CalSWEC
California Social Work Education Center

Mental Health Program Curriculum Implementation and Continuous Quality Improvement Report

June 2011

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Formation of an Academic–Public Partnership Supporting Mental Health Services

The CalSWEC Board of Directors, through the initial efforts of Dr. Beverly Buckles and Mr. John Ryan, began forging a partnership with the California Department of Mental Health and California Association of Mental Health Directors in 1996. Although this early work forged positive relationships, without financial support efforts to develop collaborative opportunities and revitalize the mental health competencies progressed slowly. Recognizing this, in 2003 Dr. James Midgley[1] enlisted the support of the CalSWEC Board to identify seed monies to support the further development of mental health collaboration as one of the focus areas of CalSWEC. Subsequently, Mr. John Cullen[2]engaged the efforts of Mr. Jeff Jue[3] to secure funding to accelerate the work of Dr. Buckles and Mr. Ryan on behalf of the CalSWEC Board. In July 2003, as a result of Mr. Jue's efforts, the California Wellness Foundation and the Zellerbach Family Foundation awarded funding to CalSWEC to bring together California's county mental health departments with its schools and departments of social work to form a public academic partnership focused on workforce development for public mental health services in California. With funding in place, CalSWEC was able to hire Ms. Janet Black[4] as a program consultant to support the mental health project and accelerate previous efforts.

And accelerate it did, in February 2004 the CalSWEC Board voted to formalize the mental health project as the Mental Health Initiative. The original (and continuing) membership of the Mental Health

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[1]Dr. James Midgley former Dean of the School of Social Welfare at the University of California, Berkeley and Primary Investigator for CalSWEC. Dr. Midgley continues as a professor and researcher at UC Berkeley School of Social Welfare.

[2] Mr. John Cullen, MSW is the former Director of the Santa Clara County Department of Social Services, CalSWEC Board member, and now serves as the Executive Director of CalSWEC.

[3] Mr. Jeff Jue was the former Director of the Stanislas County Department of Social Services.

[4] Ms. Black is Professor Emeritus from California State University at Long Beach.

Initiative consisted of representation from all of the California schools and departments of Social Work, representatives from the California Mental Health Directors Association and key stakeholders.[5]

Developed as a subcommittee of CalSWEC's Curriculum Committee, the charter of the Mental Health Initiative was to guide the implementation of the mental health competencies into the curricula of all of the MSW schools and departments, and thus address the need for specialized curricula responsive to the mental health workforce crisis in California. One of the first tasks related to this charter was the revitalization and refinement of the mental health competencies originally drafted in 1992.[6] Toward this aim numerous regional meetings were held that brought together representatives from schools and departments of social work, county mental health directors, as well as leaders from the various mental health stakeholder groups from across the state. The culmination of this initial process was the Mental Health Summit I in July, 2004 which expanded the California dialogue to include Dr. Steve Mayberg, then Director of the California State Department of Mental Health; Mr. Charles Currie, then Director of Substance Abuse and Mental Health Services Administration (SAMHSA), and Mr. John Morris, Co-Chair of the Annapolis Coalition, to engage in "Straight Talk" about the status, needs and strategies required in order to reform behavioral health workforce education.

Following the conclusion of the Mental Health Summit I, the schools/departments of social work, along with county mental health directors and other mental health stakeholders (over 200 constituent groups in all) continued to revise the curriculum competencies. With all groups voicing their final approval, the CalSWEC Board of Directors adopted the Mental Health Curriculum Competencies.. Following this confirmation the then 17 schools/departments of social work, in collaboration with their

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[5] The Mental Health Initiative Committee, now called the Mental Health Program Committee, continues to meet three times each year in various locations throughout the State as part of the regular CalSWEC meetings.

[6] Early in 1992, a small group, that combined graduate social work education program directors and county mental health directors, set out to develop curriculum competencies to support the preparation of MSW level students for employment in public mental health services. A series of joint work sessions were held resulting in a document entitled "Guiding Philosophy and Principles of Graduate Social Work Education in Community Mental Health." The document included a set of 45 knowledge and practice competencies. While there continued to be support for the idea of collaboration between social work programs/schools and mental health services, the actual process of collaboration was challenged by logistical and temperament differences and ended shortly there after.

county mental health and county contract partners began to consider strategies to support the integration of the competencies into the classroom and field experiences of supporting MSW education.

Then in November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA). Although, the California Mental Health Planning Council originally targeted the implementation of educational programs to begin in 2006, testimony by Dr. Beverly Buckles and Mr. John Ryan on behalf of CalSWEC, at one of the initial MHSA public hearings, requested that CalSWEC be provided funding to engage in early implementation of a mental health stipend training program. Evidence supporting the viability of this request included CalSWEC's experience in administering a comprehensive Title IV-E stipend training program, its development of the Mental Health Initiative (including the existence of mental health curriculum competencies), and the Social Work Education Master Plan.[7] The response of the California Mental Health Planning Council was positive, and CalSWEC became the first recipient of MHSA workforce, education and training funds.

The distinction of social work as the first mental health profession in California to be awarded MHSA funding for the education of students, represented for the members of CalSWEC nothing less than that the opportunity to demonstrate to consumers that social work educators and practitioners in California were and are committed to engaging in the necessary self-reflection and retooling to assure that emerging generations of social work professionals believe in and know how to be part of services that are consumer-directed and recovery-oriented.

Curriculum Implementation

With the launch of the MHSA funded CalSWEC Mental Health Social Work Stipend Program in 2005, the need for curriculum implementation received continued priority. While the overall management of the stipend program was assumed by CalSWEC at the School of Social Welfare at UC Berkeley,

[7] Like many other transforming ideas, the CalSWEC Mental Health Initiative benefitted from related developments which had already raised public awareness regarding the challenges facing social work education and workforce development in California. CalSWEC's California Social Work Education Master Plan was one of these developments.

responsibility for curriculum development was contracted out to Loma Linda University, under the leadership of Dr. Beverly Buckles as the principal investigator. With the assistance of Mr. John Ryan and Ms. Jan Black, implementation of the curriculum competencies and a core training curriculum began. Beginning in 2005 a series of technical assistance meetings were held with faculty and agency representatives to ensure that curriculum development proceeded efficiently and met the expectations of stakeholders such as the Department of Mental Health, the county mental health agencies, and advocacy and consumer groups. These meetings also provided resources to assist faculty in the development of appropriate curricular offerings. Particular emphasis was placed on agency field work to ensure that students were being given the best opportunities to apply their academic knowledge to practice situations. Syllabi from courses that incorporate the Mental Health Curriculum Competencies offered at MSW programs in California were collected and posted on the CalSWEC Mental Health website to support curriculum development efforts.

Meetings with California Department of Mental Health, California Association of Mental Health Directors, and other relevant stakeholders were also held to keep each apprised of the work of the CalSWEC Mental Health Initiative and its collaboration and curriculum development activities. Participation in these meetings provided an opportunity to learn about the needs of specific stakeholder groups such as the small/rural counties and to identify strategies to address these needs.

In July 2006, a survey concerning the implementation of the Mental Health Competencies, the Curriculum Competency Implementation Survey, was developed and sent to all participating schools. Two subsequent surveys were also implemented. The results of these surveys (*see–CQI Phase I: Curriculum Implementation Activities*) facilitated the identification of critically needed curriculum development and implementation and related activities in schools/departments of social work affecting implementation. In support of addressing these additional needs the Zellerbach Family Foundation awarded the CalSWEC Mental Health Initiative funding in 2007 for a project entitled “A Model for

Implementation of the Mental Health Competency Curriculum." The activities and projects under this grant addressed five main areas:

1. Collaboration and System Sustainability
2. Regional, Statewide, and National Collaboration
3. Curriculum Development and Infusion
4. Curriculum Related Development
5. Evaluation

Funding from the Zellerbach Family Foundation in 2008 allowed the Mental Health Initiative to continue to engage stakeholders and respond to the curriculum implementation needs of schools/departments and counties. As such, this round of funding provided support for a second state-wide summit and develop four Mental Health Curriculum Modules.

The second Statewide Mental Health Summit, was held in September, 2008, in Sacramento. Over 120 participants representing academia, community practice, county mental health, along with a variety of stakeholders came together to share national and statewide trends and issues. Keynote speakers included: John Morris, Annapolis Coalition; Dr. Stephen Mayberg, Director of the California Department of Mental Health, and Dr. Beverly Buckles, Chair of the Department of Social Work and Social Ecology at Loma Linda University. The summit was underwritten by funding from the Zellerbach Family Foundation. Another highlight of the Summit was a panel including Dr. Marvin Southard, Director, Los Angeles County DMH and Governing Board, CMHDA , Ms. Laurel Mildred, Executive Director, California Network of Mental Health Clients, Mr. Warren Hayes, Chief, Workforce, Education & Training, DMH, Mr. Brian Keefer, Staff, Human Resources Committee and Mr. John Ryan, Member, MHPC/Human Resources Committee. The panel members responded to the keynote presentations and identified future challenges and needs in workforce development.

The Summit was also the venue for the introduction of the four Curriculum Modules. Each of these modules was designed to consist of nine hours of lecture content, with accompanying exercises and

reference materials, and can be used as a total course or as "drop-in" lectures in a variety of courses. The four modules presented at the Summit and subsequently posted on the CalSWEC and Loma Linda University Mental Health Curriculum Resource website are:

- *Recovery* by Betty Dahlquist, MSW, Executive Director, CASRA;
- *Co-Occurring Disorders* by Dr. Sally Mathiesen, Professor, San Diego State University, School of Social Work;
- *Specialized Interventions for Older Adults with Mental Illness* by Dr. Michael Johnson, Professor, California State University, Stanislaus, Department of Social Work
- *Specialized Interventions for Children and Transitional Aged Youth with SED* by Dr. Sigrid James, Professor, Loma Linda University, Department of Social Work and Social Ecology.

In addition to the curriculum modules a series of three *Curriculum Infusion Seminars* were provided for schools/departments and county partners. The first seminar focused on recovery, and was presented by Mr. Chad Costello, MSW, director of Public Policy, Mental Health America, Los Angeles, and Ms. Heather Martin, consumer and member of MHALA's innovative program The Village. The second seminar provided content on co-occurring disorders, and was presented by Dr. Tom Freese, UCLA Integrated Substance Abuse Programs and Pacific Southwest Addiction Technology. The third seminar focused ,on specialized interventions with Children and Older Adults and was presented by Dr. Sigrid James, Loma Linda University, and Dr. Michael Johnson, California State University, Stanislaus. This seminar was offered twice to provide access to faculty and field instructors residing in the Southern, Central and Northern regions of the state.

The Curriculum Implementation team was funded for a second grant from the Zellerbach Family Foundation entitled "Implementation of the CalSWEC MH curriculum: Specialized Curricular Resource Development" for the 2008-2009 academic years. The areas of focus for this grant were:

1. Continued curriculum development and dissemination efforts, including provision of infusion seminars;

2. Focus on teaching and learning strategies and best practices in providing supported educational experiences for individuals from a variety of disability communities; and
3. A series of activities to address the relevancy and adequacy of the current CalSWEC mental health curriculum in preparing MSW students for the mental health workforce in California (i.e. CQI study, Curriculum Syllabi Survey, etc.).

Under this grant, a curriculum module was developed to address the intersection of child welfare and mental health agency services to vulnerable children and families and support the integration and transformation of public mental health in California.

The curriculum module, entitled Collaboration in Child Welfare and Mental Health was co-authored by Sigrid James, PhD, LCSW, Loma Linda University School of Social Work and Social Ecology, and Mr. Lynne Marcinich, LCSW, California Institute of Mental Health. Two training seminars around the module were presented in Los Angeles and Oakland to provide access to faculty, field instructors and stakeholder groups from across the state.

A second grant activity focused on the identification of supported education needs (i.e. teaching and learning strategies and support services) to provide successful experiences for consumer and family members participating in MSW programs.

A statewide Supported Education Symposium, focusing on supporting individuals with life experience with mental health issues to succeed in post secondary education, was held on June 19, 2009 The event was sponsored by the CalSWEC Mental Health Initiative, the Zellerbach Family Foundation and the State Department of Mental Health, and brought representatives from the schools of social work, MHSA and Vocational Rehabilitation Coordinators from local county mental health offices and members of stakeholder groups together to address this critical issue. Presentations were made by individuals with expertise in research and implementation of supported education programs throughout California, at a statewide Supported Education Symposium, focusing on supporting individuals with life experience well as specialized knowledge and experience of individuals with life experiences and knowledge about the

Americans with Disabilities Act. Small discussion groups focused on critical issues of access/safety, retention/support and success in the field and identified key areas for further work in the area. A plan for future training and support activities is under development Presentation papers, power point presentations and an extensive resource list on supported education issues were posted on the CalsWEC Mental Health Resources Website. A follow-up activity to the Symposium was the development of a Toolkit addressing strategies to develop a university based supported education program at the institutions around the state. Tim Stringari, MFT, Rick DeGette, MFT and Daniel Chandler, PhD authored the document, entitled "A Toolkit of Possibilities: Developing Supported Education Programs at California Universities

A third activity for this grant period was the presentation in both southern and northern areas of the state, of a training seminar focusing on **WRAP® – Wellness Recovery Action** Plan. WRAP® is a self management-and recovery system developed by a group of people who had mental health difficulties and who were struggling to incorporate wellness tools and strategies into their lives. The seminar provided a knowledge base for faculty teaching students about recovery intervention strategies, and provided a framework for assisting students achieve their educational goals in MSW programs. The Keynote Presenter was Mr. Matthew Federici, Executive Director, Copeland Center, http://www.copelandcenter.com.

The final activity during this phase of funding was the Continuous Quality Improvement (CQI) project that is the primary focus of this full document. The CQI survey and data analysis was completed by the Curriculum Implementation Team at Loma Linda University, with assistance from Matt Riggs, PhD, Department of Psychology, CSU San Bernardino, and Mr. Qais Alemi, Doctoral Candidate, Loma Linda University Department of Social Work and Social Ecology.

A third and final grant from the Zellerbach Family Foundation, entitled "Specialized Curricular Resources Development: Supporting Best Practices in Implementation of the Mental Health Curriculum, was funded in 2010 as part of a larger grant directed by Gwen Foster, Director of the CalSWEC Mental

Health Stipend Program. This grant included the following project areas:

1. Development of Training activities and resources focusing on the Americans with
2. Disabilities Act and the creation of pathways for consumers and family members to achieve their academic and employment goals;
3. Development of plans for training activities to support faculty in increasing their knowledge base about Recovery, Resilience and Wellness principles to provide thorough information on these topics to students; and
4. Continuation of the Continuous Quality Improvement (CQI) study begun the previous year.

Building upon the successful Statewide Supported Education symposium held in 2009, a specialized training seminar, focusing on the Americans with Disabilities Act was offered during 2010. The Seminar was offered in both southern and northern locations to provide maximum access. The Keynote Speaker was Mr. James Preiss, an attorney who specializes in legal issues around ADA and accommodation issues. The training also included a panel of individuals representing consumers, faculty and deans of schools of social work. Topics covered in the keynote and panel discussion included legal mandates and interpretation issues around ADA, reasonable accommodation, confidentiality, disclosure of mental health issues and strategies related to developing effective supported education program to assist consumer/family member students. A series of next steps for action in future years was developed as well.

A second developmental activity during this grant period involved working with community based agencies serving and staffed by consumers and family members to develop a plan for future training activities around recovery for faculties of the California schools of social work. The Working Well Together Collaborative partners four agencies focusing on services to consumers and family members (NAMI, UCAF, California Network of Mental Health Clients and California Institute of Mental Health. This group met together with MH Stipend Coordinators, interested faculty and consumers to develop a training plan for future use in the Central and Northern parts of the state. A similar effort was

launched in the South, working with Mental Health America of Greater Los Angeles (MHALA), along with Project Return Peer Support Network (PRPSN to develop a planning effort for a training seminar to provide personal presentations on recovery, empowerment, and inclusion within schools of social work in Southern California. Mental Health Stipend Coordinators and consumer and family member representatives met together with the lead agencies to develop the plan. It is hoped that funds will be available in future years to actually implement these training programs.

The final activity for this grant period was the continuation of the CQI effort. Building on the work of the previous Zellerbach grant, the survey documents developed earlier were utilized to assess the 2008-2009 cohorts of graduates from the MH stipend program. With the addition of this cohort to the total population of MH stipend graduates, all cohorts from the first four years of the stipend program were included in the CQI study.

The competencies approved by the CalSWEC Board of Directors in May 2005 have been in place for six years now. Curriculum implementation surveys, training seminars and development and sharing of resources have provided assistance to faculty to implement the competencies within their curriculum offerings. Over the past several years, there has been on-going discussion about the need to revise and update the competencies, to more clearly reflect the knowledge, skills and abilities, as well as the recovery principles reflected in the Mental Health Services Act that are critical to successful social work practice in the California public mental health system.

