's finding that nurses spent more time in direct service to patients than

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[2] Ibid., p. 125.

[3] Ibid., p. 177.

in any other activity.[4] Also, the functional aspects of their work in North Carolina reflected ". . . the tendency to use staff as 'generalists,' with a strong degree of overlap of activity among the disciplines."[5]

The range of the North Carolina community mental health nurse's activities was surely the widest of any mental health professional, encompassing medical, social, and psychological aspects of patient care. This can be graphically seen, along with some interesting exceptions to the general profiles, in the more detailed presentation of data that follows.

Detailed Results of the Data

Nurses were asked to check the most recent degree or certificate that they held in nursing.

TABLE 1

MOST RECENT DEGREE

Degree	Absolute Frequency	Relative Frequency (%)
ADN	5	7.7
BSN	14	21.5
DIPLOMA	40	61.5
LPN	1	1.5
MS	2	3.1
OTHER	3	4.6

[4]Ibid., p. 165.

[5]Ibid., p. 85.

There were far more diploma graduates in nursing than any other kind. Only two respondents held advanced degrees. There was only one L.P.N.

The nurses were asked to indicate the length of their psychiatric experience.

TABLE 2

LENGTH OF PSYCHIATRIC EXPERIENCE

	Absolute Frequency	Relative Frequency (%)	Cumulative Frequency (%)
0 to 11 months	5	7.7	7.7
1 year to 2 years 11 months	19	29.2	36.9
3 years to 4 years 11 months	12	18.5	55.4
5 years to 9 years 11 months	18	27.7	83.1
more than 10 years	11	16.9	100.0

There was a broad spread in the length of experience of the nurses, but only five had had less than one year's experience. This contrasted with Glasscote's finding that one-third of the nurses came directly from training.[6]

The nurses were asked whether or not they received

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[6] Ibid., p. 177.

psychiatric clinical experience during their nursing education.

TABLE 3

PSYCH EXPERIENCE IN BASIC EDUCATION

Yes		No	
#	%	#	%
56	86.2	9	13.8

Most of the nurses had psychiatric experience in their clinical education. Considering that nine did not, one might deplore the fact that any nursing education program could graduate a potential nurse without psychiatric experience. A similar omission of obstetrics or medical-surgical nursing would be unthinkable; and yet, over 50% of the nation's hospital beds are filled with the mentally ill, making some education in the specialty imperative for all nurses.

Nurses were asked to check the types of psychiatric experience they received during their nursing education. Using the list shown below, they were to check all the types that applied. The 13.8% who had no psych experience were asked to omit this question. See Table 4, page 27.

Most striking in Table 4 are the predominance of chronic and acute inpatient experiences and the low CMHC and outpatient figures. It would seem that nursing

TABLE 4

TYPE PSYCH EDUCATIONAL EXPERIENCE

	Yes		No	
	#	%	#	%
in-patient	45	69.2	20	30.8
out-patient	13	20.0	52	80.0
acute	41	63.1	24	36.9
chronic	38	58.5	27	41.5
state hospital	35	53.8	30	46.1
other hospital	30	46.2	35	53.8
community MHC	5	7.7	60	92.3

education was perpetuating the traditional psychiatric nursing role by the experiences offered to students. The trend to CMHC's and outpatient treatment had been under way for ten years by the time of this study.

The nurses were asked to check one answer for how they had heard of their present job.

TABLE 5

HOW HEARD OF PRESENT JOB

	#	%
nurse sought job	32	49.2
nurse was sought	30	46.2
both	2	3.1
missing response	1	1.5

These figures show no definite patterns. This writer had expected a higher percentage of the nurses to have actively sought their CMHC jobs, following other indicators that nurses in CMHC's often need to "sell" their skills and abilities to other mental health professionals.

Nurses were asked to check one of two answers indicating why they thought they were hired.

TABLE 7

WHY NURSES WERE HIRED

	Yes		No	
	#	%	#	%
to fill position already there	34	52.3	31	47.7
position created for me	31	47.7	34	52.3

This table and the preceding one seem to indicate that about one-half of the nurses were actively sought out and accommodated for their present position. It would be interesting to know what traits of the nurses were thought useful by those who created positions for them.

Nurses were asked to check one answer indicating how long they had worked at the CMHC.

TABLE 7

HOW LONG WORKED AT CMHC

	#	%	Cumulative %
0 to 11 months	13	20.0	20.0
1 year to 2 years 11 mos.	29	44.6	64.6
3 years to 4 years 11 mos.	11	16.9	81.5
5 years to 9 years 11 mos.	11	16.9	98.5
over 10 years	1	1.5	100.0

Over two-thirds had been in the center for fewer than three years. Since 92.3% of the centers had been open for more than three years, it can be seen that nurses were indeed the last of the core mental health professionals to be added to the CMHC staffs.

The nurses were asked to check one answer indicating how many hours per week they worked in the CMHC system. Part-time was considered to be less than 32 hours per week, and full time was considered to be 32 or more hours per week.

TABLE 8

NURSES WORK FULL OR PART TIME

	Yes		No	
	#	%	#	%
full time	61	93.8	4	6.2
part time	4	6.2	61	93.8

Nearly all of the nurses worked full time, thereby presumably increasing the level of their commitment to their CMHC over that of part time personnel.[7]

A fill-in-the-blank question was used to find out how many total clinical staff were employed by the centers.

TABLE 9

NUMBER CLINICAL STAFF EMPLOYED

	#	%	Cumulative %
1-25	40	61.5	61.5
26-50	18	27.7	89.2
51-75	6	9.2	98.5
over 75	1	1.5	100.0

About two-thirds of the mental health clinics that employed nurses had 25 or fewer staff members. These centers were considerably smaller than most of the centers investigated by Chu, Glasscote, and Stokes.

The total number of nurses working in the CMHC was written in a blank space by the respondent nurses. See Table 10, page 31.

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[7] Joseph A. Alutto, "On Operationalizing the Concept of Commitment," Social Forces 51 (June 1973) 4: 448.

TABLE 10

NUMBER OF NURSES WORKING IN CENTERS

Number	Frequency	Percent	Cum. Percent
1	19	29.2	29.2
2	15	23.1	52.3
3	13	20.0	72.3
4	7	10.8	83.1
5	2	3.1	86.2
6	6	9.2	95.4
7	3	4.6	100.0

The mean number of nurses in each center was 2.8, with S.D. of 1.8; median, 2.4; and mode, 1.0.

Nearly 30% of the clinics employing nurses employed only one nurse. With 85 separate CMHC locations administered by about 63 CMHC's, North Carolina had at least 27 CMHC's that did not employ even one nurse.

Nurses were asked to check one answer indicating how long their center had been open for services. See Table 11, page 32.

The centers had been open, for the most part, considerably longer than they had employed the nurses.

The nurses were asked to check all of the five essential services that their centers provided.

TABLE 11

NUMBER OF YEARS CENTER OPEN

# of Years	Frequency	Percent	Cum. Percent
1 to 3	5	7.7	7.7
3 to 5	16	24.6	32.3
5 to 10	26	40.0	72.3
Over 10	18	27.7	100.0

TABLE 12

SERVICES PROVIDED BY THE CENTERS

Service	yes #	yes %	No #	No %
In-patient	33	50.8	32	49.2
Out-patient	65	100.0	0	0.0
Emergency	50	76.9	15	23.1
Partial hosp.	39	60.0	26	40.0
Consult. & Education	63	96.9	2	3.1

Outpatient services were the only ones provided by all of the centers. Inpatient services were sometimes contracted out to local hospitals, with staffing provided by the hospital. Some clinics obviously got started with fewer than the "essential services" in operation.

Nurses were asked to fill in the percentage of time that they spent in each of the five essential services.

TABLE 13

PERCENT TIME SPENT IN BASIC FIVE SERVICES

	0		1-25		25-50		50-75		75-100	
	#	%	#	%	#	%	#	%	#	%
In-patient	49	75.4	12	18.5	2	3.1	2	3.1	0	0
Out-patient	5	7.7	13	20.0	3	4.6	17	26.2	27	41.5
Emergency	26	40.0	35	53.8	3	4.6	0	0	1	1.5
Part hosp.	40	61.5	11	16.9	1	1.5	3	4.6	10	15.4
C & E	9	13.8	46	70.7	8	12.3	2	3.1	0	0

Time in outpatient services consumed the largest amount of time. Most of the nurses did at least some consultation and education. The amount of time spent in inpatient services was very low.

The nurses were asked to check on a list of types of workers of all those employed in their centers. See Table 14, page 33.

Most of the centers had most of the types of workers; paraprofessionals and business administrators were the types of workers most often found missing.

The nurses were asked to check one answer giving the professional background of the administrative directors of their centers.

TABLE 14

TYPES OF WORKERS FOUND IN CENTERS

Name	Yes		No	
	#	%	#	%
Business adm.	39	60.0	26	40.0
Paraprofess.	45	69.2	20	30.8
Psychiatrist	54	83.1	11	16.9
Psychologist	60	92.3	5	7.7
Social worker	62	95.4	3	4.6
Other profess.	58	89.2	7	10.8

TABLE 15

BACKGROUND OF CENTER'S ADMINISTRATIVE DIRECTOR

Name	Frequency	Percentage
Business	8	12.3
Nursing	3	4.6
Psychiatry	17	26.2
Psychology	10	15.4
Social work	20	30.8
Other	6	9.2
Missing response	1	1.5

When pertaining to work setting, the 65 responses actually refer to the 36 centers having nurses.

About three-fourths of the directors were from the three professions traditionally associated with outpatient clinics: psychiatry, psychology, and social work. Nurses comprised three of the administrative directors. The two nurses working in CMHC's in North Carolina with masters degrees in nursing were not administrative directors.

Nurses were asked to rank the persons having informal influence in their centers.

