Master’s Level Clinician Competencies in Child and Youth Behavioral Healthcare

Results of a North American Survey of Senior Managers and Supervisors

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with
- The Child and Youth Evidence-Based Practices Consortium
The EBP Consortium began in 2004 when several individuals came to realize many of us were operating in a vacuum while trying to do similar activities to promote the adoption of EBP programs and practices in different parts of the US and Canada. From this a synergy developed, first via phone calls and soon at annual meetings. From there we organized along lines of interest to work on projects.

Consortium members work nationally and with states, provinces, and communities in a variety of ways, including consulting on selecting EBPs, assessing readiness for implementation, providing training and technical assistance for specific EBPs, convening conferences, and conducting research and evaluation of EBPs and implementation methods.

Join us in this exciting endeavor!
Evidence-Based Practice Consortium

A global collaboration of researchers, administrators, and consultants who seek to promote the implementation and dissemination of evidence-based and promising practices in the area of child and family behavioral health.
Discussion Agenda

- Review of the issue
- Summary of survey findings
- Next Steps - a new survey
- Open discussion
The Problem at Hand

Despite increasing urgency for the implementation of evidence-based practices in behavioral health, many are experiencing difficulty hiring clinicians who are suitably prepared to work in an evidence-based environment.
Why competencies Matter

- Behavioral child and youth health struggles with closing the research to practice gap and implementing evidence-based treatments (EBPs) with proven efficacy in practice environments.
- BUT, are clinicians are suitably trained to take on the challenge of delivering EBPs?
- Despite a growing number of evidence-based treatments for children and youth presenting with emotional and behavioral problems, a handful of reports have suggested that practitioners are not prepared to delivery them (Lehman et al., 1998; Hoge, Leighton, & O’Connell, 2004; Hoge, Tandora, and Marrelli 2005; Institute of Medicine 2000; 2001; 2003).
- We have a mental health workplace dilemma.
Our Survey Approach

Based on the concerns discussed in the literature as well as anecdotally among behavioral health care specialists in the Consortium, we conducted a survey to explore the competencies and knowledge base among Master’s trained clinicians working in child and youth behavioral health.

The survey was intended to be completed by individuals who

1) have supervisory and/or hiring responsibilities and,
2) who are involved in providing child and youth mental health services within the child and youth mental health sector, juvenile justice sector, or child welfare sector.

Survey Methods

- **Snowball sampling strategy** was used to reach as many respondents as possible. Survey links were sent to all Consortium members who themselves were asked to *snowball* the request to their networks and contacts working in this field.

- Survey was divided into several sections to capture
  - *Knowledge of Terminology* related to evidence-based practice (EBP)
  - *Key Competencies* in several areas:
    - Research and Analytical Skills
    - Assessment and Diagnosis
    - Intervention and Outcome Evaluation
    - Clinical Therapeutic Skills.
  - A section was included to capture *General Considerations regarding competencies*. 
Survey Participants

- The survey was accessed by 1009 individuals between March 21\textsuperscript{st} 2010 and August 20\textsuperscript{th} 2010.
- Among these, 900 identified themselves as 1) having supervisory and/or hiring responsibilities, and 2) involved in providing child and youth mental health services within the child and youth mental health sector, juvenile justice sector, or child welfare sector.
- Consent to participate was provided by 589 respondents, and this was our final sample.
Figure 1 Canadian Respondents

- Ontario: 87%
- Alberta: 8%
- British Columbia: 2%
- New Brunswick: 1%
- Newfoundland: 1%
- Nova Scotia: 1%
Figure 2 USA Respondents

- Arizona 2%
- California 5%
- Colorado 5%
- Connecticut 6%
- Delaware 2%
- Florida 3%
- Hawaii 5%
- Illinois 3%
- Kentucky 7%
- Louisiana 1%
- Massachusetts 1%
- Maryland 1%
- Michigan 2%
- Minnesota 4%
- Mississippi 2%
- Missouri 5%
- Nevada 2%
- New Mexico 3%
- New York 6%
- North Carolina 1%
- Ohio 12%
- Oklahoma 1%
- Oregon 3%
- Pennsylvania 6%
- Texas 2%
- Utah 4%
- Washington 4%
Respondent Characteristics