The accrediting body for schools of social work, the Council on Social Work Education, developed a revised set of Educational Policy and Accreditation Standards, including 10 areas of Core Competencies in 2008. This has provided an excellent opportunity to revise the current competencies within the context of the EPAS, and to integrate competencies from the three program areas within CalSWEC (Mental Health, Child Welfare and Aging) to reflect common as well as program area specific competencies. A workgroup has been established, led by representatives of the California Mental Health Directors Association, and including current faculty, deans and directors and curriculum development

experts. The Curriculum Competency Revision workgroup will integrate knowledge and results gained from the CQI study discussed in this report, and develop competency statements and performance criteria that will provide a measureable format supporting the integration of the revised competencies into the curricula of the MSW programs across the state.

CQI: A Multi-phase Process

The Continuous Quality Improvement process for the Mental Health Initiative has emerged over time as a three phase process: *Phase I: Curriculum Implementation Activities; Phase II: Assessment of Graduates' Perceptions; and Phase III: Assessment of Educational Effectiveness*. As such, with the implementation of the MH competencies and curriculum, discoveries have been made which pointed to the need for increased, albeit varied forms of assessment.

CQI Phase I: Curriculum Implementation Activities

The objectives of Phase I of the CQI process address the need to:

- To track activities supporting the implementation of the MH curriculum competencies by the 17 social work schools and programs;
- Synthesize and identify strengths and needs; and
- Make recommendations regarding ways to further support curricular implementation activities

To facilitate these objectives three CalSWEC MH Competencies and Curriculum Implementation Surveys have been completed for the implementation periods of 2005-2006; 2006-2007; and 2007-2009.[8] All of the 17 schools/departments of social work participating in the CalSWEC MH Stipend Program participated in each of the CalSWEC MH Competencies and Curriculum Implementation Surveys.

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[8] The 2007-2009 represents a change in the scheduling of the MH Competencies and Curriculum Implementation Surveys to an every other year format to coincide with the structure used for other CalSWEC curriculum surveys. The results of the 2005-2006 and 2006-2007 surveys have subsequently been combined into a two year reporting format .

During each of the aforementioned evaluation cycles, survey questions focused on the identification of strategies used to implement the CalSWEC Mental health competencies. Data was also collected regarding the mental health curriculum offerings provided by each of the schools for each reporting period.

The data from these surveys illustrate that the schools/departments made substantial curricular and changes and dramatically increased collaborative efforts between 2005 and 2009, evidence of their commitment to the implementation of the mental health curriculum competencies. The curriculum implementation strategies most often reported by schools/departments included: meetings with school/department curriculum committees and efforts to infuse the MH competencies throughout the entire curriculum; and the development of specialized seminars and electives in mental health. As such, the number of school/departments reporting a concentration/specialization in mental health went from 41% to 53% from 2005 to 2009; the utilization of specialized seminars and/or training opportunities to support student learning increased from 67% to 95%; and the schools/departments offering specialized electives in mental health rose from 70% to 75% (with several other schools/departments indicating that plans were in place to add specialized electives during the 2009-2010 academic year). The number of number of schools holding regular informational meetings with students rose from 73% to 100%; and the provision of specialized trainings and/or meetings for field instructors around competencies or special topics rose from 29% to 70%. Also important, schools'/departments' reported that the number of MH Stipend Coordinators participating with curriculum and sequence committees to support the implementation of the MH competencies went from 76% to 100%. In addition, the percentage of schools/departments involving consumers and family members in curriculum development and/or Advisory Board activities rose from 56% to 65% (the other 35% of the schools/departments indicated that these activities were scheduled for the 2009-2010 academic year). Finally, the engagement of schools/departments in regional meetings with their county mental health directors, Workforce and

Education Coordinators, and other MH staff rose from 70% to 100% since the start of the MH Stipend Program.

The number of innovative program activities reported by schools/departments has also increased over time and included: the inclusion of content on evidence-based and promising practices in various areas of the curriculum, such as the development of an Evidence-Based Practice field unit in a community-based contract mental health agency; collaboration with county and/or county operated mental health clinics to utilize clinic settings for the delivery of course work for MH stipend students–thus facilitating the integration of consumers and agency staff as presenters; as well as the increased utilization of collaborative regional meetings among schools/departments to share resources and strategies. Other innovative activities have included a school/department developing a collaborative partnership with a county mental health department and a department of rehabilitation to bring together the training opportunities of both for MH stipend students. Yet another school/department reported plans to develop a part-time MSW program in order to facilitate improved access for future students from remote counties in the northern part of the state.

Schools/departments have also been eager to report their efforts for future development. As such, the majority of schools/departments have identified the critical need to develop activities to engage consumers and family members in MSW programs. Other issues identified have included the desire for more opportunities to share educational resources and tools among the social work schools/departments; strategies for engaging more faculty in a dialogue about recovery and the implementation of mental health competencies; and the need for an evaluation tool to assess the implementation of the mental health competencies and students' mastery of the key knowledge, skills and abilities integrated in both classroom and field learning experiences. Finally, schools/departments have expressed the need for resources and support to further the regional collaboratives and networking activities that have been developed.

CQI Phase II: Assessment of Graduates' Perceptions

As more and more CalSWEC MH students graduated and engaged in employment in public and contracted mental health services, it became apparent that these individuals could provide valuable feedback regarding the content and utility of the MH curriculum. As such, The objective for Phase II of the CQI process Objective was:

- To assess graduates' perceptions of the MH curriculum as preparing them for employment in public and contracted mental health services

Study Methods. All study methods and procedures were reviewed and approved by the Institutional Review Board at Loma Linda University. Schools/departments of social work provided emails of their CalSWEC MH Program graduates as part of the contract stipulations which set forth expectations of awardees to participate in evaluation studies. Mental health graduates were subsequently prompted to take part in the survey through an e-invitation letter that highlighted the study objectives and provided a link to the e-survey. Consent was solicited once participants entered the online survey instrument, through the use of "implied consent" obtained as a result of the respondent completing the survey. After receiving the e-invitation, graduates were given 10 days to complete the survey. On day 10, graduates were sent an e-reminder, followed by a second e-reminder on day 20. Access to the survey was blocked on day 30. Surveys to the supervisors and Program Coordinators were sent out subsequent to the completion of the e-survey completed by graduates.

The sampling frame for this portion of the study consisted of four cohorts (2006, 2007, 2008, 2009) of CalSWEC MH Program graduates (N=713), representing the 17 schools/departments of social work in California. Graduates included in this sample needed to have been working in the field for at least one year.

Graduates were invited to participate in the CQI survey through an electronic invitation letter that was sent to each graduate in the sampling plan through the use of email addresses obtained from the 17 schools/departments of social work.

Although no specific sample size was sought, efforts were made to obtain the largest sample size possible. As such, potential participants were sent two additional reminder invitations through *Survey Monkey* a web-based survey tool. Of the potential population for this study (N=713), approximately 36 (5%) of the e-mail addresses were deemed "undeliverable," an additional three possible participants opted-out, whereas 537 of the graduates made no attempt to open the survey. Conservative statistical measures were used such as replacing missing values with overall group means for an individual question while omitting cases in which a majority of salient response categories was not completed, resulting in 12 omissions. This ultimately yielded a sample size (N) of 163, or a response rate of 23%.

Measures/Instruments. The survey instruments developed for this study were the result of six focus groups conducted with CalSWEC MH graduates across California. In each focus group graduates were asked to provide feedback regarding the competency areas considered necessary for work place success. Salient themes/concepts were extracted from focus group findings and found to substantiate the CalSWEC MH Program Advanced and Foundation Year Competencies. The competencies were subsequently categorized into knowledge, skill, and ability (KSA) areas.[9] As a result of this process the survey included 34 questions, of which the majority was closed-ended questions. A limited number of open-ended questions were also included. Respondents were also asked to complete a demographics section, which supported data collection on age, gender, race/ethnicity, and year of graduation. Respondents' perceived importance of the KSAs was assessed through a rating scale. Graduates assigned ratings of 'importance' for each KSA a 4 point Likert-type scale, where 0= "unimportant" and 4= "very important." A separate scale was utilized to measure the provision of curriculum offerings related to the KSAs. The structure of this scale allowed graduates to rate the degree to which each KSA was provided using a 0-to-4 on Likert-type scale, where 0= "not at all" and 4= "(provided) to a very great extent."

[9] The criteria for the KSAs followed the definitions used by the US Office of Personnel Management's (US OPM, 2011), which define knowledge as "a body of information applied directly to the performance of a function;" a skill as "an observable competence to perform a learned psychomotor act;" and an ability as "competence to perform an observable behavior or a behavior that results in an observable product."

In addition, to questions about importance and provision of the KSAs, respondents were asked to rate how helpful certain classroom experiences were in preparing them for the field of public mental health. Measurement for these items used a Likert-type scale, where 0= "not offered, and 5= "very helpful." Respondents were also asked provide information regarding field practicum experiences, job satisfaction, as well as open-ended questions regarding suggestions for improving the CalSWEC MH curriculum.

Data Analysis. Data from graduate surveys was retrieved from the web-based survey server and downloaded into *Microsoft Excel.* The data was subsequently exported to a data set developed in the *Statistical Package for Social Sciences (SPSS), version 18.0.* Said analysis is inclusive of, but not limited to the importance and provision ratings assigned to the various KSA areas by graduates. A factor analysis was conducted to determine what underlying structures exist for measures assessing the importance and variability of the KSA variables (Mertler & Vannatta, 2005).

Study Strengths and Limitations

The response rate for this study was very good, thus supporting stable within group data results. However, access to data for all schools was challenged by the availability of current email addresses of graduates. As such, the researchers were unable to access the graduates from one of the 17 schools/departments of social work participating in the MH Stipend Program.

Findings

Sample Description. The mean (*M*) age of graduates was reported at *M = 34.* The majority (81%, N=132) of graduates were female. Demographics for racial minorities were: White (51%, *N* = 88); "Hispanic/Latino" group (22%, *N* = 36); Asian/Pacific Islander (15.3%, N=25); followed by Native Americans (.6%, N=1). The highest response rate for groups was provided the 2007 cohort of graduates (29.4%, N=48).

Table 1. Demographics (N = 163)

	Number (%) of Grads
Age Groups	

18-24	1 (.6)
25-34	110 (67.5)
35-44	32 (19.6)
45-64	20 (12.3)
≥65	0 (0)
**Mean Age [years]*	*34 (SD = 8.17)*
Gender	
Male	31 (19)
Female	132 (81)
Race	
African American	8 (4.9)
Asian or Pacific Islander	25 (15.3)
Hispanic/Latino	36 (22.1)
Native American	1 (.6)
White	83 (50.9)
Other	10 (6.1)
Graduation Year	
2006	33 (20)
2007	48 (29.4)
2008	42 (26)
2009	40 (24.5)

Learning Experiences & Opportunities. Graduates were asked to rate classroom and field experiences in terms of helpfulness on a Likert-type scale where of 0 to 5, where '0' = "Not Offered" to '5' = "Very Helpful." As can be seen in Figure 1, graduates rated all of their classroom learning experiences above a 4.0.

In addition, Figure 2 illustrates that graduates rated all field practicum experiences above a 4.0, with *Hands on/Direct practice* (*M = 4.75*) rated as the highest or most helpful experience.

Figure 2. Field Experiences

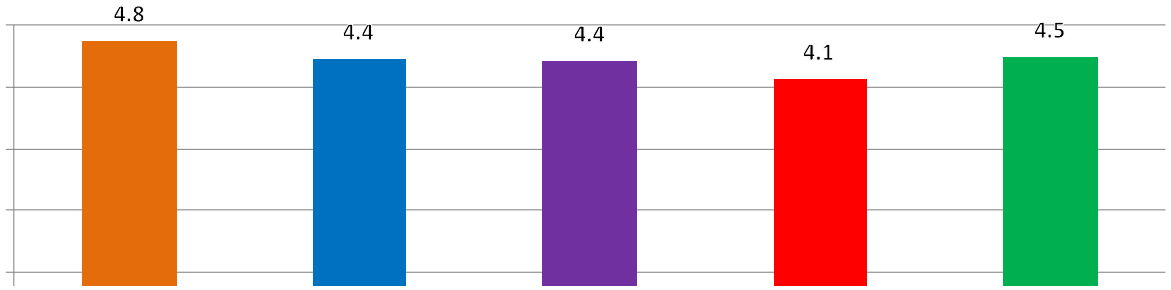


Figure 1. Classroom Experiences

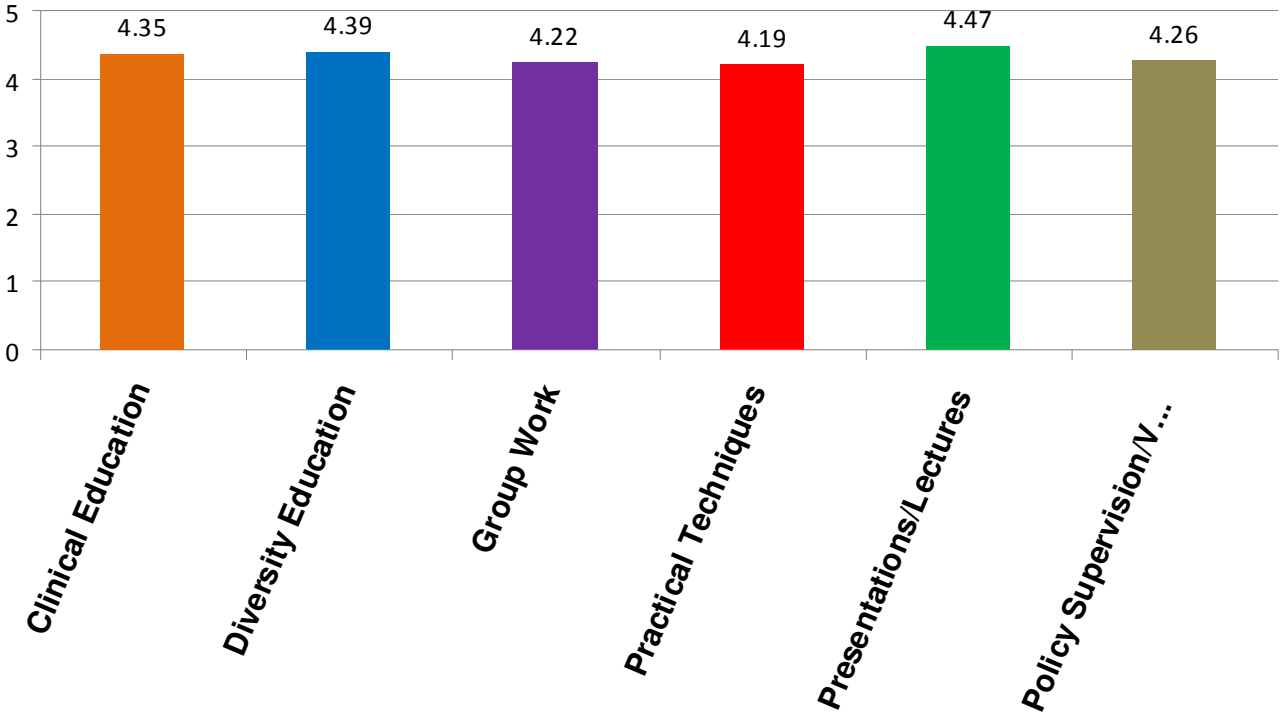


Figure 3 illustrates that the majority of respondents reported working with more than one population during their second year field placements. The single highest area reported was *Adult* ($N = 49$), followed by *Child and Teen* ($N = 33$).