TABLE 16

PERSONS WITH MOST INFORMAL INFLUENCE

Name	First #	First %	Second #	Second %	Third #	Third %	Cum.% %
Business adm.	10	15.4	12	18.5	5	7.7	41.6
Nurse	5	7.7	9	13.8	10	15.4	36.9
Paraprofessionals	0	0	4	6.2	0	0	6.2
Psychiatrist	26	40.0	9	13.8	7	10.8	64.6
Psychologist	3	4.6	14	21.5	14	21.5	47.6
Secretary	8	12.3	4	6.2	1	1.5	20.0
Social worker	9	13.8	6	9.2	14	21.5	44.5
Other	2	3.1	2	3.1	2	3.1	9.3
Missing response	2						

Psychiatrists were ranked first cumulatively in informal influence. Nurses ranked themselves fifth in informal influence. Although there was wide latitude in the

responses, the cumulative rankings roughly paralleled the levels of formal education and salary. Perhaps this paralleling of salary, education, and influence supports Osborne's theory that in the United States, prestige derives as much from pay level, office space, travel allowances, and other trappings as it does from competency. He argued that to achieve the truly interdisciplinary approach so helpful in mental health, all professional staff should be accorded parity pay, space and allowances.[3] In order to have relevant influence in the system, nurses need parity benefits with other professionals.

Nurses were asked to check all applicable responses to the question of who on their center staffs they felt on the same level with in their working relationships. See Table 17, page 37.

Not all centers had all of the types of workers listed, so the number of centers lacking each profession should also be noted in looking at the results of this question. Most nurses felt equal to the social workers in their centers, and more than half felt equal to the psychologists and other professionals. Most centers had these groups on their staffs.

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[3] Oliver H. Osborne, "Issues in Achieving Effective Professional Alliances," Hospital and Community Psychiatry 26 (April 1975): 207-213.

TABLE 17

PROFESSIONS ON LEVEL WITH IN WORKING RELATIONSHIP

Name	Yes		No		# Without	
	#	%	#	%	#	%
Business adm.	13	20.0	52	80.0	26	40.0
Nurse	39	60.0	26	40.0	0	0
Paraprofessional	9	13.8	56	86.2	20	30.8
Psychiatrist	15	23.1	50	76.9	11	16.9
Psychologist	33	50.8	32	49.2	5	7.7
Secretary	10	15.4	55	84.6	?	?
Social worker	50	76.9	15	23.1	3	4.6
Other profess.	39	60.0	26	40.0	7	10.8

The nurses were asked to rank the ways in which they were members of any social subgroupings among the center staffs.

TABLE 18

WAYS NURSES SUBGROUP SOCIALLY WITH STAFF

	First		Second		Third		Cum.Percent
	#	%	#	%	#	%	%
Friendship	19	29.2	9	13.8	7	10.8	53.8
Profession	11	16.9	8	12.3	7	10.8	40.0
Program	8	12.3	11	16.9	10	15.4	44.6
N/A *	18	27.7	-	-	-	-	27.7
No answer	9	13.8	-	-	-	-	13.8

"N/A" signifies "not applicable" in this paper.

A total of 41.5% either answered "not applicable," or failed to answer at all, possibly indicating some problem with the question's structure. About one-third of the nurses ssid that friendship was the first basis for subgroupings.

Nurses were asked to rank the top three purposes of total staff meetings in their centers.

TABLE 19

PURPOSE OF TOTAL STAFF MEETINGS

Name	First		Second		Third		Cum.%
	#	%	#	%	#	%	%
Advise decision makers	5	7.7	1	1.5	1	1.5	10.3
Case conference	12	18.5	5	7.7	3	4.6	30.8
Make decisions	3	4.6	7	10.8	10	15.4	30.8
All share info.	18	27.7	17	26.2	8	12.3	66.2
Dir. shares info.	14	21.5	11	16.9	2	3.1	41.5
Planning	5	7.7	2	3.1	10	15.4	26.2
Discuss problems	0	0	14	21.5	19	29.2	50.7
Group maintenance	4	6.2	4	6.2	5	7.7	20.1
No meetings	3	4.6	-	-	-	-	4.6
No answer	1	1.5	-	-	-	-	1.5

Information sharing by all was the purpose which scored highest. Group maintenance ranked low as a purpose of meetings. Possibly the term was unfamiliar to the respondents; or possibly this was a hidden agenda of meetings rather than a stated purpose.

The nurses were asked to check one answer indicating how they usually participated in total staff meetings.

TABLE 20

NURSES PARTICIPATION IN STAFF MEETINGS

Label	#	%	Adj.%
Unable to go	1	1.5	1.7
Discuss if asked	4	6.2	6.7
Discuss with discomfort	4	6.2	6.7
Discuss spontaneously	51	78.5	85.0
No answer	5	7.7	-

Of the five persons who did not answer, three or possibly four did not have total staff meetings. The overwhelming majority of nurses entered into discussion spontaneously.

Nurses were asked to rank those qualities for which they were rewarded in their work.

TABLE 21

QUALITIES FOR WHICH NURSES REWARDED

	First		Second		Third		Cum.%
	#	%	#	%	#	%	%
Cooperation	8	12.3	8	12.3	7	10.8	35.4
Caution	0	0	0	0	0	0	0
Dependability	13	20.0	5	7.7	15	23.1	50.8
Knowledge	13	20.0	13	20.0	9	13.8	53.8
Like change	1	1.5	0	0	2	3.1	4.6
Oppose change	0	0	0	0	0	0	0
Progressive	6	9.2	4	6.2	5	7.7	23.1
Resourceful	8	12.3	11	16.9	11	16.9	46.1
Skill	16	24.6	17	26.2	9	13.8	64.6

While the author intended for the responses to be about extrinsic rewards, this was not spelled out in the questionnaire. Nurses were rewarded for their skill above all, with knowledge, dependability, and resourcefulness following. Caution and opposition to change were not rewarded at all. Qualities related to function seemed to be more important than those related to attitude.

It seems paradoxical that nurses felt more rewarded for their skill, when much of the literature about nurses in CMHC's assumes that they came to the work with a good base on which to build, but generally unskilled. Perhaps most

of these nurses had been in community mental health long enough to pick up needed skills. (Recall that they were more experienced than those in Glasscote's study.) In light of the fact that their past training and the attitudes gained in training were considered a major help in the nurses' work, it is likely that a sizable part of the basic education and ideology carried over to the community mental health field.

Nurses were asked to rank the listed items that made their work easier.

TABLE 22

WHAT MADE NURSES' WORK EASIER

	First		Second		Third		Cum.%
	#	%	#	%	#	%	%
Good communica.	12	18.5	6	9.2	8	12.3	40.0
Highly org.	0	0	0	0	0	0	0
Informality	3	4.6	6	9.2	10	15.4	29.2
Job description	3	4.6	1	1.5	0	0	6.1
Own ideas	21	32.3	11	16.9	7	10.8	60.0
Past training	12	18.5	18	27.7	5	7.7	53.9
Support of others	8	12.3	11	16.9	16	24.6	53.8
Support of nurses	2	3.1	9	13.8	7	10.8	27.7
Supervisor	7	10.8	2	3.1	7	10.8	24.7

Their own ideas of what they should do represented the most important aid in making the nurses' work easier. Past training and attitudes acquired then were also important. A highly organized setting was not considered helpful at all. The support of other nurses was only half as important as the support of other professionals (this result may have been skewed by the nineteen nurses who worked as the only nurse in their settings).

Nurses were asked to rank the listed items that made their work more difficult.

TABLE 23

WHAT MADE NURSES' WORK MORE DIFFICULT

	First		Second		Third		Cum.%
	#	%	#	%	#	%	%
Poor communica.	23	35.4	10	15.4	2	3.1	53.6
High organization	1	1.5	0	0	0	0	0
Low organization	6	9.2	11	16.9	4	6.2	32.3
Job description	4	6.2	2	3.1	1	1.5	10.8
Own ideas	2	3.1	2	3.1	1	1.5	7.7
Past training	4	6.2	2	3.1	1	1.5	10.8
Attitudes of oth.	8	12.3	6	9.2	4	6.2	27.7
Low nsg. support	5	7.7	1	1.5	5	7.7	16.9
Supervisor	0	0	2	3.1	3	4.6	7.7

Poor communication was by far the biggest problem to the nurses--which is rather ironic for professionals who deal in communication. Low organization in the centers presented some form of a problem to about one-third of the nurses; this may have had some relationship to the poor communication problem. While not speaking of nurses per se, Glasscote presumed that those staff members who perceived communication to be a problem were most probably ". . . the staff members who, having come to work in a 'new' type of health facility, are looking for data that will help them to understand their role expectations."[9]

The nurses were asked to check one answer on the availability of clinical supervision in their centers.

TABLE 24

AVAILABILITY OF CLINICAL SUPERVISION

	#	%
Required	9	13.8
Available upon request	55	84.6
Not available	1	1.5

Only one nurse was unable to obtain clinical supervision

[9] Glasscote, p. 123.

in her center. Clinical supervision was required of 13.8% of the nurses.

The ways in which nurses acquired their clinical supervisors were listed, and the nurses were asked to select one answer.

TABLE 25

HOW ACQUIRED CLINICAL SUPERVISOR

	#	%
Assign for profess.	17	26.2
Assign for skill	7	10.8
Chose for profess.	12	18.5
Chose for skill	27	41.5
No answer	2	3.1

When nurses selected their own clinical supervisors, they selected the supervisor on the basis of his skill rather than his professional identity. However, when a supervisor was assigned to the nurse by someone else, he was selected for his professional background more often than for his skillfulness.

Nurses were asked to check one reply indicating how much they usually saw their clinical supervisors.

TABLE 26

HOW MUCH NURSES SAW SUPERVISOR

	#	%
Ad lib, informally	20	30.8
Ad lib, by appt.	21	32.3
At evaluation	0	0
By note/telephone	0	0
Case Conf. or group superv.	2	3.1
Occas., often after needed	1	1.5
Regular meetings	19	29.2
No answer	2	3.1

Most of the nurses saw their supervisors as needed. About 30% had regular meetings with their supervisors.

The nurses were asked to check all of those whom they supervised clinically. See Table 27, page 46.

Most nurses did not supervise other professionals. Nearly 40% did not supervise anyone. Usually nurses supervised students, paraprofessionals, and other nurses.

Nurses were asked if they received a written evaluation of their work. See Table 28, page 46.