- Mostly female (71.1%), 36 and 55 years of age (54.6%)
- Mostly from Social Work (40.1%), followed by Counseling (23.8%) and Psychology (21.1%).
- Highest levels of education: MA/MSW/MSc (66.2%) and PhD (10.5%).
- Majority were managers of clinical services/treatments/programs (56%) or Directors (44%).
- 84% percent were responsible for hiring MA trained clinicians, while 90.5% were supervisors of this group.
- Slightly over half (57.1%) had held these responsibilities for 1-10 years.
Organizational Characteristics

- Funding for service provider organizations in which respondents were situated was overwhelmingly from Provincial or Federal governments (92%).
- 73.4% have budgets over $2m, 27.8% at over $10m
- 67.4% located in urban centers, with 31% in rural and 2% in remote or frontier settings.
- 63.5% provider organizations serve as training sites for MA level programs related to child and youth mental health.
- 48.9% of the responding provider organizations receive training, supervisory, or fidelity support from a purveyor organization in support of a particular evidence-based practice or program.
Survey Note:

- The survey asked respondents to rate whether knowledge, competencies, or skills were important for effectiveness on the job, whether MA clinician’s had this knowledge, competency or skill when hired, and/or whether they learned the knowledge, skill or competency on the job.

- Options were provided for respondents to indicate whether the knowledge, skill or competency was ‘not relevant for their organization’, ‘not important’, or if they had ‘no opinion’.

- Responses choices were not mutually exclusive, and respondents were instructed to endorse all that applied for each item.
Figure 1: Knowledge of Evidence-Based Terminology (% of 589)

OF NOTE: Few terms understood upon entering the workforce.

<table>
<thead>
<tr>
<th>Terminology</th>
<th>Needed to be effective</th>
<th>Majority understand when hired</th>
<th>Learn in your organization</th>
<th>Not relevant/important or no opinion</th>
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<tbody>
<tr>
<td>Evidence-Based Practice</td>
<td>72</td>
<td>41</td>
<td>73</td>
<td>2</td>
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<tr>
<td>Outcome Measurement</td>
<td>71</td>
<td>37</td>
<td>72</td>
<td>1</td>
</tr>
<tr>
<td>Outcome Management</td>
<td>69</td>
<td>25</td>
<td>72</td>
<td>6</td>
</tr>
<tr>
<td>Systems of Care</td>
<td>73</td>
<td>38</td>
<td>69</td>
<td>3</td>
</tr>
<tr>
<td>Promising Practices</td>
<td>45</td>
<td>24</td>
<td>60</td>
<td>19</td>
</tr>
<tr>
<td>Fidelity</td>
<td>66</td>
<td>23</td>
<td>69</td>
<td>7</td>
</tr>
<tr>
<td>Intervention Strategy</td>
<td>79</td>
<td>65</td>
<td>62</td>
<td>1</td>
</tr>
</tbody>
</table>
**Figure 2: Competencies in Research and Analytic Skills (% of 589)**

OF NOTE: Though considered to be needed skills, few are in hand upon workforce entry.

<table>
<thead>
<tr>
<th></th>
<th>Percent of 589</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needed to be effective</td>
<td></td>
</tr>
<tr>
<td>Majority possess when hired</td>
<td></td>
</tr>
<tr>
<td>Learn in your organization</td>
<td></td>
</tr>
<tr>
<td>Not relevant/important or no opinion</td>
<td></td>
</tr>
<tr>
<td><strong>Critical Appraisal</strong></td>
<td>56</td>
</tr>
<tr>
<td><strong>Scientific Approach to Knowledge Building</strong></td>
<td>69</td>
</tr>
<tr>
<td><strong>Search Techniques</strong></td>
<td>43</td>
</tr>
</tbody>
</table>

OF NOTE: Though considered to be needed skills, few are in hand upon workforce entry.
### Figure 3: Competencies in Assessment & Diagnostic Skills (% of 589)