Figure 3. Area of 2nd Year Field Placement

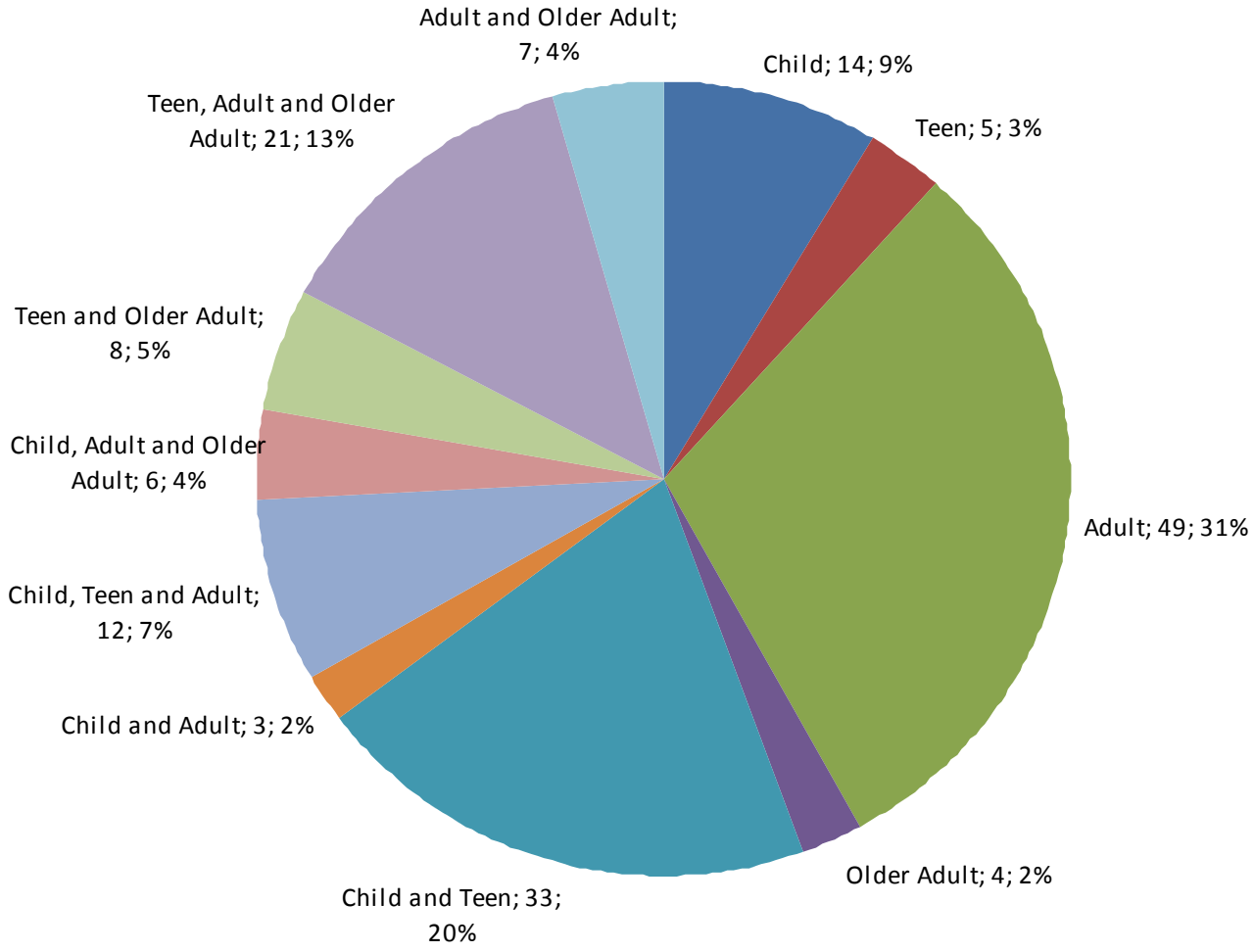


Figure 4 provides information on the primary method of practice graduates engaged in during their second year practicum experience. As can be seen, the majority (N=127, 78%) were involved in the provision of direct services to consumers.

Figure 4. Method of Practice in 2nd Year Field Placement

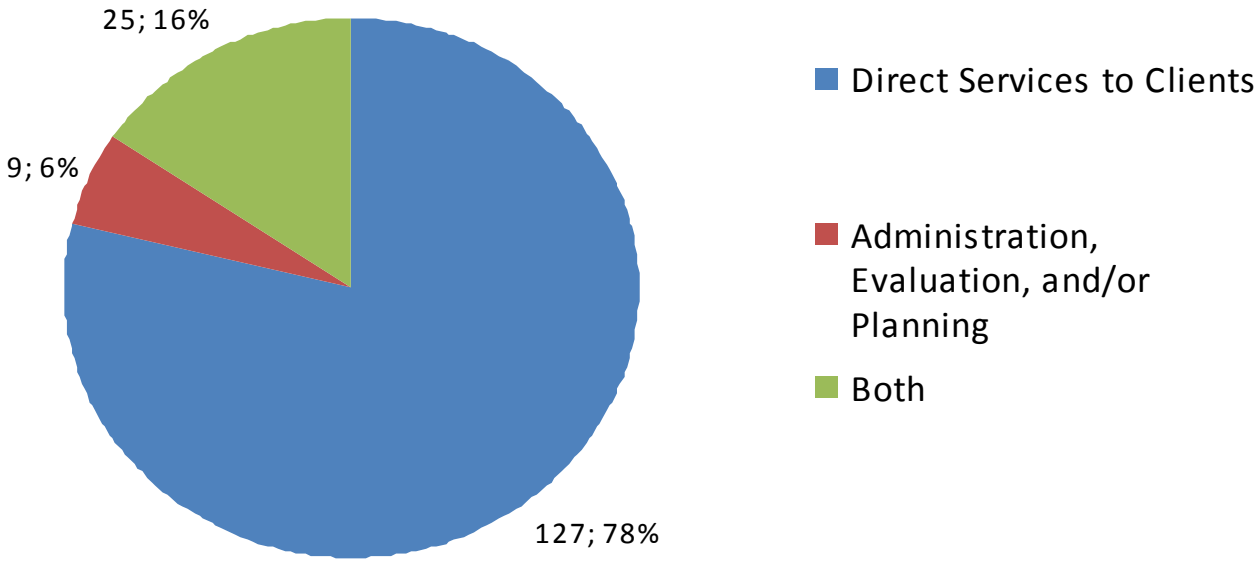


Figure 5 illustrates the distribution reported by graduates regarding the type of agency they were employed in at the time they completed the survey. As such, the majority of graduates reported working for County Contracted Non-Profit Mental Health Agencies (N = 75) and County Mental Health Agencies (*N = 71*). Seventeen (*N = 17*) graduates reported working for other types of agencies.

In addition to asking graduates about their current employment, we solicited feedback regarding

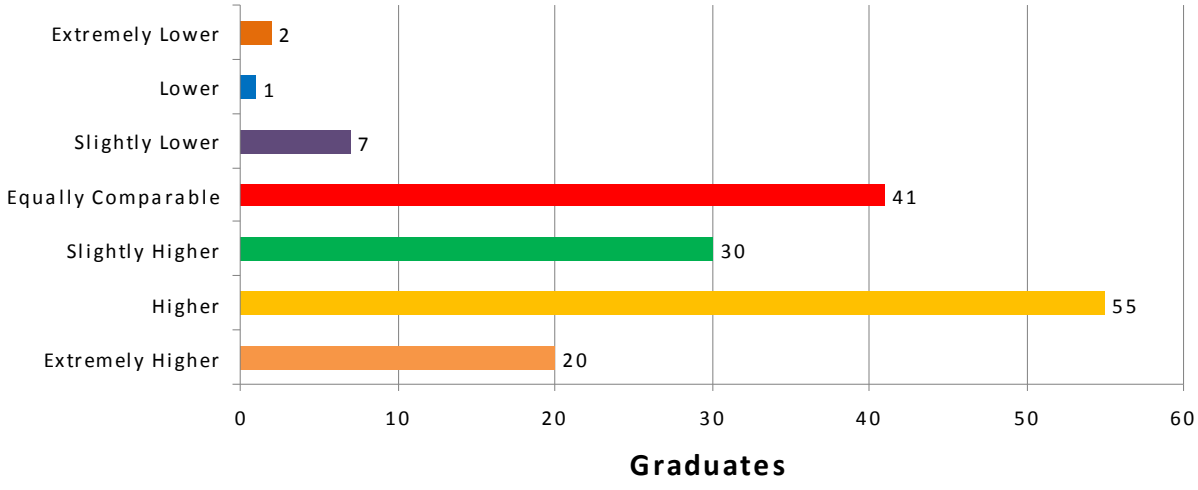
the apspects of working in mental health that graduates have found satisfying and challenging. Areas that graduates reported as satisfying included working with families and children, autonomy, empowering clients, building rapport with clients, diagnosing, inspiring hope, professional self development, supporting change and growth, helping people, and making a positive impact on the client. Challenges reported included dealing with clients' resistance to treatment, creating service plans, Medi-Cal billing, completion and handling of paperwork, learning policies, time management, low pay, diagnosis and the use of DSM-IV, understanding bureaucracy, insurance coverage restrictions, lethargy of co-workers, working collaboratively with people, and working with consumers experiencing co-occurring disorders.

Graduates were also asked to suggest a new course or content area to better prepare MSW students for work in mental health. Graduates offered the following courses/content areas: drug and alcohol classes, pharmacology and psychotropic medications, medical billing, self care, clinical note writing, Medi-Cal documentation, motivational interviewing, grant writing, DSM-IV classes, geriatric social work, stress management/burn-out prevention, and evidence-based practices and clinical interventions.

Graduates were also asked to rate their knowlege base in comparison to other recent graduates who did not participate in a MH training program. Of the 155 graduates who responded to this question, the majority (*N = 55*) reported their knowledge being *Higher* in comparison to other recent graduates. This was followed by 41 individuals who thought their knowledge was equally comparable. Only two graduates reported their knowledge base as *Extremely lower* in comparison to other recent graduates. (See Figure 6.)

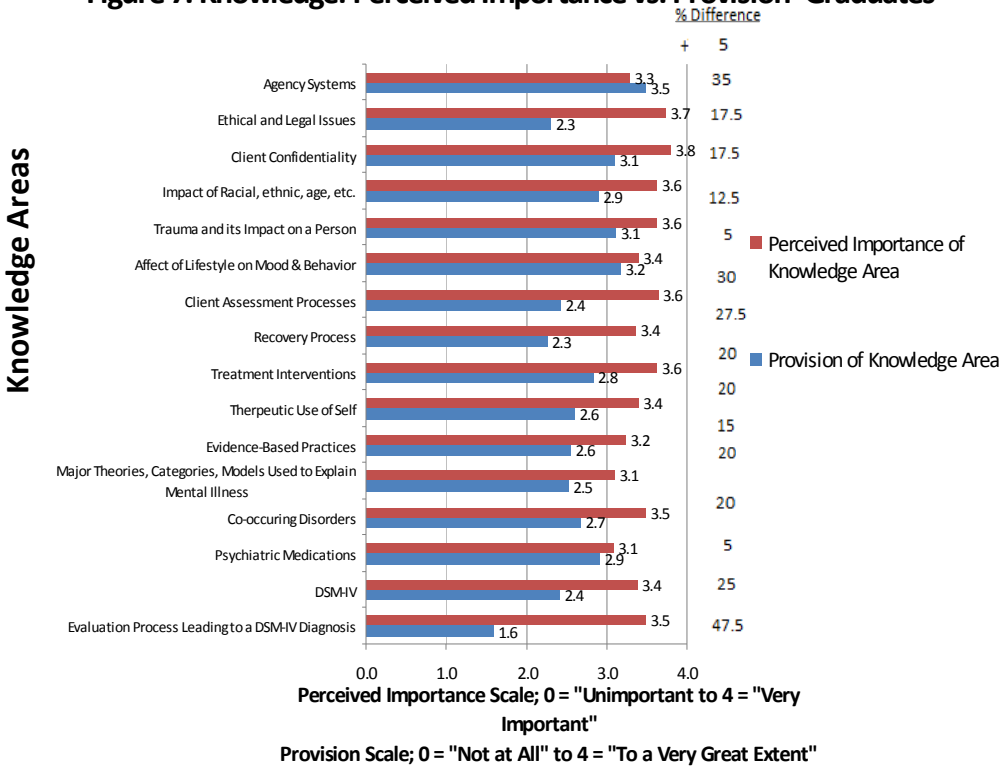
Perceived Importance and Provision of KSAs: Knowledge. Graduates were solicited on their perceptions regarding the importance of various knowledge areas for the beginning MSW mental health workers (see Figure 7) and the extent to which they received this content in classroom and/or fieldwork experiences. All KSAs were rated 3.0 or above ("important" to "very important") on a 4.0 Likert-type scale. *Client Confidentiality* received

Figure 6. Knowledge Base Compared to Other Recent Graduates



ed the highest rating with a mean rating of 3.8; whereas *Major Theories, Categories and Models Used in Explaining Mental Illness* and *Psychiatric Medications* received the lowest mean rating of 3.1.

Figure 7. Knowledge: Perceived Importance vs. Provision- Graduates



In addition to the descriptive data of graduates' perception of the importance and provision of Knowledge content areas of the KSAs, additional data analysis were conducted using Factor Analysis and ANOVA. Table 2 provides the pattern matrix of associated content areas, whereas Figures 8 and 9 illustrate the aggregate pattern of graduates perception of importance vs. provision of the knowledge content areas of the KSAs. Figures 10 and 11 present graduates' disaggregated perceptions of the importance vs. the provision of knowledge areas. Interestingly, these graphs illustrate that there is also no statistical difference in the opinions of each cohort of graduates.

Table 2. KSA--Knowledge Content Factors

Pattern Matrix[a]

	Factor		
	1	2	3
Imp_Recovery_Process	.826	-.175	-.076
Imp_Cooccuring_Disorders	.612	.126	-.151
Imp_Affect_Lifestyle_Meds	.596	-.029	.231
Imp_Psychiatric_Meds	.490	.321	-.238
Imp_Tx_Interventions	.485	.275	-.140
Imp_Trauma_Impact	.481	.018	.039
Imp_Major_Theories	.404	.357	.121
Imp_Therapeutic_Use_Self	.364	.066	.271
Imp_EBPs	.361	.319	.089
Imp_Agency_Systems_Resources	.270	.011	.013
Imp_DSM_IV	-.163	.937	-.006
Imp_Evaluation_Process	.079	.785	.056
Imp_Client_Assessment_Processes	.178	.335	.153
Imp_Client_Confidentiality	-.150	.030	.887
Imp_Ethical_Legal_Issues_Tx	-.105	.105	.825
Imp_Impact_Racial_Ethnic	.431	-.219	.520

Extraction Method: Principal Axis Factoring.
Rotation Method: Promax with Kaiser Normalization.
a. Rotation converged in 6 iterations.

Professional Practice

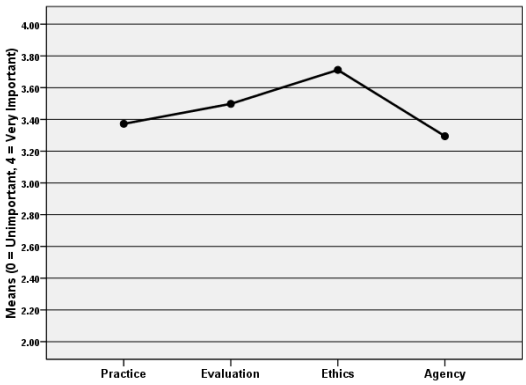
Evaluation & Assessment

Ethics & Ethnic/ Gender Issues

Agency Resources

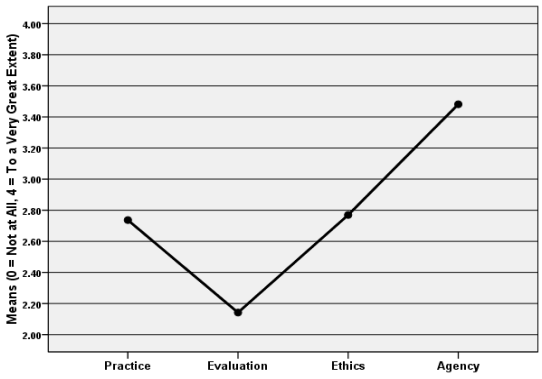
Graduates: Perception of Importance vs. Provision of KSA Knowledge Content

Figure 8. Importance of Knowledge



Within subjects Importance factor
$F(3,486) = 21.21$, $p < .001$, $eta^2 = .12$
Ethics > Evaluation, Practice, & Agency
Evaluation > Practice & Agency
Practice > Agency

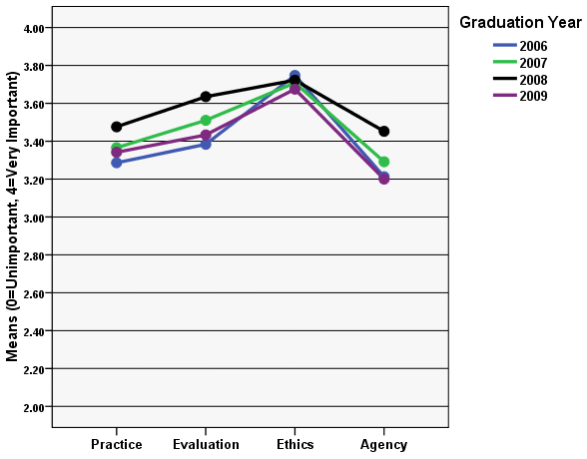
Figure 9. Provision of Knowledge



Within subjects Provision factor
$F(3,486) = 147.12$, $p < .001$, $eta^2 = .48$
Only non-significant difference between Practice & Ethics

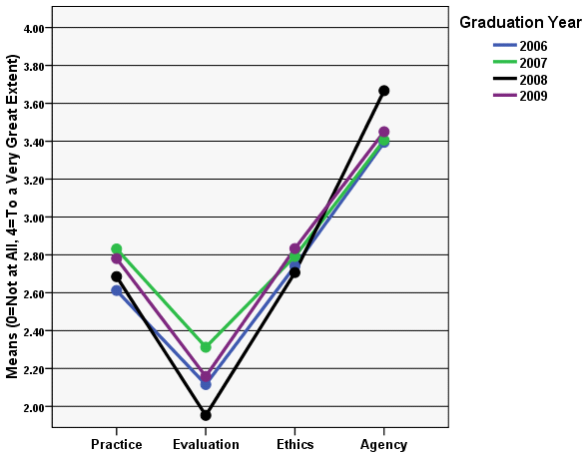
Graduates: Perception of KSA Knowledge Content by Cohorts

Figure 10. Importance of Knowledge



Within subjects Importance factor
$F(3,477) = 21.29$, $p < .001$, $eta^2 = .12$

Figure 11. Provision of Knowledge



Within subjects Provision factor
$F(3,477) = 147.62$, $p < .001$, $eta^2 = .48$

Table 3. Factoring of Select KSA Practice-Knowledge Construct

Pattern Matrix[a]

	Factor			
	1	2	3	4
Treatment — Imp_Trauma_Impact	.772	.016	-.033	-.074
Imp_Affect_Lifestyle_Mood	.564	-.079	.070	.247
Imp_Tx_Interventions	.457	.332	-.004	-.063
Imp_Recovery_Process	.433	-.035	.202	.137
Theory — Imp_EBPs	.165	.779	-.074	-.049
Imp_Major_Theories	-.180	.686	.145	.173
Imp_Cooccuring_Disorders	-.009	-.017	.854	-.038
Imp_Psychiatric_Meds	.149	.148	.475	.057
Use of Self — Imp_Therapeutic_Use_Self	.020	.061	-.062	.839

Extraction Method: Principal Axis Factoring.
Rotation Method: Promax with Kaiser Normalization.