It is evident that written evaluations of their work were relatively rare for the CMHC nurses. Possibly they received some other type of evaluation, but this was not

TABLE 27

WHOM NURSES SUPERVISED CLINICALLY

	Yes		No	
	#	%	#	%
Nurse	17	26.2	48	73.8
Paraprofessional	23	35.4	42	64.6
Psychiatrist	0	0	65	100.0
Psychologist	4	6.2	61	93.8
Secretary	12	18.5	53	81.5
Social worker	8	12.3	57	87.7
Student	23	35.4	42	64.6
Other profess.	14	21.5	51	78.5
None	25	38.5	40	61.5

TABLE 28

WRITTEN JOB EVALUATIONS - YES OR NO

	#	%
Yes	15	23.1
No	50	76.9

asked about in the questionnaire.

Nurses who received written evaluations were asked to indicate who wrote the evaluations of their work, and how often they received the evaluations.

TABLE 29

WHO WRITES NURSES' EVALUATIONS

	#	%
Director	7	10.8
Program head	2	3.1
Clinical supervisor	5	7.7
Other	1	1.5
N/A	50	76.9

TABLE 30

HOW OFTEN NURSES GET WRITTEN EVALUATIONS

	#	%
Every 1/2 year	4	6.2
Every year	11	16.9
N/A	50	76.9

Of the few nurses who received written evaluations, 73.3% received them yearly.

The nurses were asked if they worked from a job description, and if so, who wrote it.

TABLE 31

NURSES WHO WORKED FROM JOB DESCRIPTION

	#	%
Yes	46	70.8
No	18	27.7
Missing	1	1.5

TABLE 32

WHO WROTE JOB DESCRIPTION

	#	%	Adj.%
Another nurse	1	1.5	2.1
Director	9	13.8	19.1
Hosp. adminis.	0	0	0
Physician	0	0	0
Self	20	30.8	42.6
Predecessor	0	0	0
Supervisor	3	4.6	6.4
Do not know	4	6.2	8.5
Other	10	15.4	21.3
N/A	18	27.7	-

Most of the nurses worked from a job description. It is interesting that 42.6% of those with a job description wrote it themselves. Since as DeYoung and Tower observed,

other professions are not well acquainted with the variety of educations and meaning of nursing experiences, having nurses write their own job descriptions may be viewed as a flexible and positive approach.[10]

Nurses were asked to indicate how well their job descriptions fit the work they were doing in their centers.

TABLE 33

HOW JOB DESCRIPTION FITS WORK DONE

	#	%	Cum.% (Adj.)
Very well	15	23.1	31.9
Fairly well	25	38.5	85.1
Not very well	6	9.2	97.9
Not at all	1	1.5	100.0
N/A	18	27.7	-

Of those with job descriptions, nearly all had job descriptions fitting their work at least fairly well.

Nurses whose job descriptions did not fit their work "very well" were asked to indicate whether they did more or less than their job descriptions called for.

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[10] Carol DeYoung, Margaret Tower, et al., The Nurse's Role in Community Mental Health Centers--Out of Uniform and into Trouble (St. Louis: C. V. Mosby Co., 1971), p. 96.

TABLE 34

HOW JOB DESCRIPTION/WORK DIFFER

	#	%
Do less than job description	3	4.6
Do more than job description	28	43.1
N/A (plus 1 no answer)	34	52.3

Very few nurses did a smaller range of activities than their job descriptions covered, and most did more.

The nurses were asked to check one answer indicating how their duties had changed since they were hired.

TABLE 35

DUTY CHANGES SINCE NURSES WERE HIRED

	#	%
Broadened	55	84.6
Narrowed	4	6.2
Remained same	5	7.7
No answer	1	1.5

Most of the nurses had experienced a broadening of their duties.

The nurses were asked to check all applicable answers showing why their duties had changed since they were

hired. (A missing response counted as a "no.")

TABLE 36

WHY DUTIES CHANGED AFTER NURSES WERE HIRED

	Yes		No	
	#	%	#	%
Program expansion	46	70.8	19	29.2
Program decrease	0	0	65	100.0
Nurse asked for new respon.	29	44.6	36	55.4
Nurse was asked do new respon.	45	69.2	20	30.8
Acquired new skills	30	46.2	35	53.8
Could not do what asked	0	0	65	100.0
Concentrated efforts	13	20.0	52	80.0
Others left	13	20.0	52	80.0
Other	6	9.2	59	90.8

Since no nurse answered that she had been unable to do something asked of her or had been affected by a program decrease, it may be assumed that the narrowing of duties for a few nurses indicated in Table 35, occurred because they had concentrated their efforts in one area.

The nurses were not shy about asking for new responsibilities, with over 44 percent doing so. A sizable number changed duties when they acquired new skills; with 70.8% experiencing program expansion, the need for upward

professional mobility was probably great. The question on why duties had changed would have given more information on the relative importance of the reasons for changes if it had been a ranking question.

The nurses were asked to check all categories of CMHC activities in which they functioned.

TABLE 37

ACTIVITIES OF THE CMHC NURSES

	Yes		No	
	#	%	#	%
Administration	41	63.1	24	36.9
Crisis intervention	49	75.4	16	24.6
Diagnosis	42	64.6	23	35.4
Family therapy	31	47.7	34	52.3
Group therapy	48	73.8	17	26.2
Individual therapy	62	95.4	3	4.6
In-pt management	19	29.2	46	70.8
Medication management	53	81.5	12	18.5
Consult. & Education	53	81.5	12	18.5
Home visits	43	66.2	22	33.8
Intake interviews	54	83.1	11	16.9
Referrals to & from	60	90.3	5	7.7
Research	6	9.2	59	90.8
Supervision	33	50.8	32	49.2

It was surprising to find that most nurses performed most of the activities, with the marked exception of research. This further supports the idea that CMHC workers, including nurses, are increasingly used in generic, multi-functional roles.[11] In-patient management, the nurse's traditional stomping ground, had a relatively low score, possibly because in-patient care was contracted out by many centers. A majority of the nurses frankly performed "diagnosis," which is interesting in view of the legal status of "diagnosis" at the time this study was done.

Nurses were asked to rank the main four activities in which they spent the greatest amounts of time.

TABLE 38

ACTIVITIES IN WHICH NURSES SPENT MOST TIME

	1st		2nd		3rd		4th		cum.tot.	
	#	%	#	%	#	%	#	%	#	%
Admin.	5	7.7	13	20.0	9	13.8	7	10.8	34	52.3
Clinic. prac.	56	86.2	4	6.2	3	4.6	1	1.5	64	98.5
C&E	2	3.1	14	21.5	6	9.2	16	24.6	38	58.5
Home vis.	0	0	4	6.2	13	20.0	4	6.2	21	32.3
Intake	2	3.1	19	29.2	10	15.4	5	7.7	36	56.4
Referals	0	0	1	1.5	11	16.9	12	18.5	24	36.9
Research	0	0	1	1.5	0	0	0	0	1	1.5
Superv.	0	0	5	7.7	8	12.3	6	9.2	19	29.2

[11] Glasscote, p. 85.

Clinical practice was by far their main activity, which is not surprising considering that direct care is nursing's traditional, learned, and most enjoyed function.

Comparison of Tables 37 and 38 with Glasscote's more detailed analysis of staff functions showed that North Carolina's nurses were doing more individual therapy than Glasscote's, even though their level of education indicated less likelihood that they had been trained for it.[12] Perhaps group therapy was not utilized as much in North Carolina's smaller centers as it was in the large centers of Glasscote's study. North Carolina's CMHC nurses appeared to spend more time in direct clinical practice than Glasscote's nurses did, although in both studies that was the area of greatest function.[13]

The nurses were asked to indicate their feelings of adequacy to perform in the functional areas of CMHC work. If supervision was not necessary for safe functioning in an area, this was considered to be working "independently." See Table 39, page 55.

Since the figures in Table 39 do not equal the figures given in Table 37 on activities the nurses actually performed, it is likely that some nurses answered question 39 on the basis of what they actually did, whereas some

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[12]Ibid., p. 161.

[13]Ibid., p. 165.

TABLE 39

NURSES' ADEQUACY IN MAJOR FUNCTIONAL AREAS

	Independently		With Supervision		No		No Answer	
	#	%	#	%	#	%	#	%
Admin.	23	35.4	27	41.5	10	15.4	5	7.7
Crisis int.	37	56.9	24	36.9	2	3.1	2	3.1
Diagnosis	14	21.5	41	63.1	7	10.8	3	4.6
Fam. ther.	22	33.8	25	38.5	10	15.4	8	12.3
Group ther.	34	52.3	22	33.8	5	7.7	4	6.2
Indiv. ther.	49	75.4	14	21.5	1	1.5	1	1.5
In-pt.	26	40.0	12	18.5	8	12.3	19	29.2
Medication	19	29.2	41	63.1	2	3.1	3	4.6
C&E	41	63.1	20	30.8	2	3.1	2	3.1
Home visit	56	86.2	3	4.6	3	4.6	3	4.6
Intake	56	86.2	4	6.2	3	4.6	2	3.1
Referral	51	78.5	10	15.4	2	3.1	2	3.1
Research	8	12.3	21	32.3	17	26.2	19	29.2
Supervision	38	58.5	13	20.0	4	6.2	10	15.4

others answered on the basis of their competence to perform the activities. Despite the ambiguity in question design, certain patterns emerged. Nurses in general felt competent to function safely in those areas that Table 37 shows the majority of them worked in, with the rather marked exceptions of diagnosis and medication management. When compared with

the other activities done by a majority of the nurses, the activities of diagnosis and medication management were said to require supervision by larger percentages of nurses. Perhaps an awareness of the legal etiquette with diagnosis and medication management influenced the response. Most of the nurses felt competent to function independently in intake, referral, home visits, and individual therapy. They also felt competent to function in consultation and education, even though these are provinces for which the nurses almost certainly received no formal training. In the therapeutic modalities, nurses felt that they needed the most supervision for family and group therapy.

The nurses were asked to indicate whether or not they felt they had official permission and support from their centers to cover their activities in the functional areas. See Table 40, page 57.

A comparison of Table 40 with Table 37 indicates that apparently this question was answered by some nurses on the basis of what they were actually doing and by others on the basis of what they could do.

In brief, most nurses thought they had official permission and support for most of the activities, particularly the ones most often performed.

It would be interesting to know how this "official permission and support" was communicated to the nurses.