<table>
<thead>
<tr>
<th>Competency</th>
<th>Needed to be effective</th>
<th>Majority possess when hired</th>
<th>Learn in your organization</th>
<th>Not relevant/important or no opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening Tools</td>
<td>71</td>
<td>43</td>
<td>71</td>
<td>3</td>
</tr>
<tr>
<td>DSM-IV</td>
<td>68</td>
<td>73</td>
<td>44</td>
<td>7</td>
</tr>
<tr>
<td>Combines EBP and Client Needs</td>
<td>68</td>
<td>25</td>
<td>71</td>
<td>0</td>
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<tr>
<td>Supervision</td>
<td>80</td>
<td>64</td>
<td>58</td>
<td>0</td>
</tr>
<tr>
<td>Diagnosis &amp; Planning</td>
<td>81</td>
<td>60</td>
<td>63</td>
<td>0</td>
</tr>
<tr>
<td>Theories of Change</td>
<td>72</td>
<td>61</td>
<td>55</td>
<td>0</td>
</tr>
<tr>
<td>Active Client Participation</td>
<td>78</td>
<td>53</td>
<td>64</td>
<td>0</td>
</tr>
</tbody>
</table>
Figure 4: Competencies in Intervention & Outcome Evaluation Skills (% of 589)

<table>
<thead>
<tr>
<th></th>
<th>Needed to be effective</th>
<th>Majority possess when hired</th>
<th>Learn in your organization</th>
<th>Not relevant/important or no opinion</th>
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</thead>
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<tr>
<td>Client Engagement</td>
<td>84</td>
<td>49</td>
<td>68</td>
<td>1</td>
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<tr>
<td>Goal Attainment</td>
<td>79</td>
<td>49</td>
<td>68</td>
<td>0</td>
</tr>
<tr>
<td>Outcome Expectations</td>
<td>77</td>
<td>44</td>
<td>66</td>
<td>0</td>
</tr>
<tr>
<td>Strength-Based Approach</td>
<td>81</td>
<td>56</td>
<td>66</td>
<td>0</td>
</tr>
</tbody>
</table>
Figure 5: Competencies in Clinical Therapeutic Skills (% of 589)

- **Needed to be effective:**
  - Skill in One EBT: 69%
  - Can Use Basic EBPs: 71%
  - Apply research: 57%
  - Good communication skills: 84%
  - Life-long learning: 78%
  - Behavior change: 75%
  - Factors affecting mental health: 80%

- **Majority possess when hired:**
  - Skill in One EBT: 38%
  - Can Use Basic EBPs: 44%
  - Apply research: 24%
  - Good communication skills: 80%
  - Life-long learning: 62%
  - Behavior change: 59%
  - Factors affecting mental health: 65%

- **Learn in your organization:**
  - Skill in One EBT: 70%
  - Can Use Basic EBPs: 69%
  - Apply research: 60%
  - Good communication skills: 53%
  - Life-long learning: 57%
  - Behavior change: 56%
  - Factors affecting mental health: 61%

- **Not relevant/importance or no opinion:**
  - Skill in One EBT: 3%
  - Can Use Basic EBPs: 0%
  - Apply research: 0%
  - Good communication skills: 0%
  - Life-long learning: 0%
  - Behavior change: 0%
  - Factors affecting mental health: 0%

*OF NOTE: Core EBPs not part of skill set upon workforce entry.*
Discussion Points

- Individual competency is but one determinant of effective work performance (Hoge et al., 2005), and consequently, only one factor that will impact mental health outcomes. Individual competency is necessary but not sufficient for effective performance in the workplace. Organizational characteristics must also be considered, including the nature of the information available, the environment, the tools available, and the factors that can enhance employee motivation and readiness for practice change.

- We cannot pay attention to individual competencies in the absence of developing the learning capacities of our provider organizations. Research on organizational change has demonstrated that provider adoption of EBPs is influenced by institutional resources, attitudes of program leaders, and organizational climate (Corrigan, Steiner, McCracken, Blaser, & Barr, 2001; Lehman, Greener, & Simpson, 2002; Rosenheck, 2001).
Moving Forward

- Our study was an attempt to better define the knowledge, skills, and competencies required of the behavioral healthcare workforce working in child and youth mental health, from the perspective of those individuals in positions of hiring and supervising new clinicians. This fulfills the first recommendation made by The Annapolis Coalition; that behavioral health competencies should be identified for a broadly defined workforce. We have used survey methods with opportunities provided for open ended responses to questions of competency, knowledge, and skill.
The competencies identified in our study mirror those highlighted as essential by the Coalition: the identification, assessment, treatment, and prevention of mental health problems or illnesses and substance use disorders, including the care of individuals with co-occurring mental and addictive disorders.