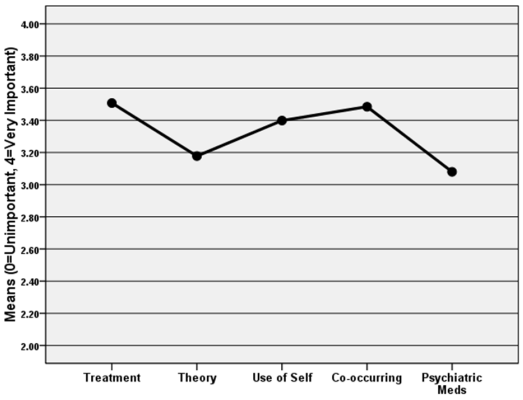
a. Rotation converged in 7 iterations.

*Decision made to analyze Co-occurring Disorders and Psychiatric Meds as separate variables.

The factor analysis of the Knowledge areas of the KSAs indicated that additional patterns emerged when considering the relationship of the specialized practice content areas of the KSAs. Table 3 provides the pattern matrix for these specialized practice content areas. Further depicting the patterns that emerge in Table 3, are the graphs found in Figures 12 and 13. In addition, the disaggregated perceptions of graduates' presented in Figures 14 and 15 illustrate once again that there is no statistical difference in the opinions of each cohort of graduates regarding the importance and provision of specialized practice content areas, respectively.

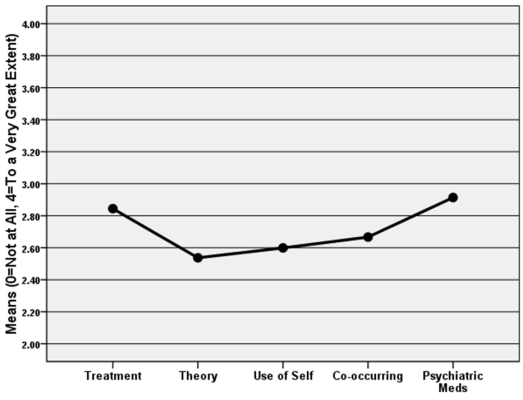
Graduates: Perception of Importance vs. Provision of Select KSA Practice-Knowledge Content

Figure 12. Importance of Select Practice-Knowledge



Within subjects Importance factor
$F(4,648) = 20.30$, $p < .001$, $eta^2 = .11$
Treatment, Use of Self, & Co-occurring Disorders > Theory & Psychiatric Meds

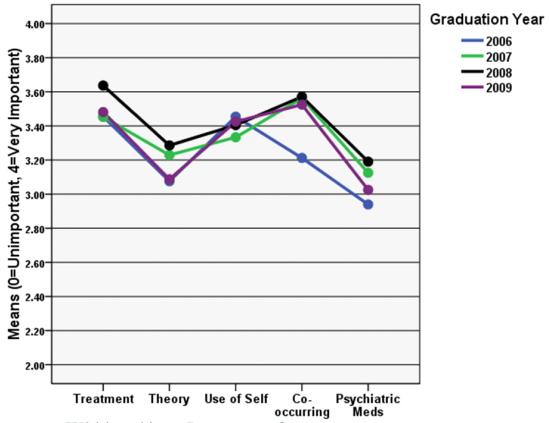
Figure 13. Provision of Select Practice-Knowledge



Within subjects Importance factor
$F(4,648) = 9.80$, $p < .001$, $eta^2 = .06$
Treatment > Theory & Use of Self
Psychiatric Meds > Theory, Use of Self, & Co-Occurring Disorders

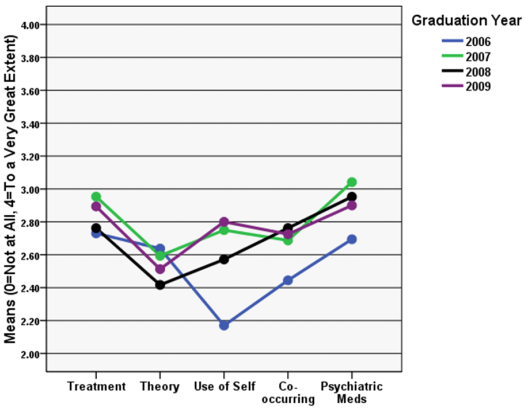
Graduates: Perception of Select KSA Knowledge-Practice Content by Cohorts

Figure 14. Importance of Select Practice-Knowledge



Within subjects Importance factor
$F(4,636) = 20.33$, $p < .001$, $eta^2 = .11$
Treatment > Theory & Psychiatric Meds
Use of Self & Co-occurring Disorders > Theory & Psychiatric Meds

Figure 15. Provision of Select Practice-Knowledge



Within subjects Importance factor
$F(4,636) = 9.48$, $p < .001$, $eta^2 = .06$
Treatment > Theory & Use of Self
Psychiatric Meds > Theory, Use of Self, & Co-occurring

Perceived Importance and Provision of KSAs: Skills. On average, graduates rated all types of skills above '3' indicating that they are all "important." The highest rated type of skill in terms of its importance was Communication (M = 3.8). The lowest rated skill area was Technical (Use of Computers and Various Programs Including the Internet) (M = 3.0). Notable discrepancies in the perceived level of importance assigned to a certain skill area and its provision in the classroom and/or through fieldwork experiences was reported in Documentation/Charting within Medi-Cal Guidelines, Revising Treatment Plans, and Case Management. (See Figure 16.)

Factor Analysis and ANOVA statistics were also used to further analysis the convergence of the skills areas of the KSAs. Table 4 provides the pattern matrix of associated content areas, whereas Figures 17 and 18 illustrate the aggregate pattern of graduates perception of importance vs. provision of the skill areas of the KSAs. Figures 19 and 20 present graduates' disaggregated perceptions of the importance vs. the provision of skill areas. These graphs illustrate that there is also no statistical difference in the opinions of each cohort of graduates.

Table 4. KSA Skills Content Factors

Pattern Matrix[a]

	Factor 1	Factor 2	Factor 3
Imp_Assessment_Indv_Fam	.902	-.010	.045
Imp_Communication	.604	-.010	-.023
Imp_Devt_Tx_Int_Dis_Plans	.527	.070	-.228
Imp_Technical	-.134	.732	-.107
Imp_Writing	.101	.596	.070
Imp_Case_Management	-.022	-.067	-.869
Imp_Documentation_MediCal	.009	.059	-.568
Imp_Revising_Tx_Plans	.249	.086	-.541

Treatment Planning

Writing & Tech

Treatment Planning

Extraction Method: Principal Axis Factoring.
Rotation Method: Oblimin with Kaiser Normalization

a. Rotation converged in 7 iterations.

Figure 16. Skills: Perceived Importance vs. Provision- Graduates

Graduates: Perception of Importance vs. Provision of KSA Skills Content

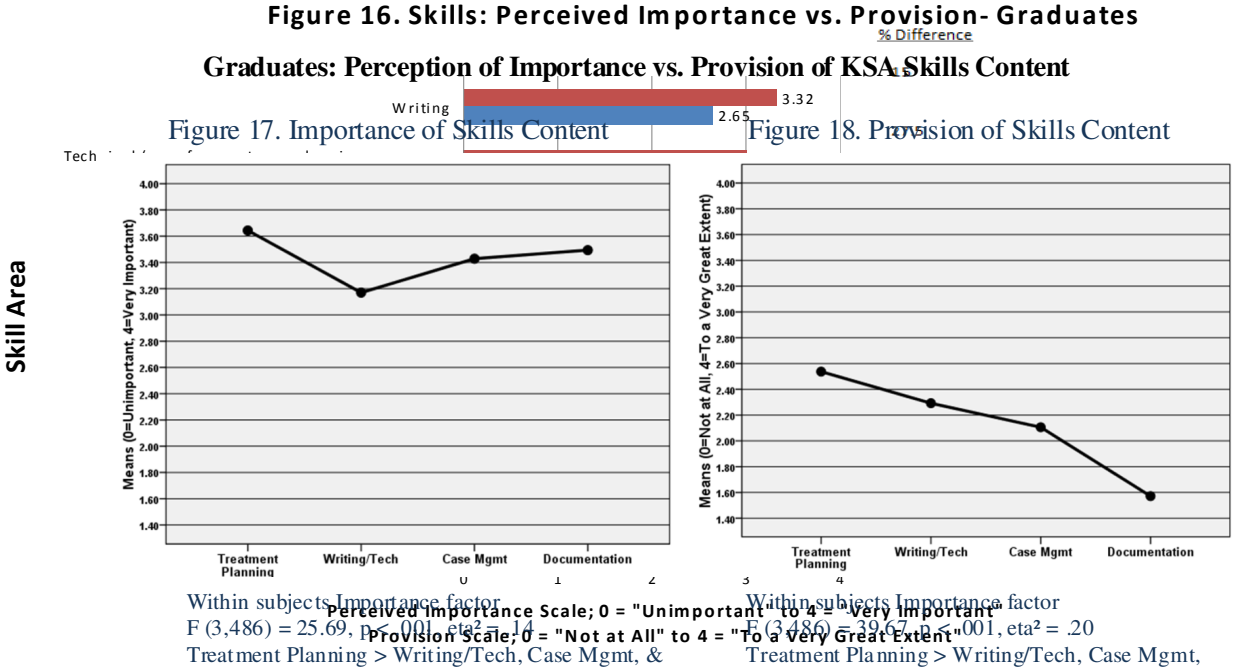


Figure 17. Importance of Skills Content

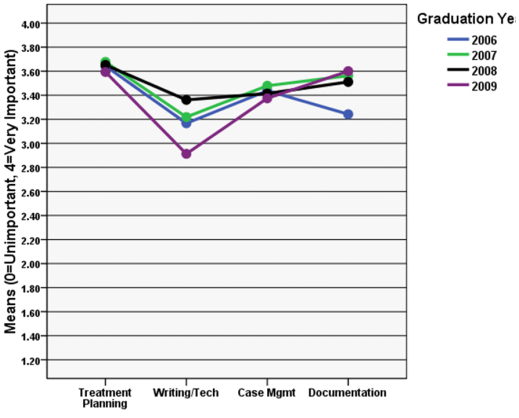
Within subjects Importance factor
F (3,486) = 25.69, p < .001, eta² = .14
Treatment Planning > Writing/Tech, Case Mgmt, & Documentation
Case Mgmt, & Documentation > Writing/Tech

Figure 18. Provision of Skills Content

Within subjects Importance factor
F (3,486) = 39.67, p < .001, eta² = .20
Treatment Planning > Writing/Tech, Case Mgmt, & Documentation
Writing/Tech & Case Mgmt > Documentation

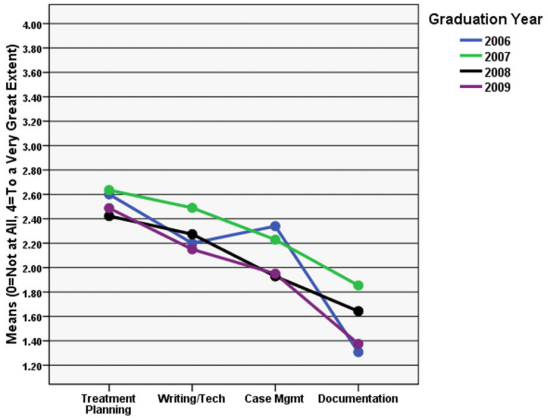
Graduates: Perception of KSA Skills Content by Cohorts

Figure 19. Importance of Skills Content



Within subjects Importance factor
$F(3,477) = 25.98$, $p < .001$, $eta^2 = .14$
Treatment Planning > Writing/Tech, Case Mgmt, & Documentation
Increase in Documentation from 2006 to later years
Drop in Writing/Tech in 2009 compared to previous years

Figure 20. Provision of Skills Content

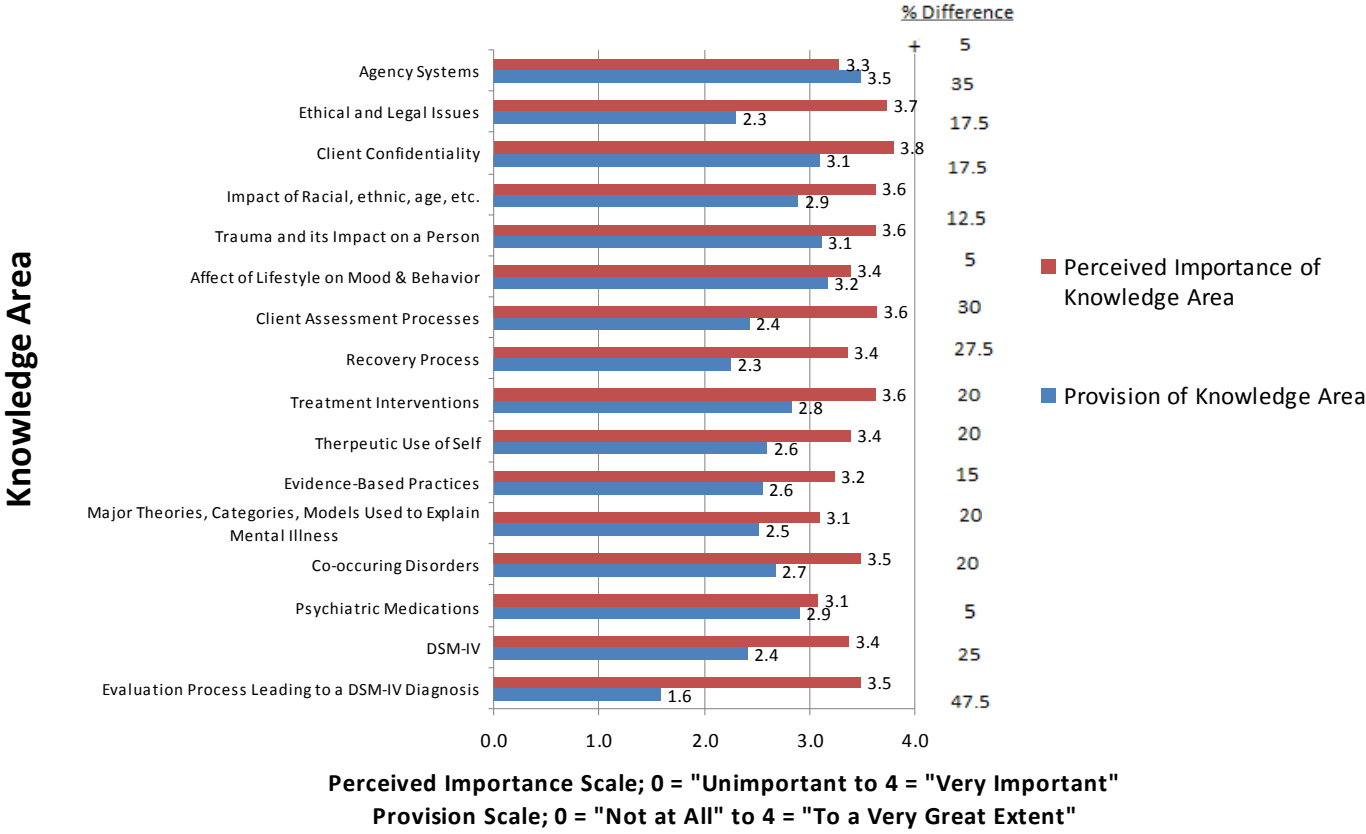


Within subjects Importance factor
$F(3,477) = 41.03$, $p < .001$, $eta^2 = .21$
Treatment Planning > Writing/Tech, Case Mgmt, & Documentation
Writing/Tech & Case Mgmt > Documentation

Perceived Importance and Provision of KSAs: Abilities. On average, all 163 grads who answered this question rated all types of abilities above '3' indicating that they are all "important." The highest rated types of abilities in terms of its importance were Crisis Intervention (M = 3.7), Development of Therapeutic Relationship (M = 3.7), and Maintaining Appropriate Boundaries (M = 3.7). The lowest rated ability area was Facilitating Self-Help/Peer-Support Interventions (M = 3.18). (See Figure 21.)