TABLE 40

OFFICIAL PERMISSION AND SUPPORT FOR ACTIVITIES

	Yes		No		Uncertain		No Answer	
	#	%	#	%	#	%	#	%
Admin.	39	60.0	13	20.0	8	12.3	5	7.7
Crisis int.	54	83.1	4	6.2	4	6.2	3	4.6
Diagnosis	46	70.8	5	7.7	10	15.4	4	6.2
Fam. Ther.	49	75.4	7	10.8	3	4.6	6	9.2
Group ther.	54	83.1	5	7.7	2	2.1	4	6.2
Indiv. ther.	61	93.8	2	3.1	1	1.5	1	1.5
In-pt.	33	50.8	4	6.2	9	13.8	19	29.2
Medic.	56	86.2	3	4.6	3	4.6	3	4.6
C&E	55	84.6	4	6.2	1	1.5	5	7.7
Home visit	55	84.6	2	3.1	4	6.2	4	6.2
Intake	59	90.8	4	6.2	0	0	2	3.1
Referral	60	92.3	1	1.5	1	1.5	3	4.6
Research	20	30.8	16	24.6	12	18.5	17	26.2
Supervision	47	73.3	4	6.2	7	10.8	7	10.8

Glasscote and Chu[14,15] found that quality control in the form of treatment review committees or other such means was

[14]Ibid., p. 186.

[15]Franklin D. Chu and Sharland Trotter, Nadar Report on Community Mental Health Centers, Volume I (1973), Chapter II, pp. 117-118.

often absent in the laissez-faire atmospheres of the CMHC's they studied. Peer review, in the form of PSRO (Professional Standards and Review Organization) actions, has been slow to be organized and will probably be a long time in getting to nursing outpatient activities.[16] At the time of the study, diagnosis was an illegal act for a nurse. Perhaps support for nurses acting in the functional areas evolved, as Stokes found, through gradual acceptance of the nurse's proven abilities.[17]

The nurses were asked to check one answer indicating how others in the CMHC's accepted their decisions and/or recommendations concerning each area of activity. See Table 41, page 59.

In general the nurses' decisions/recommendations were accepted most often in those areas where they worked most. Family therapy, administration, and supervision received the lowest scores, not counting research and inpatient management, which were done by relatively few.

The nurses were asked how often they felt a need to justify what they did in their work to listed categories of people. See Table 42, page 60.

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[16]Interview with Duane Barlow, Washington, D.C., April 24, 1976. Exec. Dir., NE N.C. PSRO, Inc.

[17]Gertrude A. Stokes, ed., A Giant Step: The Roles of Psychiatric Nurses in Community Mental Health Practice (Brooklyn, New York: Faculty Press, Inc., 1969), p. 38.

TABLE 41

ACCEPTANCE BY OTHERS OF NURSING DECISIONS

	Often		Sometimes		Rarely		No Answer	
	#	%	#	%	#	%	#	%
Admin.	27	41.5	27	14.5	5	7.7	6	9.2
Crisis int.	49	75.4	10	15.4	2	3.1	4	6.2
Diagnosis	38	58.5	21	32.3	4	6.2	2	3.1
Fam. ther.	29	44.6	16	24.6	5	7.7	15	23.1
Group ther.	42	64.6	13	20.0	3	4.6	7	10.8
Ind. ther.	56	86.2	6	9.2	1	1.5	2	3.1
In-pt.	29	44.6	7	10.8	8	12.3	21	32.3
Medication	52	80.0	11	16.9	0	0	2	3.1
C&E	46	70.8	15	23.1	2	3.1	2	3.1
Home visit	47	72.3	7	10.8	1	1.5	10	15.4
Intake	54	83.1	5	7.7	4	6.2	2	3.1
Referral	56	86.2	5	7.7	1	1.5	3	4.6
Research	10	15.4	16	24.6	14	21.5	25	38.5
Supervision	32	49.2	17	26.2	7	10.8	9	13.8

Eleven nurses at times felt a need to justify their actions to other nurses in the centers. Nearly one-half needed often or sometimes to justify their actions to other professionals in the center.

TABLE 42

THOSE TO WHOM NURSES NEED JUSTIFY ACTIONS

	Often		Sometimes		Rarely		No Ans.	
	#	%	#	%	#	%	#	%
Clients/patients	4	6.2	11	16.9	49	75.4	1	1.5
Nurses in ctr.	3	4.6	8	12.3	42	64.6	12	18.5
Nurses in commun.	1	1.5	12	18.5	50	76.9	2	3.1
Other profess in ctr.	1	1.5	29	44.6	34	52.3	1	1.5
Other profess. in commun.	2	3.1	20	30.8	42	64.6	1	1.5

Nurses were asked how often they felt satisfied with their work in meeting the needs of listed groups.

TABLE 43

SATISFACTION IN MEETING NEEDS

	Often		Sometimes		Rarely		No Answer	
	#	%	#	%	#	%	#	%
Clients/Pts.	56	86.2	8	12.3	0	0	1	1.5
Center	46	70.8	17	26.2	1	1.5	1	1.5
Self	40	61.5	22	33.8	3	4.6	0	0

All of the nurses were often or sometimes satisfied with their work in meeting the needs of their patients. The figures for the nurses' satisfaction in meeting their needs through CMHC work were high. Since there is, according to Brophy's theory, ". . . a positive relationship between

vocational satisfaction and occupational role acceptance,"[18] it would seem that the functions and expectations associated with the CMHC nurses were generally to their liking. Many of the nurses wrote their own job descriptions, sought out their own jobs, and performed in a wide variety of ways; so, perhaps the settings contributed to the chance for the nurses to build individually self-fulfilling roles for themselves.

The nurses were asked to indicate the percentages of time that they worked with listed patient groups.

TABLE 44

TIME SPENT WITH VARIOUS PATIENT GROUPINGS

	Using Time #	%	Mean % time	Mode % time	Use 25% + time	No time
Children	28	43.1	11.0	5.0	3	37
Adolescents	32	50.3	12.3	5.0	3	32
Adults,A&D	36	55.4	14.3	5.0	5	29
Adult-acute	58	89.2	23.4	10.0	25	7
Adult-chr.	64	98.5	38.4	50.0	44	1
Geriatric	46	70.8	9.8	10.0	2	19
Ment.ret.	45	69.3	11.6	5.0	3	20

[18] Alfred L. Brophy, "Self, Role and Satisfaction," Genetic Psychology Monographs 59 (1959): 281.

There was a wide range of times reported within each patient group. It is clear that in North Carolina in 1973, CMHC nurses spent most of their time with the chronic adult patient population. Acute adult patients also were seen by most of the nurses, but a great deal more time was spent with chronic patients than with any other group. Undoubtedly, working with chronic adult patients met the need for services in the nurses' communities. Chu and Trotter expressed ". . . a point of view, which growing numbers of mental health professionals share, that we must establish priorities to care for the most severely disabled in the light of our limited resources in mental health. . . ."[19]

DeYoung et al. wrote of the fact that in CMHC's, nurses usually acquire a case load heavy with chronic patients, and called this phenomenon ". . . the dumping syndrome."[20] It has been suggested that nurses may be more comfortable with illness than with wellness, and show their practical competence best when working with the most disabled individuals.[21] Possible reasons why nurses often carry much of the chronic loads in their centers have been explored in other studies. To illustrate, Glasscote said

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[19]Chu, p. 21.

[20]DeYoung, p. 98.

[21]Ibid.

that his nurses were dissatisfied with the treatment programs in their centers because they did not really understand chronicity, relapsing and phasic mental illness, and therefore were more easily discouraged.[22] DeYoung, however, said that the nurse can work well with chronic patients because she can be satisfied with ". . . less tangible results than curing."[23] In North Carolina, the chronic patients would have been most like those whom the nurses would have encountered during their training experiences, which took place mostly in hospitals.

The nurses were asked to indicate how well their jobs fit their expectations.

TABLE 45

EXPECTATIONS VERSUS LIKING JOB

	#	Rel.Freq.	Cum.Freq.
Like more than exp.	34	52.3	52.3
Like as well as exp.	26	40.0	92.3
Like less than exp.	4	6.2	-
No answer	1	1.5	-

[22] Glasscote, p. 112.

[23] DeYoung, p. 98.

A majority liked their jobs more than they had expected to; and nearly all of the nurses liked their jobs at least as well as they had expected to like them. Assuming that few people would take a job expecting to dislike it, the results of this question speak well for the vocational satisfaction of the CMHC nurses. According to Brophy's research on nurses, there is a positive relationship between an expected function, actual function, and satisfaction.[24]

The nurses were asked to list two of their work activities which gave them the most personal satisfaction.

TABLE 46

MOST PERSONALLY SATISFYING ACTIVITIES

	Absolute Freq.	Relative Freq.%
Administration	5	7.7
Clinical treatments	45	69.2
Consul. & Education	8	12.3
Home visits	5	7.7
Children	7	10.8
Adolescents	2	3.1
Drug & Alcohol	2	3.1
Chronic emot. prob.	7	10.8
Geriatrics	1	1.5
Ment. retardation	2	3.1
Acute situations	2	3.1
No answer	6	9.3

[24] Brophy, p. 281.

There were two spaces for favorite items; 32 nurses wrote one answer, 27 nurses wrote two answers, and six did not respond. The categories were not all mutually exclusive, so subjective judgment was used in compiling the data from this question. Some persons listed patient groups as their favorite and others listed therapeutic activities applicable to any patient group; because of this blurring, the results are not as definitive as they might be. Clinical treatments were the most satisfying activities for most nurses, which agrees with Glasscote's findings.[25]

The nurses were asked to list two of their work activities which gave them the least personal satisfaction.

TABLE 47

LEAST PERSONALLY SATISFYING ACTIVITIES

	Absolute Freq.	Relative Freq.%
Administration	7	10.8
Paper work	30	46.2
Consul. & Educ.	2	3.1
Intake	3	4.6
Medications	7	10.8
Children	3	4.6
Adolescents	1	1.5
Drug and alcohol	5	7.7
Chronic problems	8	12.3
Geriatrics	2	3.1
Mental retardation	4	6.2
No answer	14	21.5

[25]Glasscote, p. 106.

Paper work led in unpopularity; medications, chronic patients, and administration were somewhat less unpopular--again showing the nurses' preference for direct patient contact. While few people in any mental health profession would be expected to rank "paper work" as a favorite, the listing of "paper work" by so many nurses may have indicated some special problems. Perhaps new forms had been introduced, the nurses' paper work load had increased, or the patient load left little time for paper work. It would be interesting to know.