Our results went further, however, by identifying other competencies deemed essential for effective clinical service in an evidence-based environment.

Respondents identified the importance of business-related skills, communication and reporting skills, and an appreciation for the important of lifelong learning as key ingredients of competency.

Respondents in our survey also identified the importance of cultural competency and respect for diversity. The importance of teamwork and systems are highlighted in their 5th recommendation, and shows itself in our survey findings as well.
Conclusions

- Of the many areas of knowledge, skill, & competency regarded as necessary for effectiveness on the job, *most are learned on the job*. MA trained clinicians are arriving on the job with much yet to learn.

- Preparation for evidence-based practice falls largely on CYMH provider organizations that have varying capacity to fulfill on-the-job workforce preparation due to cost and clinical service imperatives.

- Gaps in competencies between the academic & practice worlds were identified. Gaps largely mirror the areas of competence believed to be of greatest important for effectiveness on the job.

- Minimal dialogue occurs between provider organizations and institutions of higher learning. Most pertains to teaching or practicum logistics, and attempts to advocate for changes in curriculum are barely noticed in most instances.

- Fewer than 3% of the new MA clinician workforce is perceived to be ‘very prepared’ for clinical practice in child and youth behavioral healthcare.
Recommendations for Service Providers

1. Identify gold standard EBP professional development and implementation models to replicate across organizations;

2. Behavioral healthcare providers need to engage with institutions of higher learning (IHLs) to discuss and explore common needs and develop competencies in collaboration with other groups (e.g., care recipients, experts);

3. Behavioral healthcare provider organizations should take steps to incorporate the characteristics of learning organizations and build a culture of evidence-based practice.
Recommendations for Accreditation Bodies

1. Work with institutions of higher learning, service provider organizations, and other stakeholders to define core competencies and ensure they are embedded in accreditation standards (e.g., APA) for university programs in behavioral healthcare;

2. Explore methods of reward, recognition, and consequences for EBP service delivery and implementation and innovation in these areas.
Recommendations for Higher Learning

1. Identify gold standard EBP teaching models to replicate across IHLs and engage in curriculum renewal;

2. Engage with service provider organizations and practicum sites to dialogue and explore common needs and develop competencies in collaboration with other groups (e.g., care recipients, experts) and improve their readiness to renew curricula and meet the needs of the field.
Recommendations for Research

1. Replicate the competencies identified in research to date;
2. Study the clinician competencies and client outcomes for practitioners coming from exemplary, gold standard programs;
3. Study the characteristics of organizational learning and change in mental health systems.
Next Steps

- Survey graduate programs, beginning with MSW programs in US & Canada
NIRN Framework

- NIRN Intervention Components:
  - Model definition (key activities elements & phases that are hopefully manualized)
  - Theory Base(s) that support the elements, activities
  - Population Characteristics (not simply classic age, gender race/ethnicity demographics but also behavioral, social supports, etc)
  - Theory of Change (how the key elements & activities when implemented with fidelity contribute to what improved outcomes in the target population)
  - Alternative models (and why they were rejected)
- We are asking questions about the first four intervention components
Dilemma of Defining Evidence-Based

- Dilemma we pondered
  - Social Work defines EBP very broadly
  - Our choice to query instruction in evidence based treatment models
- We hope to inspire discussion in faculty of each program
Our Definition of EBP

“Evidence-based practice” (EBP) or “evidence-based treatment” (EBT) refers to those specific treatment models that meet the following criteria:

- Clearly defined target population(s)
- A treatment manual specifying phases of treatment and key activities for implementation/delivery of the model
- A rigorous basis of empirical support demonstrating the effectiveness of the model through random-assignment control group studies.
Upcoming Survey of Graduate Programs

- We plan to also explore field and post graduate opportunities to apply knowledge/skills developed in EBP courses

- We also want to learn what barriers the programs face in teaching evidence based treatment models
Thoughts from Audience