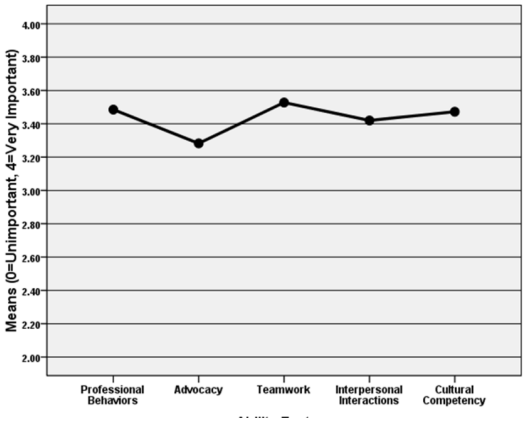
Factor Analysis and ANOVA statistics were also used to further analysis the convergence of the abilities areas of the KSAs. Table 5 provides the pattern matrix of associated content areas, whereas Figures 22 and 23 illustrate the aggregate pattern of graduates perception of importance vs. provision of the skill areas of the KSAs. Figures 24 and 25 present graduates' disaggregated perceptions of the importance vs. the provision of skill areas. These graphs illustrate that there is also no statistical difference in the opinions of each cohort of graduates.

Figure 21. Knowledge: Perceived Importance vs. Provision- Graduates



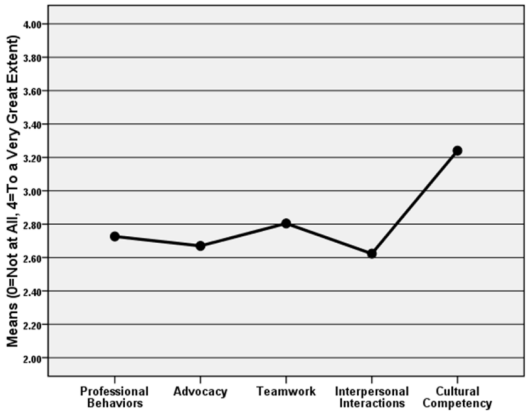
Graduates: Importance vs. Provision of KSA Abilities Content

Figure 22. Importance of Abilities Content



Within subjects Importance factor
$F(4,648) = 7.67$, $p < .001$, $eta^2 = .05$
Professional Behaviors, Teamwork, & Cultural Competency > Advocacy

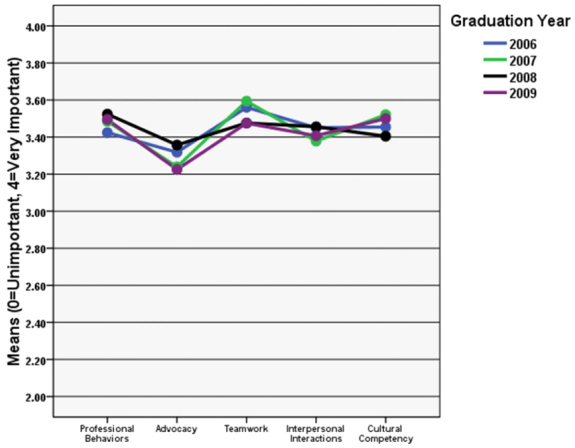
Figure 23. Provision of Abilities Content



Within subjects Importance factor
$F(4,844) = 34.00$, $p < .001$, $eta^2 = .14$
Cultural Competency > Professional Behaviors, Advocacy, Teamwork, & Interpersonal Interactions
Teamwork > Interpersonal Interactions

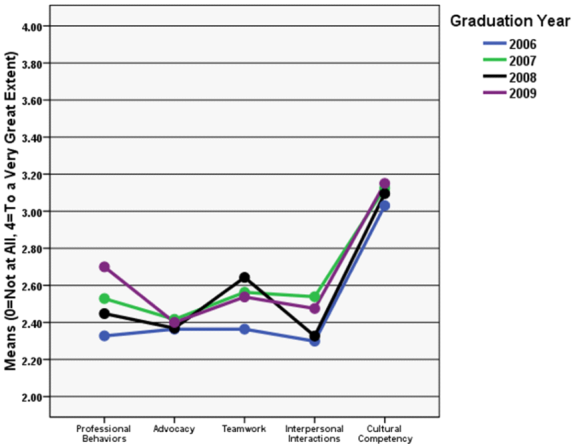
Graduates: Perception of KSA Abilities Content by Cohorts

Figure 24. Importance of Abilities Content



Within subjects Importance factor
$F(4,636) = 7.15$, $p < .001$, $eta^2 = .04$
Professional Behaviors, Teamwork, & Cultural Competency > Advocacy

Figure 25. Provision of Abilities Content



Within subjects Importance factor
$F(4,636) = 37.53$, $p < .001$, $eta^2 = .19$
Cultural Competency > Professional Behaviors, Advocacy, Teamwork, & Interpersonal Interactions

Phase III: Assessment of Educational Effectiveness

As the analysis of graduates perceptions of the importance and provision of the KSAs progressed it became clear that graduates' perspectives represented only one measure in evaluating the implementation of the competencies-based MH curriculum. It was noted that other perspectives, such as the views of supervisors of graduates working in mental health services, CalSWEC MH Program Coordinators, and consumers could substantially add to our understanding of the educational effectiveness of the MH curriculum to prepare competent social workers to work in mental health services.[10] Thus, it was determined that Phase III of the CQI study would be to complete a pilot study comparing the perceptions of graduates with those of supervisors, and MH Program Coordinators. To add further objectivity to this effort it was also decided to conduct a content analysis of syllabi. As noted in Phase I, the curriculum implementation

[10]Consideration was given to also obtaining data from consumers receiving services. However, given the methodological and human subject challenges associated with collecting data from consumers, it was decided that Phase III of the CQI process would utilize data from supervisors of MH graduates and CalSWEC MH Program Coordinators.

surveys that schools/departments completed, have provided self-report information from the schools/departments regarding their implementation activities. It was felt that a content analysis of syllabi would serve to not only support the previous reports of the schools, but also provide a mechanism for comparing graduates' perceptions of content provided. It was felt that this combination of data sets, i.e., multiple perceptions and the content analysis of syllabi could support the development of methodology for determining the educational effectiveness of the MH curriculum. As such, the objectives for Phase III were:

- To establish a methodology to assess the educational effectiveness of the CalSWEC MH Program
- Develop initial indicators of educational effectiveness
- Recommend next steps in the development of CQI process that would support statement of strong conclusion validity regarding educational effectiveness

Data Triangulation.

Because no singular measure can tell an entire story, data triangulation was selected as the most appropriate methodology to determine the educational effectiveness of the MH curriculum. The use of data triangulation supports the conditions needed to demonstrate strong conclusion validity.[11]

Perceptions of Supervisors and MH Program Coordinators.

Study Methods. All study methods and procedures were reviewed and approved by the Institutional Review Board at Loma Linda University. The sampling frame for this portion of the study consisted of supervisors of graduates of the CalSWEC MH Stipend Program and CalSWEC MH Program Coordinators working in one of the 17 participating schools/departments of social work. As before, although no specific sample size was sought, efforts were made to obtain the largest sample size possible. Sampling of these two populations resulted in 44 supervisors and 12 MH Program Coordinators responding.

[11]Conclusion validity is the degree to which conclusions reached about relationships in data are reasonable. The likelihood of making correct conclusions is greater if attention is given to improving the conditions needed for strong conclusion validity. These conditions include: a) the exact or conceptually the same content; b) large sample size; c) reliability; d) independent samples; and e) consistent/standardized implementation of methodology.

Measures/Instruments. The instrument supporting Phase III applied the same survey materials utilized to collect perceptions from graduates, albeit some additional demographic and educational questions were included.

Data Analysis. The *Statistical Package for Social Sciences (SPSS), version 18.0.* was used to analyze data from supervisors and MH Program Coordinators. As with the data from graduates, factor analysis and ANOVA were utilized to determine what underlying structures exist for measures assessing the importance and variability of the KSA variables (Mertler & Vannatta, 2005).

Study Strengths and Limitations

The most notable challenge to this study was the size of the sample. And, although the Supervisor data provided a moderate sample size, adequate for statistical analysis, a larger N was needed to support the Program Coordinators data-minimal sample size; Statistically adequate, however larger sample will be needed if the conditions for Conclusion Validity are to be supported. The same is true for the sample of MH Program Coordinators. However, more importantly, MH Programs may not be the appropriate group to sample, i.e., they may not be teaching courses and/or may not have a deep understanding of the entire MSW curriculum and academic assessment measures and procedures.

Findings[12]

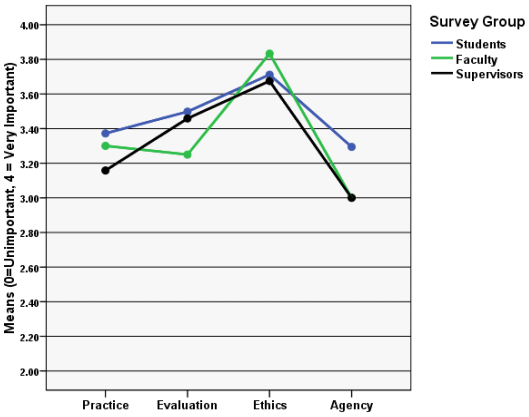
Perceived Importance and Provision of KSAs: Knowledge. Figures 26 and 27 illustrate the convergence and divergence of graduates perceptions with those of supervisors and MH Program Coordinators. As such, there is no statistical difference in the perceived importance the knowledge content of the KSAs by graduates, supervisors and MH Program Coordinators. There is, however, noted variability between the perceptions of these groups with regard to the provision of knowledge content. Whereas the exact reasons for these differences is not known, a few explanations can be offered, including: a) the altered perception of knowledge needs by graduates may be due to the increased awareness of the realities and requirements of employment versus those associated with being a student; b) some of the responding MH

[12]See Appendix A for the complete CQI data.

Program Coordinators reported that they were not familiar with all aspects of the MSW curriculum; and c) the size of the samples for the MH Program Coordinators and supervisors, although acceptable are not large enough to support strong conclusions.

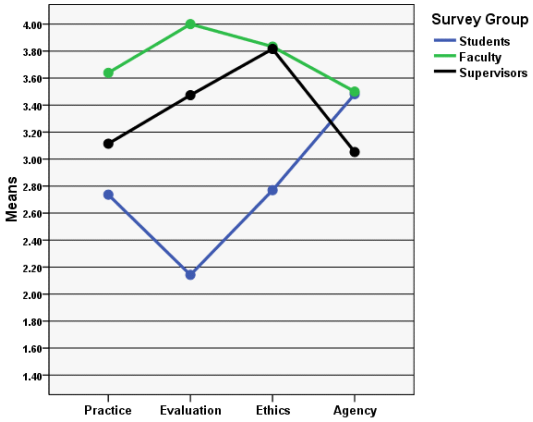
Importance of KSA Knowledge Content by Groups
(Graduates, Program Coordinators, Supervisors)

Figure 26. Importance of Knowledge Content



F (3,648) = 29.68, p < .001, eta² = .12
Ethics > Practice, Evaluation, & Agency
Practice & Evaluation > Agency

Figure 27. Provision of Knowledge Content



Figures 28 and 29 illustrate a similar pattern regarding the comparative perceptions of graduates, supervisors and MH Program Coordinators with regard to the importance versus the provision of the skill area of the KSAs.

Perception of KSA Skills Content by Groups
(Graduates, Program Coordinators, Supervisors)

Figure 28. Importance of Skills Content

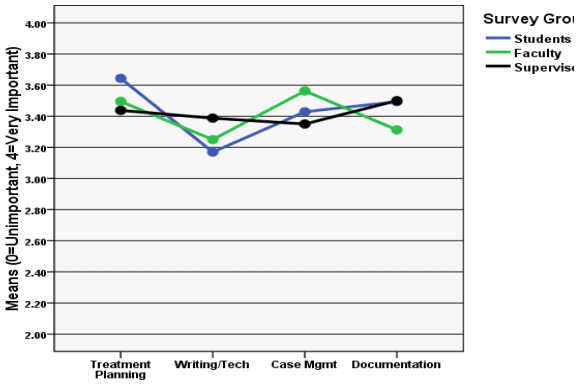
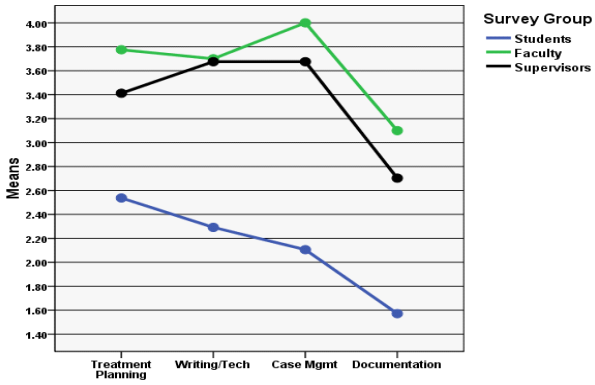


Figure 29. Provision of Skills Content



Within subjects Importance factor
$F(3,648) = 4.23, p = .006, eta^2 = .02$
Treatment Planning > Writing/Tech

Figures 30 and 31 illustrate a similar pattern regarding the comparative perceptions of graduates, supervisors and MH Program Coordinators with regard to the importance versus the provision of the skill area of the KSAs.

Perception of KSA Abilities Content by Groups (Graduates, Faculty, Supervisors)

Figure 30. Importance of Abilities Content

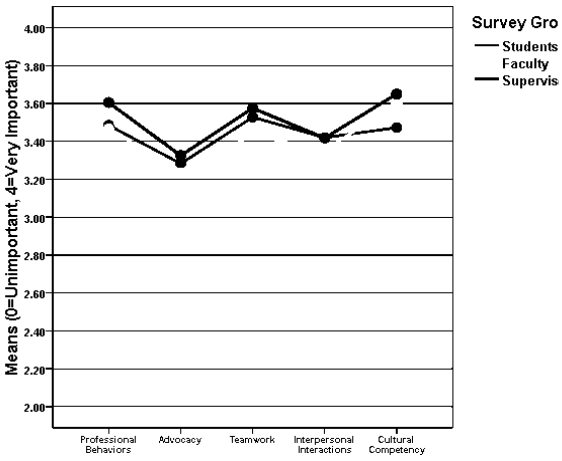
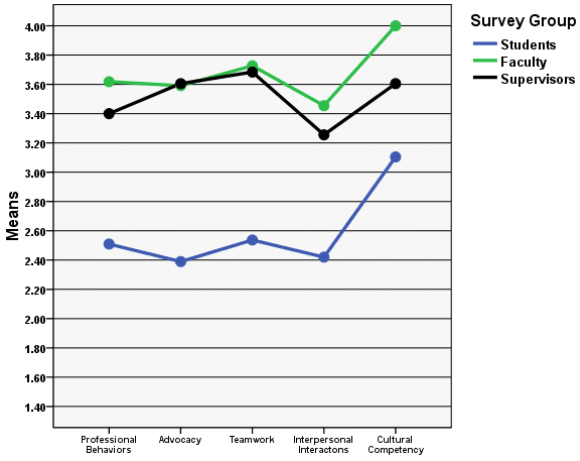


Figure 31. Provision of Abilities Content



Within subjects Importance factor
$F(4,860) = 7.32, p < .001, eta^2 = .03$
Professional Behaviors, Teamwork, & Cultural Competency > Advocacy

Content Analysis of Syllabi

As stated earlier the purpose of the content analyis of MH syllabi provided by the schools/departments was to review the integration of the KSAs (Key concepts from competencies).

Study Methods. The schools/deparments of social work particating in the CalSWEC MH Program were sent letters in late September 2010 requesting that each submit all of their latest syllabi that demonstrated the implementation of the MH competencies. A 100% response rate was obtained which resulted in the submission of 115 syllabi. The research team who evaluated the syllabi consisted of Dr. Sarah Taylor, from CSU East Bay and three of MSW students. An instrument developed using Surveymonkey supported data collection (www.surveymonkey.com). As such, team members completed the online instrument based upon the instructions provided and the informaiton provided in the syllabi. In addiiont, Discovertext was used to create word cloud and counts (www.discovertext.com) to illustrate the predominance of terminology found in the syllabi.

Study Strengths and Limitations. A strength of this approach relates to the expectation that syllabi are a contract between students and faculty, and thus are to be representative of the learning that occurs in the classroom. However, it is widely accepted that syllabi are also an incomplete portrait of what happens in the classroom. Thus, the use of syllabi to do content analysis can be viewed as both a strength and a limitation. In addition, schools/departments interpreted the call for syllabi differently. This difference may have affected which or the number of syllabi that were submitted for analysis. Finally, members of the research team (MSW students) were also consumers of the product they were analyzing. And, although every percaution was taken to orient students to ensure objectivity, some consideration needs to be given to possibility of reviewer bias.