The nurses were asked to rank the top three ways their work was usually rewarded by their center.

TABLE 48

WAYS WORK USUALLY REWARDED BY CENTER

	1st		2nd		3rd		N/A	
	#	%	#	%	#	%	#	%
Approval	31	47.7	16	24.6	3	6.2	14	21.5
Salary	6	9.2	12	18.5	16	24.6	31	47.7
Adm.auth.	10	15.4	4	6.2	11	16.9	40	61.5
Clin. auth.	7	10.8	18	27.7	8	12.3	32	49.2
Not rewarded	10	15.4	2	3.1	2	3.1	51	78.5
Other	0	0	2	3.1	2	3.1	61	93.8

As noted earlier in Table 21, the nurses felt most rewarded for their skill, knowledge, and dependability. Table 48 indicates that the reward was most often in the form of approval from other staff. Administrative

authority was a reward more often than was clinical authority. Fifteen percent of the nurses were usually not rewarded at all; these nurses would be expected to have relatively poor organizational morale,[26] particularly if they saw other professionals being rewarded in some way. "The concept of relative deprivation holds that people evaluate their environmental rewards in comparison with the amount of reward typically attained by members of groups to which they belong."[27]

The nurses were asked to rank the top three ways they would have preferred to see their work rewarded

TABLE 49

HOW NURSES WOULD PREFER WORK REWARDED BY CENTER

	1st		2nd		3rd		N/A	
	#	%	#	%	#	%	#	%
Approval	14	21.5	9	13.8	10	15.4	32	49.2
Salary	27	41.5	14	21.5	5	7.7	19	29.2
Adm. auth.	4	6.2	7	10.8	7	10.8	47	72.3
Clin. auth.	2	3.1	12	18.5	16	24.6	35	53.8
No change	13	20.0	1	1.5	0	0	51	78.5
Other	3	4.6	2	3.1	3	4.6	57	87.7

[26] Ibid., p. 127.

[27] Brophy, p. 270.

There was a semantic problem with the categories from which the respondents had to choose, in that "no change" could have been taken to mean either that no change was desired in the reward system or that no changes at all would be a reward. This investigator intended for "no change" to mean that the respondent was happy with the way she was being rewarded, thereby creating an overlap with other categories.

Salary was the most desired reward, possibly because the aforementioned concept of relative deprivation was operating within the CMHC professional staffs. If one accepts Osborne's theory that salary meets more than subsistence needs in our society, the nurses' desire for that type of reward can be seen as a desire to meet some of Maslow's "higher" needs for status and self-esteem.[28]

The nurses were asked to indicate whether or not they planned to stay in CMHC work.

TABLE 50

PLAN TO STAY IN CMHC WORK

	Absolute Freq.	Relative Freq.%
Yes	51	78.5
No	1	1.5
Uncertain	13	20.0

[28]Oliver H. Osborne, "Issues in Achieving Effective Professional Alliances," Hospital and Community Psychiatry 26 (April 1975): 207-213.

Most of the nurses planned to stay in the field of community mental health. A fair percentage, 20% were uncertain, and one would like to know what had affected their decisions.

The nurses who were uncertain or planning to change jobs were asked to indicate what would influence them most to leave CMHC work.

TABLE 51

WHY NURSES WOULD LEAVE CMHC WORK

	Absolute Freq.	Relative Freq.%
Salary	9	13.8
Spouse's job	4	6.2
Dependents	8	12.3
Poor job satisfaction	14	21.5
Prefer other nursing	1	1.5
Role conflicts with others	0	0
Tired of working	2	3.1
Other	4	6.2

It is obvious from the figures in Table 51 that some of the nurses who planned to stay in CMHC work answered this question, which diluted the results. Poor job satisfaction was a reason for about 20%; however, some

of the respondents may have been answering hypothetically. Possibly the most interesting thing in this table is the fact that none of the nurses either were leaving or would leave their jobs because of role conflicts with other disciplines. Much has been written about the role conflicts in CMHC work, and about the problems of nurses faced with them. Apparently, the nurses either had found a way of handling the extended role conflicts, or the issue was not perceived as a big problem.

TABLE 52

SALARY SCALE SUITABILITY

	Yes		No		No Ans.	
	#	%	#	%	#	%
Suits preparation	36	55.4	26	40.0	3	4.6
Suits responsibilites	20	30.8	41	63.0	4	6.2
Suits activities	23	35.4	39	58.5	3	4.6

The general dissatisfaction with salary is indicated by the table. Just over half of the nurses thought the salary fit their education, which was predominantly from diploma schools of nursing (see Table 1). The nurses indicated a much poorer fit between salary and activities or responsibilities. The issue of parity pay, determined by a multifaceted evaluation of CMHC personnel qualifications, may have been a factor in the nurses' dissatisfaction

with the appropriateness of their salaries. "In this connection, many studies point out that employees are less concerned with the absolute level of their wages than in their relationship to the wages of other workers.[29]

The nurses were asked to indicate their annual salary range.

TABLE 53

ANNUAL SALARY RANGES

	Absolute Freq.	Relative Freq.	Cum. Freq.
Under $5,000	2	3.1	3.1
$5,000-6,999	6	9.2	12.3
$7,000-8,999	36	55.4	67.7
$9,000-11,000	11	16.9	84.6
Over $11,000	10	15.4	100.0

The bulk of the nurses made between $7,000 and $9,000 per year, with just over two-thirds making less than $9,000. Ten nurses made over $11,000 per year. If Table 53 were to be cross-tabulated with education and function, it could be known whether these salaries are on a parity

[29]Warren W. Haynes and Joseph L. Massie, Management--Analysis, Concepts, and Cases (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1969), p. 105.

with other professions similarly prepared and functioning. The very lowest salaries might be expected to belong to the four part time nurses and the one L.P.N., but that still leaves some very low salaries.

The nurses were asked if the requirements of their jobs had revealed any gaps in their training.

TABLE 54

DOES NURSE NEED MORE TRAINING?

	Absolute Freq.	Relative Freq.%
Yes	46	70.8
No	17	26.2
No answer	2	3.1

The 25% who said that they did not need any additional training for their work were more surprising to this writer than the 70% needing some additional training. Only graduate education in nursing specifically prepares nurses for the functions of CMHC work, and only two nurses had masters degrees in nursing. Although one cannot be sure without a cross-tabulation, it could be that the 70% needing more training roughly corresponds to the 70% with less than a BSN.

The nurses were asked to list the kinds of training they needed. Three blanks were provided.

TABLE 55

KINDS OF TRAINING NURSES NEED

	Absolute Freq.	Relative Freq.%
Administration	8	12.3
Crisis Intervention	1	1.5
Diagnosis	1	1.5
Family ther.	9	13.8
Group ther.	22	33.9
Individual ther.	14	21.5
Medications	5	7.7
Research	3	4.6
Consul. & Education	3	4.6
Intake	1	1.5
Supervision	3	4.6

The training needs were similar to those Glasscote found in his study, with nurses needing clinical training more than any other kind.[30] Administrative training was needed by about the same percentage of nurses as in Glasscote's study.[31] Since nurses usually carried substantial clinical responsibilities in their centers, it was not surprising that this was the area in which they felt

[30]Glasscote, p. 84.

[31]Ibid.

the greatest need.

The nurses were asked to indicate how helpful their general nursing education in other specialty areas was to their CMHC work.

TABLE 56

HOW USEFUL IS GENERAL NURSING IN CMHC

	Absolute Freq.	Relative Freq.	Cum. Freq.
Necessary	11	16.9	16
Very helpful	23	35.4	52.3
Helpful	29	44.6	96.9
Not helpful	2	3.1	100.0

Nearly all of the nurses found their general nursing education to be at least a help, and a majority considered it to be either very helpful or necessary to their work. General nursing was not absolutely necessary to many nurses, so the picture of the CMHC nurse in North Carolina as a "generalist" is reinforced by this data.

The nurses were asked to indicate how they saw the opportunities for continued professional growth and education in the centers. See Table 57, page 75.

Roughly one-third of the nurses considered the opportunities for growth and education to be poor or fair, and roughly two-thirds considered them to be good or

TABLE 57

PROFESSIONAL GROWTH AND EDUCATION OPPORTUNITIES

	Absolute Freq.	Relative Freq.	Cum. Freq.
Excellent	13	20.0	20.0
Good	28	43.1	63.1
Fair	28	30.8	93.9
Poor	4	6.2	100.0

excellent.

The nurses were asked to indicate whether or not they had received any form of continuing education while working at the CMHC.

TABLE 58

INCIDENCE OF CONTINUING EDUCATION

	Absolute Freq.	Relative Freq.
Yes	60	92.3
No	5	7.7

Those who had received continuing education were asked to list all of the providers of the continuing education.

Many of the nurses had received continuing education

TABLE 59

WHO PROVIDED CONTINUING EDUCATION

	Yes		No	
	#	%	#	%
Education institute	39	60.0	26	40.0
Profess. organiz.	25	38.5	40	61.5
State Dept. of MH	34	52.3	31	47.7
CMHC	48	73.8	17	26.2
Other	14	21.5	51	78.5

from several sources. Their own CMHC had conducted continuing education for about three-fourths of the nurses.

The nurses were asked to indicate whether or not the continuing education had been multidisciplinary.

TABLE 60

WHO CONTINUING EDUCATION WAS FOR

	Abs.Freq.	Rel.Freq.
Multidisciplinary	45	69.2
For nurses only	10	15.4
Both	5	7.7
No answer	5	7.7

Most of the continuing education was multidisciplinary,

probably an advantage in fostering the team approach to mental health care in the centers.

The nurses were asked to indicate how long it had been since they had attended a continuing education session.

TABLE 61

HOW LONG SINCE CONTINUING EDUCATION

	Abs.Freq.	Rel.Freq.
0 to 6 months	44	67.7
7 to 12 months	13	20.0
More than 1 year	4	6.2
No answer	4	6.2

About two-thirds of the nurses had had some form of continuing education within six months; for about one-third, it had been longer than that. Maybe one reason why one-third of the nurses named their opportunities for growth in the center to be only poor to fair was the infrequency of continuing education.