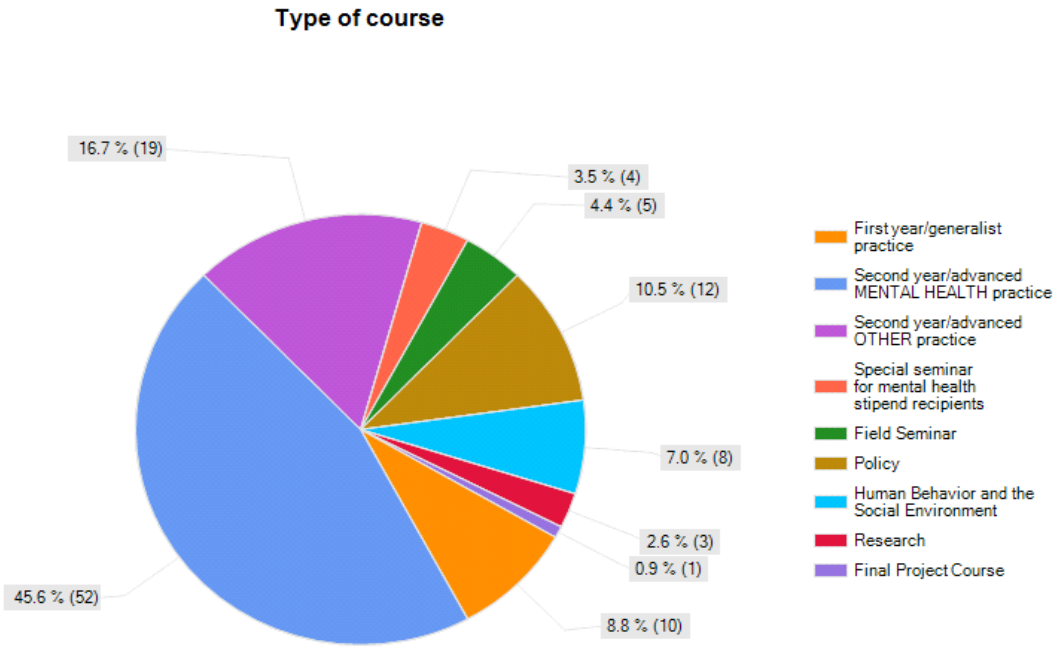
Findings[13]

Figure 32 summarizes the types of syllabi submitted by the schools/departments of social work. Due to the differences in how schools interpreted the request, a wide variety of types of syllabi

[13]See Appendix B for the complete report of the Syllabi Content Analysis Study.

were also received, though many (45.6%) were for second year or advanced-level mental health practice courses, followed by other second-year or advanced practice courses (16.7%).

Figure 32: Types of Syllabi Received



Due to the limited time available for the analysis, keyword searches were selected as the primary research method for evaluation of KSA content. Keyword searches are useful for identifying the presence or absence of specific topics within syllabi. However, keyword searches must be interpreted cautiously. In some cases, a syllabus may appear to cover a topic, but if the keyword appears only in the title of a journal article in the bibliography at the end of the syllabus, that is not

necessarily an indication of adequate coverage. In other cases, the topic may be covered, but referred to using different terms that those searched, and therefore does not appear in the results.

For this keyword search, all syllabi were uploaded into DiscoverText (http://discovertext.com), a web-based qualitative software package. An "archive" of syllabi was created and each KSA area was searched separately. Each of the tables below lists the KSA topic area as provided to the research team, the keywords used to search the term, and the number of syllabi that used the term. Quotes around the keywords indicate that the words were searched as a phrase. If "no useful results" are reported, that was because almost all syllabi used the keyword, but not in a way that indicated that the topic is covered in the course. For example, almost all syllabi note that there are "writing requirements" for papers (typically 12 pt. font, one-inch margins, APA style, etc.), but this gives no indication as to whether the course supports improvement in student writing. Similarly, many syllabi use the term "confidentiality", but it is typically in the context of reminding students to maintain their clients' confidentiality in class and in papers by using pseudonyms. As some of the KSA areas overlap with the key themes of the MHSA that were searched more thoroughly through full review of each syllabus, the team obtained a more accurate understanding of how well these areas are covered. These areas of overlap include recovery, diversity, and co-occurring conditions.

Based on feedback during the oral presentation, additional searches were done for terms relating to co-occurring disorders/dual diagnosis. The results of these additional searches are as follows:

- Co-morbidity: 14
- Co-morbid: 9
- Co-morbidity OR co-morbid OR "dual diagnosis" OR co-occurring: 43

Tables 6, 7, and 8 summarize of the integration of the KSA knowledge, skills and abililities concepts respectively, identified as a result of the analysis of syllabi.

Table 6. Integration of Knowledge Areas

Knowledge Categories	Keywords Searched	Number of syllabi listing
Agency systems and resources	agency	55
Ethical and legal issues in treatment	ethics	79
Client confidentiality	No useful results	
Impact of racial, ethnic, age, class, cultural identity, gender identity, and sexual orientation on mental health practice	diverse	74
	diversity	73
	"cultural competence"	29
	"cultural humility"	1
	"cultural sensitivity"	3
	oppression	38
Trauma and its impact on a person	trauma	51
Affect of lifestyle on mood and behavior	not searched	not searched
Client assessment processes	assessment	101
Recovery process	recovery	56
Treatment interventions	intervention	86
Therapeutic use of self	"use of self"	91
Evidence-Based Practices	"evidence-based practice"	31
Major theories, categories, and models used in explaining mental illness	"mental illness"	64
	"mental disorder"	12
Co-occurring disorders (mental illness/substance abuse)	co-occurring	28
	"dual diagnosis"	19
Psychiatric medications	medication	32
	psychopharmacology	18
DSM IV	DSM	56
Evaluation process leading to a DSM-IV diagnosis	"case formulation"	6

Table 7. Integraton of Skill Areas

Skill Categories	Keywords Searched	Number of syllabi listing
Writing	No useful results	
Technical (use of computers/programs/internet)	software	7
Documentation/charting within Medi-Cal	documentation	28
Guidelines	Not searched	
Communication (includes listening and empathy)	communication	54
	listening	13
	empathy	15
Assessment of individual and his/her family	assessment	101
Development of tx, intervention, and d/c plans	"treatment plan"	23
Revising treatment plan	captured in "treatment plan"	
Case management	"case management"	38

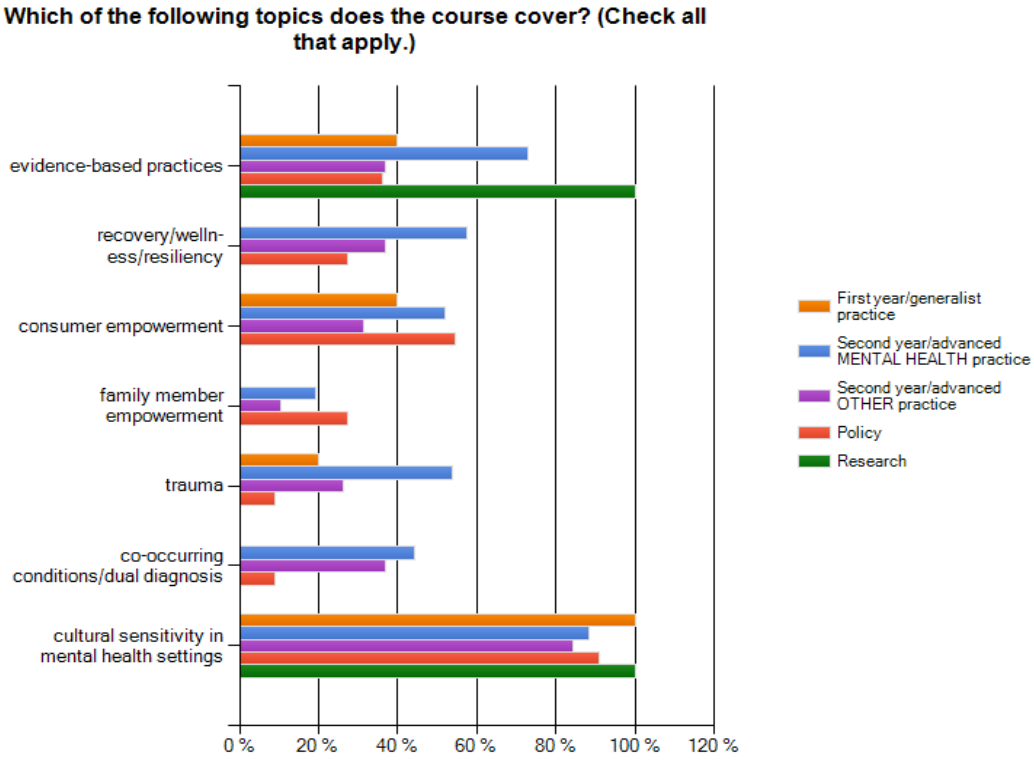
Table 8. Integration of Ability Areas

Ability Categories	Keywords Searched	Number of syllabi listing
Integrating theory into practice	"theory into practice"	41
Advocacy	advocacy	42
	"social justice"	50
Assertiveness	No useful results	
Cultural competency	See Knowledge slide	
Crisis intervention	crisis	47
Conflict resolution	"conflict resolution"	3
Multidisciplinary/Interdisciplinary teamwork	multi-disciplinary	20
	inter-disciplinary	22
Collaboration with coworkers and community	collaboration	44
Development of therapeutic relationship	"relationship building"	9
	rapport	6
	"therapeutic alliance"	5
Engaging client before beginning treatment	engagement	33
Facilitating self help/peer support interventions	"self-help"	14
	"peer support"	8
Handling non compliance/resistance to treatment	motivation	20
	motivational	28
	resistance	13
Maintaining appropriate boundaries	boundaries	25
Time management- plan, prioritize and monitor completion of assigned activities	No useful results	
Utilization of supervision	supervision	23
Stress management/self care in reducing work-related stress factors	"self-care"	10
Strategies to continue learning/maintaining professional growth	"professional development"	14

Incorporation of Key Themes of the Mental Health Services Act. To evaluate how well syllabi covered key themes of the MHSA, including evidence-based practices, recovery, consumer empowerment, family member empowerment, trauma, co-occurring conditions, and cultural sensitivity in mental health settings, the research team reviewed each syllabus individually for content

related to these areas. The research team was instructed not to mark a syllabus as covering an area if the area was only noted in a reading in the bibliography. If the area was clearly covered within the core text (e.g. a text focused specifically on psychosocial rehabilitation) or a reading for a class session, that was considered acceptable. Figure 34 shows how well five different types of courses incorporate key themes of the MHSA.

Figure 33: Incorporation of MHSA Key Themes in Five Types of Courses



Inclusion of CalSWEC Curriculum Competencies for Public Mental Health in California.

Nineteen percent of syllabi explicitly listed the competencies the course covered on the syllabus itself, or, in the case of one school, on a separate matrix provided to the research team. Of those that listed the competencies explicitly on the syllabus itself, most (57%) included a special section for the

competencies. Figure 35 shows how syllabi that listed the competencies did so. The areas covered are shown in Figure 36.

Figure 34: Where Syllabi Explicitly List Competencies Covered in the Course

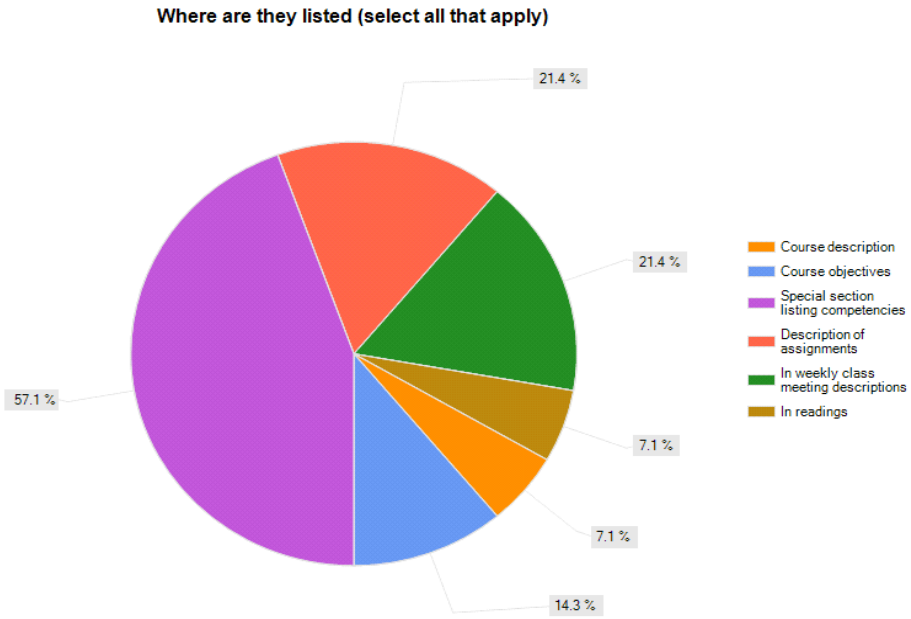
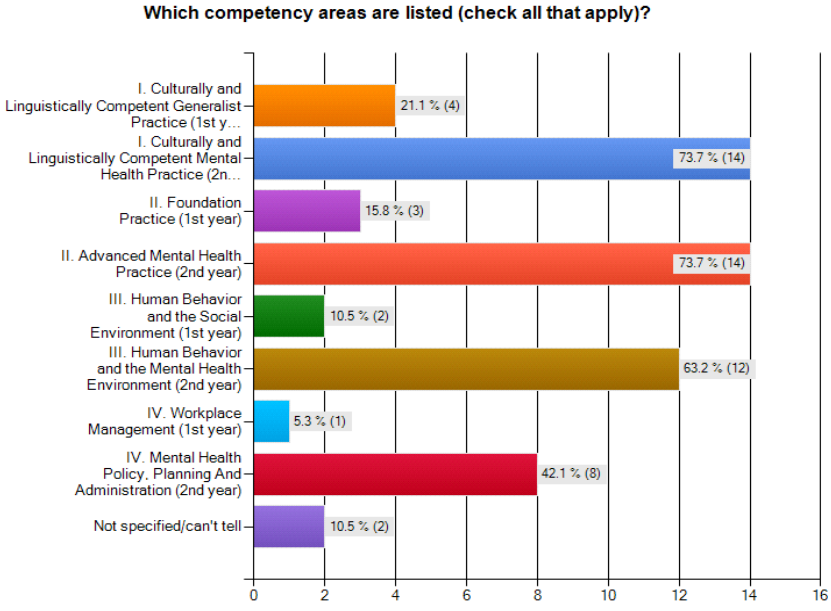


Figure 35: Areas Covered by Syllabi Explicitly Listing Competencies

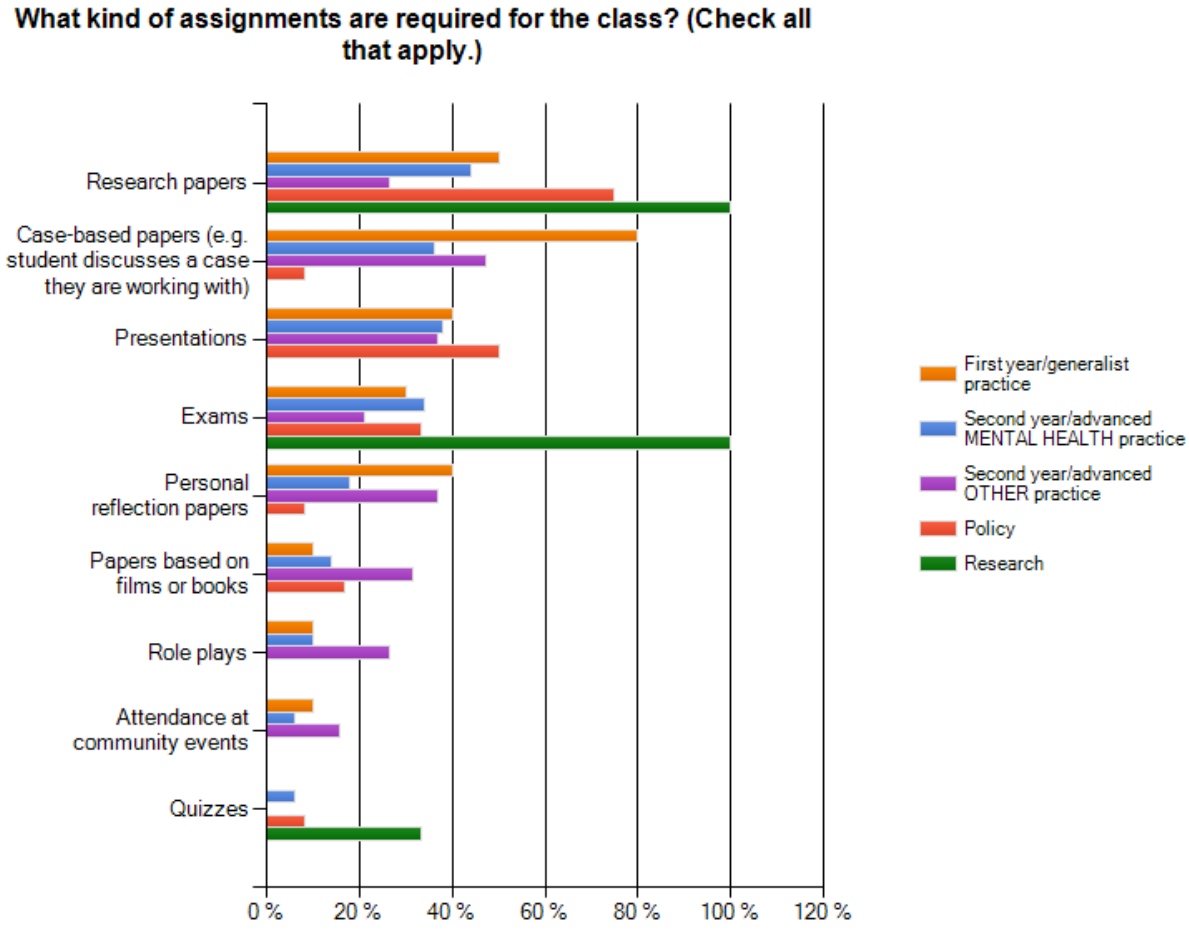


The research team was asked whether syllabi that did not explicitly list the competencies covered at least some competencies, and then asked to provide three examples of how the course covered one or more competencies. The research team indicated that 100% of syllabi covered at least some of the competencies. Due to limited time, the team was unable to complete in-depth analyses of these open-ended responses (the examples of how the competencies were covered). However, the word cloud below was created using Wordle (www.wordle.net) to show the topics noted by the research team as being covered. The size of the text indicates frequency of topic/word appearance, with the largest words being the most frequently appearing.

Figure 36: Open-Ended Responses Regarding Coverage of MH Competencies

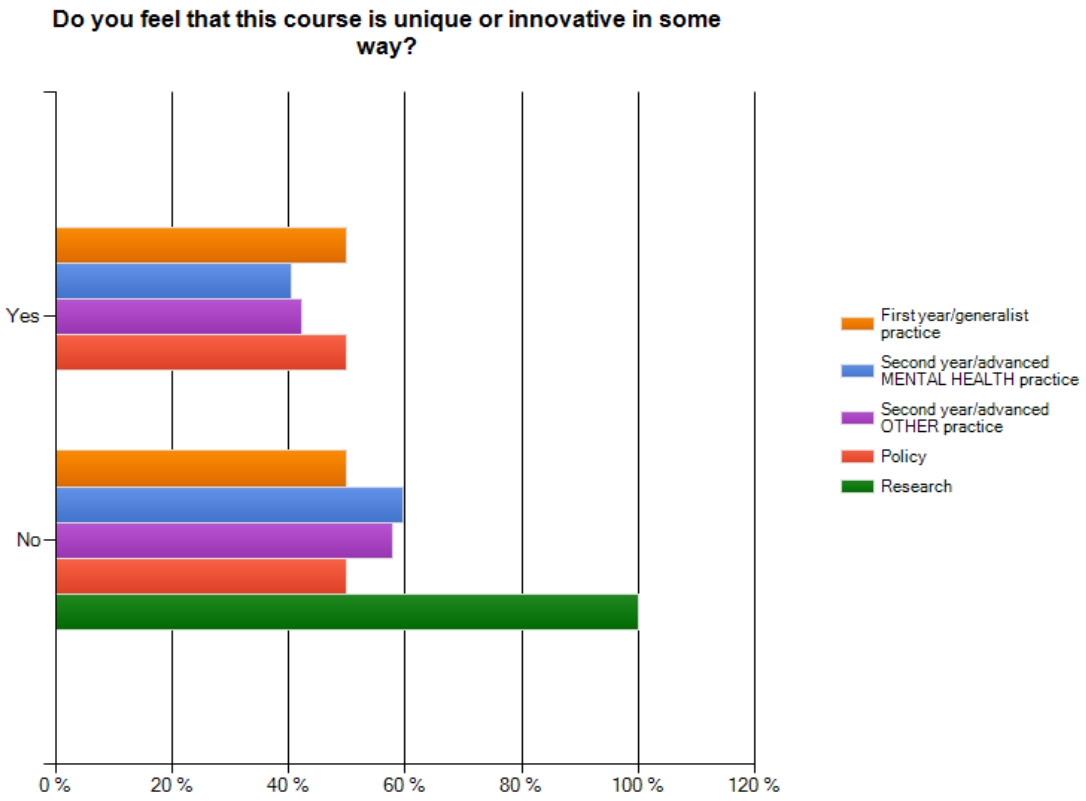
Assignments. The team was asked to review the types of assignments required for each course, and to describe how the assignments helped students learn the MH Competencies and/or the key themes of the MHSA. The types of assignments required for five types of courses are presented in Figure 37.

Figure 37: Assignments Required for Five Types of Courses



Innovation. The researchers were asked to use their judgment in determining whether a syllabus was "innovative". Overall, they rated 48% of syllabi as innovative. The team's ratings (innovative: yes or no) are shown in Figure 38 for five types of courses.

Figure 38: Researcher Ratings of Syllabi as Innovative



Following the rating of a syllabus as innovative, the researcher was asked to describe what was innovative about the course. The team most frequently identified assignments as innovative. Some of the assignments described were:

- Agency visits
- A "menu" of assignment choices
- Attendance at a client self-help meeting
- Advocacy-related assignments
- Attendance at a community meeting (e.g. an MHSA planning meeting)

- Experiential learning assignments
- WRAP plans
- Self-assessment assignments
- Mock licensing exam
- Creation and sharing of an artistic work (visual art, creative writing, etc.) to demonstrate growth and learning over the course of the semester

Other aspects of courses identified as innovative included:

- Guest speakers
- Comprehensiveness of material covered
- Group field trips
- Recovery focus
- Online learning opportunities
- Cultural diversity expressed through readings, topics, and guest speakers

One syllabus was noted for having multiple innovative components. The researcher, Amanda Ng, described it as innovative because it includes:

1) Attending mental health clinics for observation

2) Developing a Wellness Recovery Action Plan

3) Developing a strength-based and culturally sensitive model for consumers

4) Guest speakers on topics such as trauma and cultural humility

5) The parallel layout of course objectives, program objectives, and assignments under the Course Objectives section

6) Hybrid course with two online meetings

7) Discussion posts and News article discussions related to topics of mental health stigma, cultural sensitivity, etc.

When the Principal Investigator contacted the faculty member who created the syllabus, Donna Jensen, for permission to use it as an example, Ms. Jensen commented on the unique process through which the syllabus was developed. She wrote:

> It was a great process in that
> 1. The development/offering was paid for by the Superior Region Collaborative
> 2. In developing it I took it to the Collaborative meetings for feedback which included feedback from MH directors, WET coordinators, MHSA coordinators, consumers, family members, WWT and CIMH.
> 3. My MH Advisory Board at CSUC reviewed it.
> (D. Jensen, personal communication, December 8, 2010)

This suggests that a potential area for future investigation is the process of developing syllabi that meet CalSWEC MH Competencies, incorporate MHSA key themes, and teach to the KSA areas identified by alumni and employers.

Using an arbitrary cut-off whereby approximately 80% of syllabi appear to focus on a particular area, schools/departments participating in the CalSWEC MH Program are covering the following areas well:

- Assessment
- Intervention
- Professional use of self
- Ethics
- Cultural sensitivity in mental health settings
- Evidence-based practices (when focusing specifically on research and second-year/advanced mental health courses)

Some key areas which fell below 80% coverage across all course types, including second-year/advanced mental health courses, based on thorough review of syllabi by course type, include:

- Recovery
- Trauma
- Co-occurring disorders/dual diagnosis

- Family member empowerment
- Consumer empowerment

Some areas that also fell below 80% coverage when using the (less accurate) keyword search strategy across all course types include:

- Agency/organizational issues
- DSM-IV
- Advocacy
- Managing resistance/motivational interviewing
- Psychopharmacology
- Collaboration
- Integrating theory into practice
- Empathy & listening skills
- Conflict resolution
- Peer support/self-help
- Use of software and other technology
- Documentation
- Relationship-building
- Self-care
- Supervision
- Treatment planning
- Continuing professional education and development

Overall Findings and Recommendations

Findings:

Following are the findings regarding the CQI study process:

Perceived Importance.

- Strong and consistent data relationships were identified by the triangulation of the three data sets for graduates, supervisors and MH Program Coordinators.
- Because the perceptions of graduates, supervisors and MH Program Coordinators were not statistically different, it suggests that we could make a statement of strong conclusion validity regarding agreement of the importance of KSAs in providing an educational framework for the MH curriculum.

Perceived Provision.

- Data from graduates, supervisors and MH Program Coordinators demonstrate considerable variation in perceptions regarding the provision of select KSAs.
- Whereas some of the KSAs are covered well in the syllabi submitted, the content analysis of program syllabi suggests that there may be discrepancies between what occurs in courses vs. what is written in syllabi.
- Triangulation of data supports the need to strengthen the content of select content areas, including theory, practice evaluation, co-occurring disorders, ethics, professional behaviors, advocacy (empowerment), teamwork, interpersonal interactions.

Recommendations.

- Data variations between graduates' perception of importance vs. provision should be examined to assure that differences are not the result of new employee anxiety, e.g., are there changes in performance expectations that help to explain variations?

- Additional attention should be given to studying the variations in the perceptions of the provision of select KSAs by Graduates, Supervisors, and Faculty and subsequent appropriate emphasis placed on intensifying the provision of identified KSAs.
- Increased attention should be given to closer adherence to the language of KSAs in program syllabi.

CQI: Next Steps in Demonstrating Educational Effectiveness

There is evidence to support the need for continuing the CQI process. In so doing, a number of methodological issues need to be addressed, including obtaining larger sample sizes for all groups, as well as a review of the instruments for consistency in the structure of all questions and scales. In addition, and prior to the next study, efforts should be made to assure that schools/departments interpret and apply the competencies in consistent ways. To support this, the language of the competencies should support the KSAs. In addition, greater consistency between schools/departments would be supported by the development of performance criteria and an assessment rubric for the KSAs. Although difficult, the ability to make statement regarding the educational effectiveness of the MH curriculum would be strengthened if students/graduates could be assessed with both formative and summative assessment measures (e.g., prior to and one year after graduation).

Appendices:

Appendix A-CQI Graphs

Appendix B-CQI Graphs (Factor Analysis, ANOVA)

Appendix C-Content Analysis of Syllabi

Appendix D-PowerPoint Presentation

APPENDIX A
CalSWEC Mental Health Stipend Survey
2010 Survey Highlights

ABSTRACT

Purpose: This Continuous Quality Improvement study examined areas potentially needing revision and/or additional emphasis in graduate level Social Work curriculum content used to guide the implementation of the California-based Prop. 63 Mental Health Stipend Program. *Methods:* Electronic surveys were used to collect data from social work graduates working in the field of mental health (*N* = 163) in order to assess their perceptions on the importance of various curriculum offerings as well as the extent to which competencies were provided in classrooms and field experiences. We triangulated this primary data source by surveying faculty (*N* = 12) from the schools and programs of social work representative of the institutions attended by graduates as well as supervisors from county and county contracted mental health agencies (*N* = 40). *Results:* On average the level of importance assigned to KSAs were consistently rated between important to very important among students (*M* = 3.5, *SD* = 0.1), faculty (*M* = 3.4, *SD* = 0.6), and supervisors (*M* = 3.4, *SD* = 0.2). Though, students revealed significant disparities in the provision of certain KSAs, notably items such as the evaluation process leading to a DSM diagnosis (47.5% difference), documentation charting within Medi-Cal guidelines (47.5% difference), and crisis intervention (32.5% difference). More than half of supervisors indicated that graduates were not prepared with respect to knowledge of evidence-based practices and the recovery process, skills such as documentation/charting within Medi-Cal guidelines, and abilities including handling non-compliance. Faculty indicated that graduates were not prepared to facilitate self-help/peer support groups; which was closely followed by Conflict Resolution. *Conclusion:* Considerable challenges remain in constructing social work curriculum that is relevant and appropriate to practice in the field, and effective learning can be ensured through facilitating the integration of knowledge gained in classrooms directly to situations in practice.

CQI Summary of Results

METHODS

Study Participants & Sampling Procedures

Our student sampling frame consisted of 713 mental health stipend graduates from the 17 schools and programs of social work across the state of California to include the 2006 through 2009 cohorts who have been working in the field for at least one year. We obtained lists of archived graduate names and email addresses from liaisons at all 17 institutions in order to send the formal electronic or e-survey invitation letter. No specific sample size was sought; however, efforts were made to feasibly secure the largest sample possible. Upon sending the invitation letter and two reminder invitations to graduates through the *Survey Monkey* web based survey tool, approximately 36 (5%) e-mail addresses were deemed "undeliverable", three individuals opted-out, 537 did not attempt opening the survey. Conservative statistical measures were used such as replacing missing values with overall group means for an individual question while omitting cases in which a majority of salient response categories was not completed, resulting in 12 omissions. This ultimately yielded a sample size (N) of 163, or a response rate of 23%. Faculty and supervisors were recruited from the 17 institutions and from county and county-contracted mental health departments, respectively. This was facilitated through pre-established relationships with these sub-groups per authors JB and JR. Our faculty sampling frame included 26 individuals of which 12 responded to an e-survey similarly administered to graduates, and 40 supervisors responding to a paper-based survey.

Measures/Instruments

In developing the survey instrument, several focus groups were conducted with recent mental health graduates across southern California. Responses were elicited on competency areas participants perceived as necessary for graduates to possess for success and productivity in the field of public mental health. Salient themes were extracted from focus group findings and were cross-checked with competencies outlined in the CalSWEC Advanced and Foundational Year Competencies Handbook. The purpose of this was to limit duplication of certain competencies and to promote a disparate array of measures that we intended on including in the survey. Themes/competencies were subsequently categorized into knowledge, skill, and ability (KSA) areas. To facilitate this process, we used the US Office of Personnel Management's (US OPM, 2011) definition of knowledge as "a body of information applied directly to the performance of a function"; a skill as "an observable competence to perform a learned psychomotor act"; and an ability as "competence to perform an observable behavior or a behavior that results in an observable product.

The final student survey included 34 questions, mainly composed of closed- and a limited number of open-ended questions. The questionnaire included a section on demographics where respondents answered questions on age, gender, race/ethnicity, year of graduation, and degrees in addition to the MSW. Respondents' perceived importance of KSAs within the rubric of 'competencies' was assessed through a rating scale. Graduates assigned ratings of 'importance' for each KSA or competency area on a 0-to-4 Likert-type response scale where 0= "unimportant" and 4= "very important." A separate scale was utilized to measure the provision of curriculum offerings related to the competencies, which is also given on a 0-to-4 Likert-type response scale where 0= "not at all" and 4= "(provided) to a very great extent." Scores were not aggregated for any of the aforementioned scales. Other rating scales included a question that asked respondents how helpful certain classroom experiences were in preparing them for the field of public mental health. This was also given a Likert-type response scale where 0= "not offered and 5= "very helpful." Other questions relate to

public mental health experiences while in school, job satisfaction, as well as open-ended questions eliciting suggestions for improving MSW curriculum.

A variant of the graduate survey was extended to faculty and mental health supervisors, which contained similar constructs as the graduate survey but exclusive of a number of student-specific questions. Additionally faculty and supervisors were solicited on how well prepared they perceived mental health graduates to be, upon graduation and in the field, respectively (with regard to each competency area).

Procedures

All study methods and procedures were reviewed and approved by the Institutional Review Board at Loma Linda University. Schools and programs of social work established initial contact with their graduates via e-mail by encouraging them to take part in an upcoming survey- an activity that graduates are expected to engage in as outlined in the stipulations of receiving the mental health stipend. Mental health graduates were subsequently prompted to take part in the survey through an invitation letter highlighting the study's objectives, which contained a link to the e-survey. Consent was solicited once participants entered the online survey instrument, and "implied consent" was obtained as graduates proceeded to completing the survey. Graduates were given 10 days to complete the survey before two reminder letters, separated by 10-day increments were sent to their e-mail addresses. Once an ample amount of graduate surveys was obtained, access to the survey was blocked as data analysis commenced. This provided an opportunity to examine preliminary data from this primary source and to make informed decisions as to the type of questions faculty and supervisors ought to be asked. We later triangulated our primary data source by referring to faculty through an online survey and supervisors through a paper-based survey.

Data Analysis

Data from student and faculty surveys was retrieved from the web-based survey instrument's server and was downloaded in *Microsoft Excel* and subsequently exported to a dataset developed in the *Statistical Package for Social Sciences (SPSS), version 18.0.* Given the exploratory nature of this study design, descriptive statistics were generated for a majority of responses. Such an analysis is inclusive of, but not limited to the importance and provision ratings assigned to the various KSA areas and preparedness ratings of graduates. A factor analysis was conducted to determine what underlying structures exist for measures assessing the importance and provision of all KSA variables (Mertler & Vannatta, 2005).