The nurses were asked whether or not they would seek another degree or certificate in nursing, circumstances permitting. See Table 62, page 78.

Over 80% of the nurses said that they would seek more nursing education if they had the opportunity. Since nearly that many planned to stay in mental health work,

TABLE 62

INTEREST IN ANOTHER NURSING DEGREE OR CERT.

	Abs.Freq.	Rel.Freq.
Yes	54	83.1
No	10	15.4
Missing	1	1.5

they must have expected nursing to contribute to their future performance in their generic roles.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

Summary

The purpose of this study was to describe nursing in community mental health centers in North Carolina in 1973, including the dimensions of setting, preparation for the job, functions and satisfactions of the nurses. All of the nurses working in North Carolina CMHC's in 1973 were sent a written questionnaire, consisting of 61 questions of varying format. The questionnaire was designed to gather data to answer the following questions:

1. How were the nurses prepared for their jobs?
2. What did the nurses do?
3. What were the settings in which they worked?
4. What were their sources of, and obstacles to, job satisfaction?

The data were analyzed by computerized descriptive statistical methods.

The literature review focused on the following two areas: historical background and other studies of CMHC personnel, and literature used to develop the questionnaire. The development of the questionnaire and of all research

methods used were detailed in the study.

Nearly all of the nurses responded to the questionnaire. Though some answers showed wide diversity, there were some definite trends.

On the basis of the questionnaire results, general profiles of a "typical" nurse working in a North Carolina CMHC, her work setting, activities, and her satisfactions were provided. A detailed analysis of all data collected in the study was then presented.

Conclusions

In the early stages of this study, much time was spent in designing a tool that would interest the population, with more emphasis on comprehensiveness than on later ease of collation and presentation of the data. Consequently, the return rate of respondents (96%) was superb; and the presentation of data was cumbersome. More demographic data on the nurses' previous employment, dependents, length of time since formal education, and immigration would have been helpful in describing the nurses who entered the CMHC field in North Carolina. Some of the data were planned for cross-tabulation, and were of marginal interest in this presentation.

The most startling thing about the results of this study was the percentage of response--nearly the entire population responded, 65 out of 68. This was beyond the

most optimistic hopes, considering the length and complexity of the questionnaire. Perhaps, somehow, issues near to the respondents' experiences were suggested; or maybe having a chance to describe their situations helped bring in the responses.

As stated in the introduction the results from this study were consistent with Glasscote's finding that nurses preferred direct work with people.[1] The CMHC nurses were not directly prepared for their new roles by their education, but seemed to find a substantial carryover in usefulness of their basic education. They performed what is surely the largest range of activities of any mental health professional, testifying to the broad base of their preparation.

These nurses related that they spoke out spontaneously at staff meetings, and many of them sought their jobs and wrote their job descriptions. They valued good communication and their own ideas of what they should do. They chose their supervisors, when possible, for skill, and they felt rewarded for their own skills. Nearly all of the nurses did more than they had been doing when hired, and they were moving in the direction of increased

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[1] Raymond N. Glasscote, John E. Gudeman, et al., The Staff of the Mental Health Center (Washington, D.C.: The Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, 1969), p. 85.

responsibility. The nurses by-and-large functioned independently with sanction from their centers and acceptance of their decisions in those areas with which they were familiar. They were generally satisfied with their work relative to meeting the needs of patients. They liked their work and most of them planned to stay, although they would have liked to reorder the extrinsic reward system somewhat.

With all of the confidence and excitement about their work displayed in the responses, there was also a recognition of problems--even a rare bitter comment in the margin. Nurses ranked themselves well below other professionals in informal influence, and they supervised few people. The third most frequent cause of work difficulties was unpleasant attitudes of other professionals. Nurses got little formal feedback on their job performance. They needed to justify their actions to other professionals in the center more than to any other group, and nursing support was not appreciably helpful. Approval was the most frequent reward, and salaries were for the most part low. Even though they had relatively low influence and status among mental health professionals, the North Carolina nurses were performing more mental health activities than any other professional group.

From this study one can see that nurses in North Carolina's community mental health centers were doing many

things that were not envisioned in their basic education. Furthermore, they were not being asked to return to their traditional functions because of inadequacy when presented with new expectations. On the contrary, North Carolina's CMHC nurses were both asking for and being asked to assume greater duties and responsibilities.

Recommendations

The following recommendations are offered on the basis of the results from this study and supporting literature.

1. Results in Table 4 indicate that very few of the nurses in the CMHC's had outpatient experiences during their professional education. However, the trend has been toward outpatient care for psychiatric patients for at least thirteen years. The State Board for Nursing for North Carolina should require that all schools of nursing accredited by them will provide psychiatric theory and experience in both in-patient and out-patient settings.
2. Block found that nurses scored second (just under psychologists, but well above social workers, special educators, and psychiatrists) on the Community Mental Health Ideology Scale, which measured professional attitudes on: (1) prevention

of mental illness through environmental intervention, (2) focus on the total population, and (3) involvement of a variety of community resources in working with the mentally ill.[2] This study indicates, however, that nurses were used primarily in direct service to patients. It is recommended that CMHC's in North Carolina capitalize on the potential nurses provide for consultation and education services as well as direct care.

3. DeYoung contended that the most effective development of the nurse's role in mental health occurs with masters prepared nurses in an outpatient setting. Graduate education is helpful in carrying an independent case-load, and in interdisciplinary communication, consultation, and education.[3] This study documents the contribution nurses are already making in community mental health services in North Carolina.

It is recommended that an effort be made to recruit

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[2]William E. Block, "The Study of Attitudes About Mental Health in the Community Mental Health Center," Community Mental Health Journal 10 (1974): 216-220.

[3]Carol D. DeYoung, Margaret Tower, et al., The Nurse's Role in Community Mental Health Centers--Out of Uniform and into Trouble (St. Louis: C. V. Mosby Co., 1971), p. 8, 87.

nurses with advanced preparation in psychiatric nursing into the CMHC's, with compensation and responsibilities on a par with their colleagues from the other mental health professions. There is a great demand for these master's prepared nurses in teaching and administration, and of late the rewards for them have been greater in those areas, in both compensation and recognition.

4. Osborne and Haynes and Massie discussed the fact that parity compensation improves organizational loyalty and facilitates communication among professions.[4] This study documents the fact that, although nurses actually "thought and did" community mental health with an unparalleled lattitude among the professions, their influence was relatively low. In order to improve their status, and consequently their chances of being heard in the system, it is recommended that standards of preparation, experience, and function be set up along with a parity compensation scale at the state level for psychiatric/mental health nurses. A suggested model might be that of the

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[4]Oliver H. Osborne, "Issues in Achieving Effective Professional Alliances," Hospital and Community Psychiatry 26 (April 1975): 207-213. Warren W. Haynes and Joseph L. Massie, Management--Analysis, Concepts, and Cases (Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1969), p. 102-141.

APPENDIX 1

QUESTIONNAIRE

Questionnaire for Nurses
Working in Community Mental Health Centers
in North Carolina

PLEASE LEAVE BLANK

1. ____
2. ____
3. ____
4. ____

1. What is the most recent degree or certificate that you hold in nursing? (PLEASE CHECK ONE.) 5. ____
   ___ADN
   ___BSN
   ___Diploma
   ___Doctorate
   ___LPN
   ___MS
   ___Other (please specify) _____

2. How many years of psychiatric experience do you have? (PLEASE CHECK ONE.) 6. ____
   ___0-11 months
   ___1 year to 2 years, 11 months
   ___3 years to 4 years, 11 months
   ___5 years to 9 years, 11 months
   ___More than 10 years

3. Did you have a psychiatric clinical experience during your nursing education? 7. ____
   ___Yes ___No

If "No", go on to question 5.

4. If so, what type? (PLEASE CHECK ALL THAT APPLY.)
   ___In-patient 8. ____
   ___Out-patient 9. ____
   ___Acute 10. ____
   ___Chronic 11. ____
   ___State hospital 12. ____
   ___Other hospital 13. ____
   ___Community mental health center 14. ____

5. How did you hear about your present job? (PLEASE CHECK ONE.) 15. ____
   ___You actively looked into this job.
   ___Someone sought you out for this job.

6. Why do you think you were hired? (PLEASE CHECK ONE.) 16. ____
   ___To fill a position that was already in existence
   ___A position was created to use your skills and personality

7. How long have you worked at this center? (PLEASE CHECK ONE.) 17. ____
   ___0-11 months
   ___1 year to 2 years, 11 months
   ___3 years to 4 years, 11 months
   ___5 years to 9 years, 11 months
   ___More than 10 years

8. Current employment: (PLEASE CHECK ONE.) 18. ____
   ___I work 32 or more hours a week in the mental health center system.
   ___I work less than 32 hours a week in the mental health center system.

9. How many total staff are employed by your center (excluding secretaries and maintenance personnel)? _____ 19. ____ 20. ____

PLEASE LEAVE BLANK

10. How many nurses, including you, work at your mental health center, including outreach clinics? _____ 21. _____

11. How many years has your center been open for services? (PLEASE CHECK ONE.) 22. _____
___0-11 months
___1 year to 2 years, 11 months
___3 years to 4 years, 11 months
___5 years to 9 years, 11 months
___More than 10 years

12. Which of the "5 essential services" does your center provide? (PLEASE CHECK ALL THAT APPLY.)
___In-patient (24-hour care) 23. _____
___Out-patient 24. _____
___Emergency (including crisis and suicide services) 25. _____
___Partial hospitalization (day and/or night care) 26. _____
___Consultation and education 27. _____

13. What PER CENT of your time do you devote to the following services? (PLEASE ANSWER IN PERCENTAGES.) 28. _____
_____% In-patient services 29. _____
_____% Out-patient services 30. _____
_____% Emergency services 31. _____
_____% Partial hospitalization 32. _____
_____% Consultation and education 33. _____
34. _____
35. _____
36. _____
37. _____

14. PLEASE CHECK ALL of the types of workers at your center.
___Business administrator 38. _____
___Nurse 39. _____
___Paraprofessional (Community worker, mental health aide, etc.) 40. _____
___Psychiatrist 41. _____
___Psychologist 42. _____
___Social worker 43. _____
___Other professionals (ARC Counselors, Ministers, OT, etc.) 44. _____

15. What is the professional background of the Administrative Director of your center? (PLEASE CHECK ONE.) 45. _____
___Business
___Nursing
___Psychiatry
___Psychology
___Social work
___Other (please specify) _____

16. NUMBER IN IMPORTANCE (1=HIGH) the persons who have the most informal influence in your center. (PLEASE LEAVE BLANK THOSE WHICH DO NOT APPLY.)
___Business administrator 46. _____
___Nurse 47. _____
___Paraprofessional (Community worker, mental health aide, etc.) 48. _____
___Psychiatrist 49. _____
___Psychologist 50. _____
___Secretary 51. _____
___Social worker 52. _____
___Other professionals (ARC Counselors, Ministers, OT, etc.) 53. _____

PLEASE LEAVE BLANK

17. Who on the center staff do you feel on the same level with in your working relationship? (PLEASE CHECK ALL THAT APPLY.)

___Business administrator	54.	_____
___Nurse	55.	_____
___Paraprofessional (Community worker, mental health aide, etc.)	56.	_____
___Psychiatrist	57.	_____
___Psychologist	58.	_____
___Secretary	59.	_____
___Social worker	60.	_____
___Other professionals (ARC Counselors, Ministers, OT, etc.)	61.	_____

18. On what basis are you a member of any social groups among the center staff? (NUMBER IN IMPORTANCE THOSE WHICH APPLY, 1=HIGH)

___Personal friendship	62.	_____
___Professional discipline	63.	_____
___Program involvement	64.	_____
___Does not apply	65.	_____

19. What is the purpose of total staff meetings at your center? (NUMBER THE 3 MOST IMPORTANT, 1=HIGH)

___Advisory to Director or Executive Group, who will make decisions	66.	_____
___Case conference	67.	_____
___Decision making by the group	68.	_____
___Information sharing by all	69.	_____
___Information sharing by Director	70.	_____
___Planning	71.	_____
___Problem discussion	72.	_____
___Promoting staff spirit and relationships	73.	_____
___No meetings	74.	_____

If "No meetings", go on to question 21.

20. How much do you usually participate in total staff meetings? (PLEASE CHECK ONE.) 75. _____

___Unable to go
___Do not enter discussion
___Enter discussion when called on
___Enter discussion with discomfort
___Enter discussion spontaneously

---

1. _____
2. _____
3. _____
4. _____

21. NUMBER IN IMPORTANCE (1=HIGH) the qualities for which you are rewarded in your work. (LEAVE BLANK THOSE WHICH DO NOT APPLY.)

___Ability to cooperate	5.	_____
___Caution	6.	_____
___Dependability	7.	_____
___Knowledge	8.	_____
___Liking for change	9.	_____
___Opposition to change	10.	_____
___Progressiveness	11.	_____
___Resourcefulness	12.	_____
___Skill	13.	_____

PLEASE LEAVE BLANK

22. NUMBER IN IMPORTANCE (1=HIGH) the items below that make your work easier. (PLEASE LEAVE BLANK THOSE WHICH DO NOT APPLY.)

___Good communication in your center	14.	_____
___Things very organized	15.	_____
___Things informal and not too organized	16.	_____
___Job description	17.	_____
___Own ideas of what I should do	18.	_____
___My past training and attitudes gained there	19.	_____
___Support from other types of mental health workers	20.	_____
___Support from other nurses	21.	_____
___Your supervisor	22.	_____

23. NUMBER IN IMPORTANCE (1=HIGH) the items below that make your work more difficult. (PLEASE LEAVE BLANK THOSE WHICH DO NOT APPLY.)

___Poor communication in your center	23.	_____
___Things very organized	24.	_____
___Things informal and not too organized	25.	_____
___Job description	26.	_____
___Own ideas of what I should do	27.	_____
___My training and attitudes gained there	28.	_____
___Unpleasant attitudes of other mental health workers	29.	_____
___Lack of nursing support	30.	_____
___Your supervisor	31.	_____

24. Is clinical supervision (assistance with patient care through discussion with a "supervisor") in your center: (PLEASE CHECK ONE.) 32. _____

___Required?
___Available upon request?
___Not available?

If "Not available", go on to question 27.

25. If available, is your clinical supervisor: (PLEASE CHECK ONE.) 33. _____

___Assigned by someone else by professional discipline?
___Assigned by someone else for skill?
___Chosen by you by professional discipline?
___Chosen by you for skill?

26. If supervision is available, how much do you usually see your clinical supervisor? (PLEASE CHECK ONE.) 34. _____

___As needed, but informally, in the hallway, between meetings, etc.
___As needed, through appointments
___At evaluation time
___By note and telephone
___Only at case conferences or group supervision
___Only occasionally, often after the need has passed
___Regularly scheduled meetings at set intervals

27. Whom do you supervise clinically? (PLEASE CHECK ALL THAT APPLY.)

___Nurse	35.	_____
___Paraprofessional	36.	_____
___Psychiatrist	37.	_____
___Psychologist	38.	_____
___Secretary	39.	_____
___Social worker	40.	_____
___Student (please specify discipline) _____	41.	_____
___Other (please specify discipline) _____	42.	_____
___None	43.	_____

PLEASE LEAVE BLANK

28. Do you receive written evaluations of your work? 44. _____
___Yes ___No

If "No", go on to question 30.

29. If "Yes", from whom?_____ 45. _____
How often?_____ 46. _____
47. _____
48. _____

30. Do you work from a job description? 49. _____
___Yes ___No

If "No", go on to question 34.

31. If so, who wrote it? (PLEASE CHECK ONE.) 50. _____
___Another nurse
___Center director
___Hospital administrator
___Physician
___Self
___The person who held your job before you
___Your supervisor
___Do not know
___Other (please specify)_____

32. How well does your job description fit the work that you are doing in this community mental health center? (PLEASE CHECK ONE.) 51. _____
___Very well
___Fairly well
___Not very well
___Not at all

If "Very well", go on to question 34.

33. If your job description does not very well fit the work that you are actually doing, how does it differ? (PLEASE CHECK ONE.) 52. _____
___I am doing a <u>smaller</u> range of activities than my job description indicates.
___I am doing a <u>larger</u> range of activities than my job description indicates.

34. Have your duties changed since you were hired? (PLEASE CHECK ONE.) 53. _____
___My duties have broadened.
___My duties have narrowed.
___My duties have remained about the same.

If "They have remained about the same", go on to question 36.

35. If your duties have changed, why did the change come about? (<u>PLEASE CHECK ALL THAT APPLY</u>.)
___Center's program expanded 54. _____
___Center's program decreased 55. _____
___<u>You</u> asked to take on new responsibilities 56. _____
___You <u>were asked</u> to take on new responsibilities 57. _____
___You acquired new skills 58. _____
___You could not do the things the center wanted you to do 59. _____
___You concentrated on certain programs 60. _____
___Other personnel left 61. _____
___Other (please specify)_____ 62. _____

PLEASE LEAVE BLANK

36. Which of the following do you do? (PLEASE CHECK ALL THAT APPLY.)

___Administration (program planning, evaluation, staff assignment, etc.)	63.	
___Crisis intervention	64.	
___Diagnosis	65.	
___Family therapy	66.	
___Group therapy	67.	
___Individual therapy	68.	
___In-patient management (including partial hospitalization)	69.	
___Medication management	70.	
___Consultation and education	71.	
___Home visits	72.	
___Intake interviews	73.	
___Referrals to and from other agencies	74.	
___Research	75.	
___Supervision	76.	

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37. NUMBER IN IMPORTANCE (1=HIGH) the four activities in which you spend the greatest amount of time. (IF FEWER THAN FOUR APPLY, JUST NUMBER THOSE WHICH APPLY.)

___Administration (program planning, evaluation, staff assignment, etc.)	5.	
___Clinical practice (specific therapies and patient management)	6.	
___Consultation and education	7.	
___Home visits	8.	
___Intake interviews	9.	
___Referrals to and from other agencies	10.	
___Research	11.	
___Supervision	12.	

38. At your stage of professional development, do you feel that you can usually work adequately in the following? (PLEASE CHECK ONE ANSWER FOR EACH ACTIVITY.) (IF SUPERVISION IS NOT NECESSARY FOR YOU TO PRACTICE SAFELY IN AN AREA, CONSIDER YOURSELF TO BE WORKING "INDEPENDENTLY".)

Administration	___Independently	___With supervision	___No	13.	
Crisis intervention	___Independently	___With supervision	___No	14.	
Diagnosis	___Independently	___With supervision	___No	15.	
Family therapy	___Independently	___With supervision	___No	16.	
Group therapy	___Independently	___With supervision	___No	17.	
Individual therapy	___Independently	___With supervision	___No	18.	
In-patient management	___Independently	___With supervision	___No	19.	
Medication management	___Independently	___With supervision	___No	20.	
Consultation and education	___Independently	___With supervision	___No	21.	
Home visits	___Independently	___With supervision	___No	22.	
Intake interviews	___Independently	___With supervision	___No	23.	
Referrals	___Independently	___With supervision	___No	24.	
Research	___Independently	___With supervision	___No	25.	
Supervision	___Independently	___With supervision	___No	26.	

PLEASE LEAVE BLANK

39. Do you feel that there are official permission and support from your center to cover your activities in the following areas? (PLEASE CHECK ONE ANSWER FOR EACH ACTIVITY.)

Administration	___Yes	___No	___Uncertain	27.	_____
Crisis intervention	___Yes	___No	___Uncertain	28.	_____
Diagnosis	___Yes	___No	___Uncertain	29.	_____
Family therapy	___Yes	___No	___Uncertain	30.	_____
Group therapy	___Yes	___No	___Uncertain	31.	_____
Individual therapy	___Yes	___No	___Uncertain	32.	_____
In-patient management	___Yes	___No	___Uncertain	33.	_____
Medication management	___Yes	___No	___Uncertain	34.	_____
Consultation and education	___Yes	___No	___Uncertain	35.	_____
Home visits	___Yes	___No	___Uncertain	36.	_____
Intake interviews	___Yes	___No	___Uncertain	37.	_____
Referrals	___Yes	___No	___Uncertain	38.	_____
Research	___Yes	___No	___Uncertain	39.	_____
Supervision	___Yes	___No	___Uncertain	40.	_____

40. Do others in your center accept your decisions and/or recommendations concerning the following? (PLEASE CHECK ONE ANSWER FOR EACH ACTIVITY.)

Administration	___Often	___Sometimes	___Rarely	41.	_____
Crisis intervention	___Often	___Sometimes	___Rarely	42.	_____
Diagnosis	___Often	___Sometimes	___Rarely	43.	_____
Family therapy	___Often	___Sometimes	___Rarely	44.	_____
Group therapy	___Often	___Sometimes	___Rarely	45.	_____
Individual therapy	___Often	___Sometimes	___Rarely	46.	_____
In-patient management	___Often	___Sometimes	___Rarely	47.	_____
Medication management	___Often	___Sometimes	___Rarely	48.	_____
Consultation and education	___Often	___Sometimes	___Rarely	49.	_____
Home visits	___Often	___Sometimes	___Rarely	50.	_____
Intake interviews	___Often	___Sometimes	___Rarely	51.	_____
Referrals	___Often	___Sometimes	___Rarely	52.	_____
Research	___Often	___Sometimes	___Rarely	53.	_____
Supervision	___Often	___Sometimes	___Rarely	54.	_____

41. Do you feel a need to justify what you do to: (PLEASE CHECK ONE FOR EACH CATEGORY.)

Clients or patients	___Often	___Sometimes	___Rarely	55.	_____
Other nurses in the center	___Often	___Sometimes	___Rarely	56.	_____
Other nurses in the community	___Often	___Sometimes	___Rarely	57.	_____
Other professionals in the center	___Often	___Sometimes	___Rarely	58.	_____
Other professionals in the community	___Often	___Sometimes	___Rarely	59.	_____

42. Are you satisfied with your work relative to meeting the needs of: (PLEASE CHECK ONE ANSWER FOR EACH CATEGORY.)

Clients or patients	___Often	___Sometimes	___Rarely	60.	_____
The center	___Often	___Sometimes	___Rarely	61.	_____
Yourself	___Often	___Sometimes	___Rarely	62.	_____

PLEASE LEAVE BLANK

43. What PER CENT of your time do you spend working with the following patient groups? (PLEASE ANSWER IN PERCENTAGES.) 63.

_____% Children 64.
_____% Adolescents, including those with drug problems 65.
_____% Adults with alcohol and drug problems 66.
_____% Adults with acute emotional disturbances 67.
_____% Adults with chronic emotional disturbances 68.
_____% Geriatrics (problems of aging) 69.
_____% Mentally retarded 70.
71.
72.
73.
74.
75.
76.

44. How does your job fit what you expected it to be? (PLEASE CHECK ONE.) 77.

___I like it more than I thought I would.
___I like it as well as I thought I would.
___I like it less than I thought I would.

1.
2.
3.
4.

45. Which of your work activities gives you the most personal satisfaction? (PLEASE WRITE IN YOUR ANSWER.) 5.
6.
1. _____ 7.
2. _____ 8.

46. Which of your work activities gives you the least personal satisfaction? (PLEASE WRITE IN YOUR ANSWER.) 9.
10.
1. _____ 11.
2. _____ 12.

47. How is your work usually rewarded by your center? (PLEASE NUMBER IN IMPORTANCE (1=HIGH) THE TOP THREE.)

___Approval from other staff 13.
___Higher salary 14.
___More administrative authority 15.
___More clinical authority 16.
___Not rewarded 17.
___Other (please specify) _____ 18.

48. How would you prefer to see your work rewarded? (NUMBER IN IMPORTANCE (1=HIGH) THE TOP THREE.)

___Approval from other staff 19.
___Higher salary 20.
___More administrative authority 21.
___More clinical authority 22.
___No change 23.
___Other (please specify) _____ 24.

49. Do you plan to stay in community mental health work? (PLEASE CHECK ONE.) 25.

___Yes ___No ___Uncertain

If "Yes", go on to question 51.

PLEASE LEAVE BLANK

50. What would influence you the most to leave community mental health work? (PLEASE CHECK ONE.) 26. _____
___Better salary elsewhere
___Change in spouse's job
___Commitments to dependents
___Poor job satisfaction for me in this center
___Prefer other types of nursing
___Role conflicts with other disciplines
___Tired of working
___Other (please specify) _____

51. Is your salary on a suitable scale considering the following? (PLEASE CHECK ONE FOR EACH CATEGORY.)

Your preparation	___Yes	___No	27. _____
Your responsibilities	___Yes	___No	28. _____
Your activities	___Yes	___No	29. _____

52. What is your annual salary? (PLEASE CHECK ONE.) 30. _____
___Less than $5,000
___$5-6,999
___$7-8,999
___$9-11,000
___More than $11,000

53. Have the requirements of your job revealed any gaps in your training? 31. _____
___Yes ___No

If "No", go on to question 55.

54. If "Yes", what kinds of training do you need? (PLEASE WRITE IN YOUR ANSWERS.)
32. _____
1. _____ 33. _____
34. _____
2. _____ 35. _____
36. _____
3. _____ 37. _____

55. In the work I am now doing, my general nursing education (Med-Surg, OB, etc.) is: (PLEASE CHECK ONE.) 38. _____
___Necessary
___Very helpful
___Helpful
___Not helpful

56. How do you see the opportunities for your continued professional growth and education in this center? (PLEASE CHECK ONE.) 39. _____
___Excellent
___Good
___Fair
___Poor

57. Have you had any continuing education (short courses, workshops, inservice, etc.) while you have been working at this center? 40. _____
___Yes ___No

If "No", please go on to question 61.

PLEASE LEAVE BLANK

58. If "Yes", from whom? (PLEASE CHECK ALL THAT APPLY.)
___Educational institutions 41. _____
___Professional organizations (NCSNA, etc.) 42. _____
___State Department of Mental Health 43. _____
___Your mental health center (inservice education) 44. _____
___Other (please specify) _____ 45. _____

59. Were these sessions (PLEASE CHECK ONE.) 46. _____
___Multidisciplinary?
___For nurses only?

60. How long has it been since you last attended such a session? (PLEASE CHECK ONE.) 47. _____
___0-6 months
___7-12 months
___More than 1 year

61. If circumstances permitted, would you seek another degree or certificate in nursing? 48. _____
___Yes ___No

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. A SUMMARY OF OUR FINDINGS WILL BE SENT TO YOU WHEN THEY ARE COMPLETED.

APPENDIX 2

PRETEST WORKSHEET

PRETEST WORKSHEET

PLEASE ANSWER THIS QUESTIONNAIRE AS THOUGH YOU WERE STILL WORKING IN A COMMUNITY MENTAL HEALTH CENTER. WE ARE INTERESTED IN LEARNING YOUR RESPONSES TO THE QUESTIONNAIRE AS AN INFORMATION GATHERING TOOL, AND WILL APPRECIATE YOUR CONSIDERING THE FOLLOWING EVALUATIONS AS YOU FILL OUT THE QUESTIONNAIRE.

1. Please comment on the directions for answering the questionnaire, referring to specific questions that were a problem.

2. Was there any problems with the wording of specific questions? Obscurities, etc.

3. Are the questions relevant? If not, which ones? Any areas of relevancy omitted?

4. What was your emotional response to the cover letter and questionnaire? Were you fired up and committed, or bored and turned off? Did you have a negative feeling after any specific questions?

5. How long did the questionnaire take to complete? In your opinion, was the length of time required a factor operating in your motivation to fill out the questionnaire?

6. Any comments you have will be helpful to us!

APPENDIX 3

COVER LETTER

Conference Group Study
c/o Box 85
Carrington Hall
Chapel Hill, North Carolina
27514

Your position, as one of the approximately sixty nurses who are working in Community Mental Health Centers in this state, has made you a person whose experiences would be helpful to us. Having worked ourselves in community mental health centers as nurses, we want to get your ideas about the nurse's position as you see it.

With support from the North Carolina State Nurses' Association Psychiatric Nursing Conference Group, and with approval from the four Regional Mental Health Commissioners, we are conducting a study of the environment in which you are working, and what it is like for you.

No individual or mental health center will be identified in any report or summary resulting from this survey. A summary and recommendations from our study will be made available to the State Department of Mental Health, to the Regional Commissioners, and to the Conference Group, with an eye toward improving the standing of nurses in community mental health work, and toward improving opportunities to further your skills.

We will greatly appreciate your returning the enclosed study form within the next week, and we intend to send a summary of the results to you.

Yours truly,

Tamara M. Barlow, R.N.

Virginia Michaux, R.N.

APPENDIX 4

LETTER FOLLOW-UP

Conference Group Study
c/o Box 85, Carrington Hall
University of North Carolina
Chapel Hill, North Carolina
27514

We are eager to receive your response to our questionnaire concerning your experience in community mental health work. If you have not had a chance to send it back yet, this is to remind you that we are looking forward to receiving your response.

We will greatly appreciate your returning the enclosed study form, and we intend to send a summary of the results to you.

Thank you for giving time to this study.

Yours truly,

Tamara M. Barlow

Virginia Michaux

APPENDIX 5

TELEPHONE FOLLOW-UP

APPENDIX V

Protocol for Telephone Follow-up to Request Appointment to Administer Questionnaire by Telephone

Hello, Mrs. _____

This is (V. Michaux/T. Barlow) calling in regard to a questionnaire I mailed to you in April.
(PROBABLE RESPONSE) INTERVIEWER OPTIONS:

1. Questionnaire has just been completed and returned.
   Thank you very much for returning it. I appreciate how busy you must be.
2. Interviewee states that questionnaire will be completed and returned in a few days.
   I would really appreciate it if you could drop the questionnaire in the mail during the next day or two. I appreciate how busy you must be.
3. Interviewee does not volunteer return of questionnaire, but offers no negative comments.
   I appreciate how busy you must be. I wonder whether I can make an appointment to call you to administer the questionnaire over the telephone, at your convenience? Where can you be reached?
4. Interviewee does not wish to participate in the study.
   I respect your desire to not be included at this time. Certainly you are not obligated to participate. I wonder whether you feel free to share whether there was anything particular in the questionnaire that swayed your decision not to participate?

I enjoyed talking to you, and I appreciate your cooperation. We will mail you a summary of our findings when they are all in and we have analyzed them. Thank you, again.

Good-bye.

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