RESULTS

Sample Description

Of the 163 graduates completing the online survey, the school with the smallest representation of the entire sample accounted for the highest response rate (Humboldt State, N = 11, 45.5% response rate. However, highest in terms of the sheer number of responses and the proportion of responses based on the sample, USC reported 20 responses, accounting for 12.3% of all responses. Furthermore, little representation came from CSU Bakersfield in which only one person responded to the e-survey. A major problem in recruitment, especially with this school was the inability to reach such individuals due to undeliverable e-mail addresses. However, attempts were made for obtaining most current addresses, where in most cases out comes were not successful. The mean (*M*) age of grads was reported at *M = 34* with the highest representation from the 25-34 age category. A majority of grads reported being female (N = 132), which accounted for 81% of the sample. Fifty-one (*N* = 88) grads reported being "White", which was followed by the "Hispanic/Latino" group (*N* = 36). Grads who reported being "Other" (*N = 10*) identified themselves as "Black and White", Native American and White", and "Asian Indian." In terms of year of graduation the highest representation was reported in the 2007 cohort with 48 grads- accounting for 29.4% of the sample.

Our overall response rate was 23%. Humboldt State, a school with the lowest representation in terms of potential grads (*N = 11*) reported the highest school response rate (45.5%). However, highest in terms of the sheer number of responses and the proportion of responses based on the sample, USC reported 20 responses, accounting for 12.3% of all responses. A major problem in recruitment was the inability to reach such individuals due to undeliverable e-mail addresses. However, attempts were made for obtaining most current addresses, where in some cases results were more successful than in others. Lastly, schools with a mental health concentration included: CSU Bakersfield, CSU Chico , CSU East Bay, CSU San Jose, CSU San Bernardino, Loma Linda University (LLU), UC Berkeley, UCLA, and USC.

Table 1. Demographics (N = 163)

	Number (%) of Grads
Mean Age [years]	34 (*SD* = 8.17)
Age Groups	
18-24	1 (.6)
25-34	110 (67.5)
35-44	32 (19.6)
45-64	20 (12.3)
≥65	0 (0)
Gender	
Male	31 (19)
Female	132 (81)
Race	
African American	8 (4.9)
Asian or Pacific Islander	25 (15.3)
Hispanic/Latino	36 (22.1)
Native American	1 (.6)
White	83 (50.9)
Other	10 (6.1)
Graduation Year	
2006	33 (20)
2007	48 (29.4)
2008	42 (26)
2009	40 (24.5)

Table 2. Response Rates

School Attended	Number (% of total sample) of Grads (*N = 163*)	Sampling Frame (*N = 713*)
CSU System		
Bakersfield	1 (.6)	19
Chico	8 (4.9)	30
East Bay	9 (5.5)	56
Fresno	3 (1.8)	36
Humboldt	5 (3)	11
Long Beach	19 (11.6)	70
Los Angeles	5 (3)	26
Sacramento	16 (9.8)	70
San Bernardino	7 (4.3)	56
San Diego	15 (9.2)	57
San Francisco	13 (8)	38
San Jose	7 (4.3)	39
Stanislaus	3 (1.8)	16

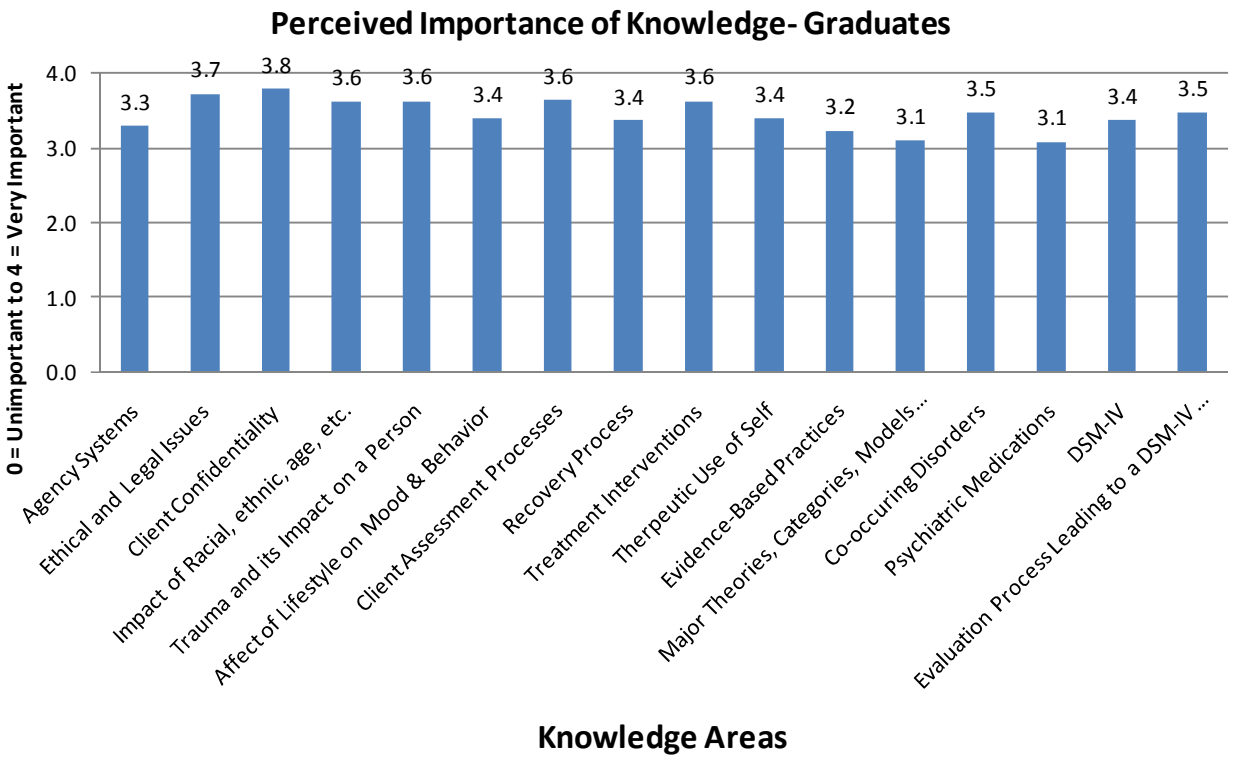
Loma Linda University	10 (6.1)	33
University of Southern California	20 (12.3)	78
UC System		
Berkeley	10 (6.1)	41
Los Angeles	12 (7.4)	37

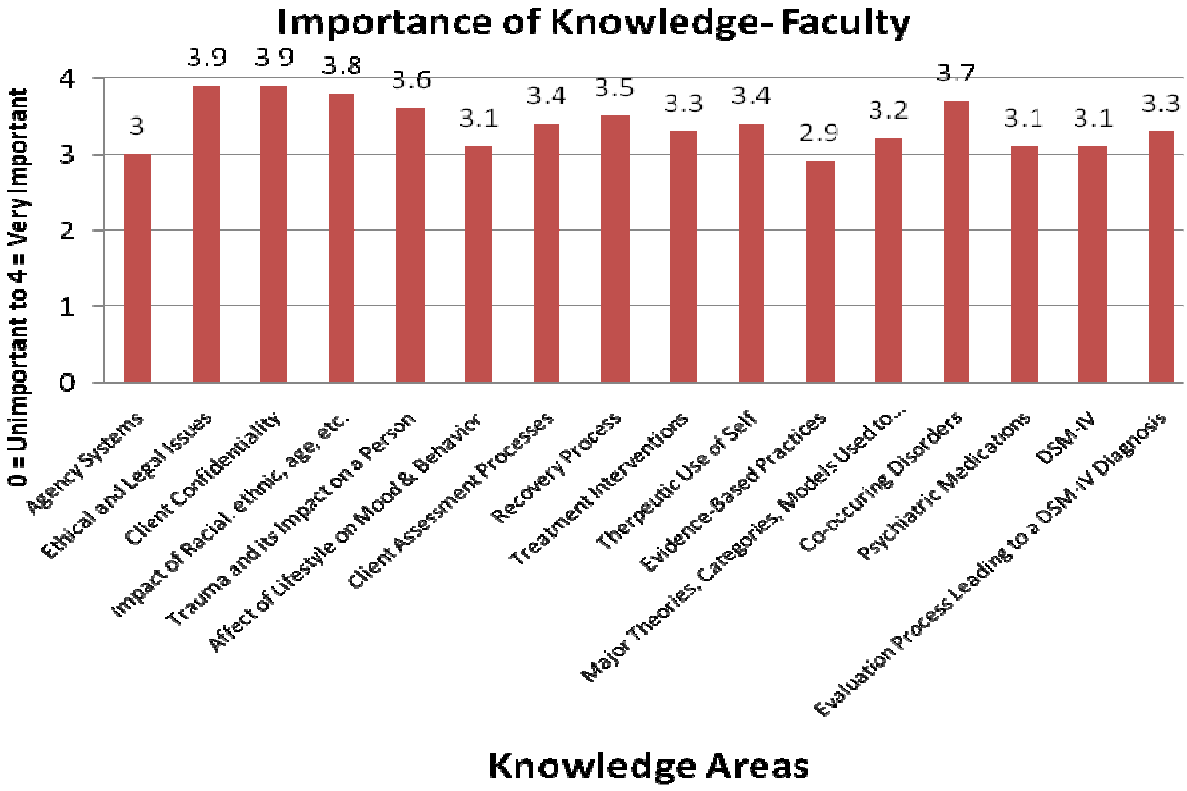
Perceived Importance, Provision, and Preparedness of Knowledge: Graduates, Faculty, and Supervisors

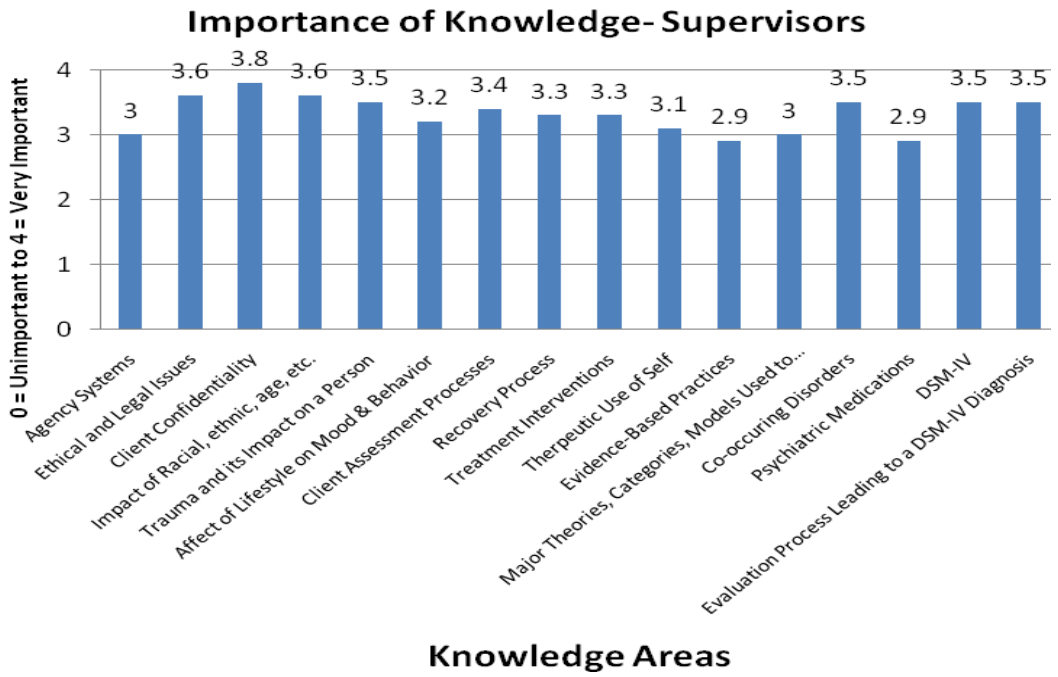
Graduates were solicited on their perceptions regarding the importance of various knowledge areas for the beginning MSW mental health worker and the extent to which they received them in classroom and/or fieldwork experiences. On average grads rated Client Confidentiality as most important with a mean rating of 3.8, and rated Major Theories, Categories, and Models Used in Explaining Mental Illness along with Psychiatric Medications lowest with a mean rating of 3.1. However, all areas were rated '3' or above ("important" to "very important"). On average supervisors rated all knowledge areas as "important" with the exception of EBPs (*M* = 2.9) and Psychiatric Medications (M = 2.9), which all fell slightly below the "important" benchmark. Similarly, faculty also reported the importance of EBPs with a similar rating- i.e. 'less than important.' Client confidentiality was rated as the single most important knowledge area with a reported mean of 3.8 by supervisors, as indicated by faculty as well (*M* = 3.9). On average, with the exception of EBPs, faculty rated all knowledge areas as "important." The knowledge areas that supervisors idenitified most with respect to grads not being prepared were Psychiatric Medictions (*N* = 18); secondly, Evidence-Based Practices (*N* = 18); and closely followed by Recovery Process (*N* = 16). Approximately 11 to 12 faculty responded to this question, and those who responded identified Psychiatric Medictions(*N* = 3) as an area that grads are not prepared for upon graduation. A majority of knowledge areas were unanimously rated as 'prepared.'

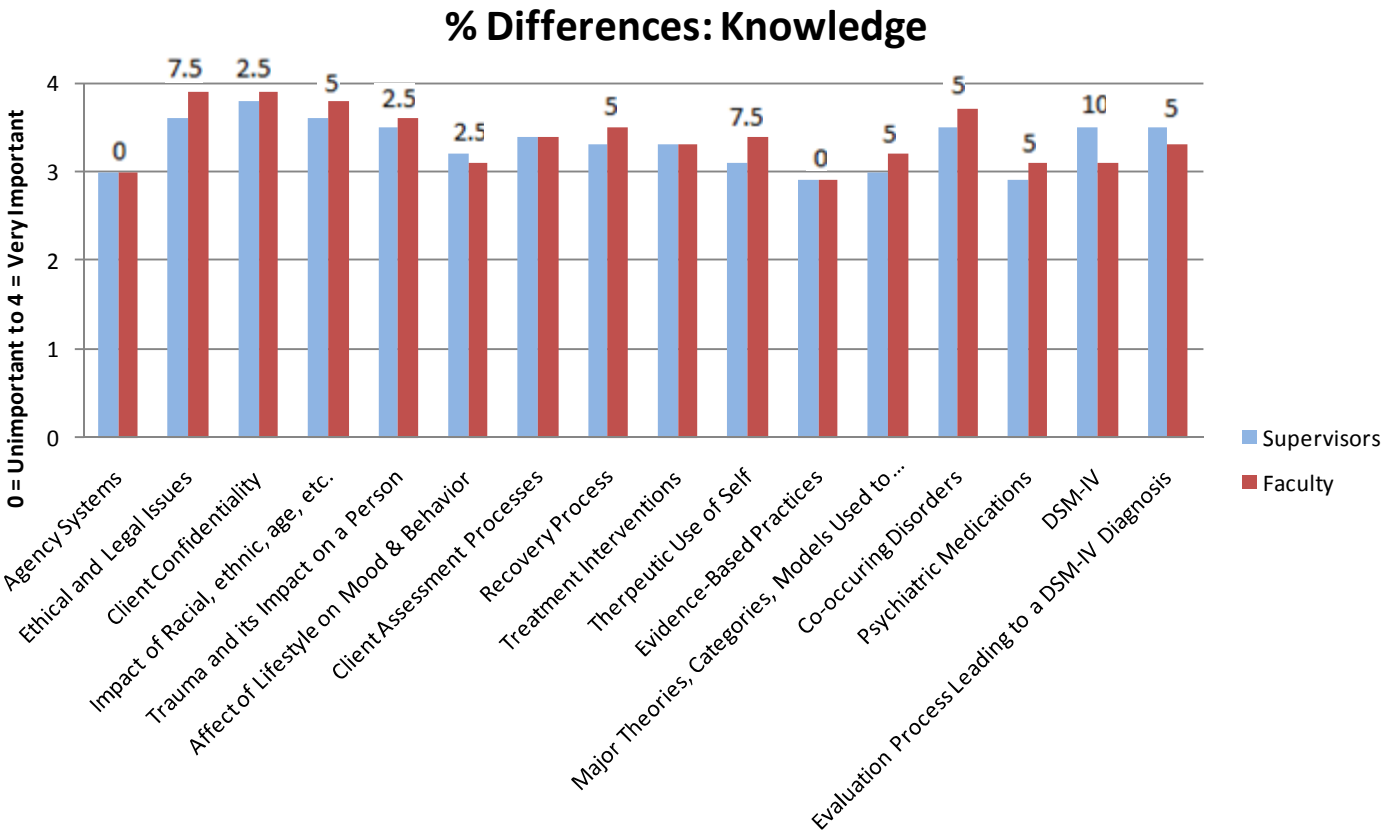
We also analyzed importance of knowledge areas as a function of years of supervisory experience. The chart is relatively consistent across all areas as those with '7 to 10' years experience rated knowledge areas as lowest in all categories with the exception of Affect of Lifestyle on Mood and Behavior, Therapeutic Use of Self, and Major Theories, Categories, Models Used to Explain Mental Illness. Moreover, with the exception of Major Theories, etc., and Therapeutic Use of Self, supervisors reporting 7 to 10 years experience rated all areas lowest in comparison to other supervisor experience groups.

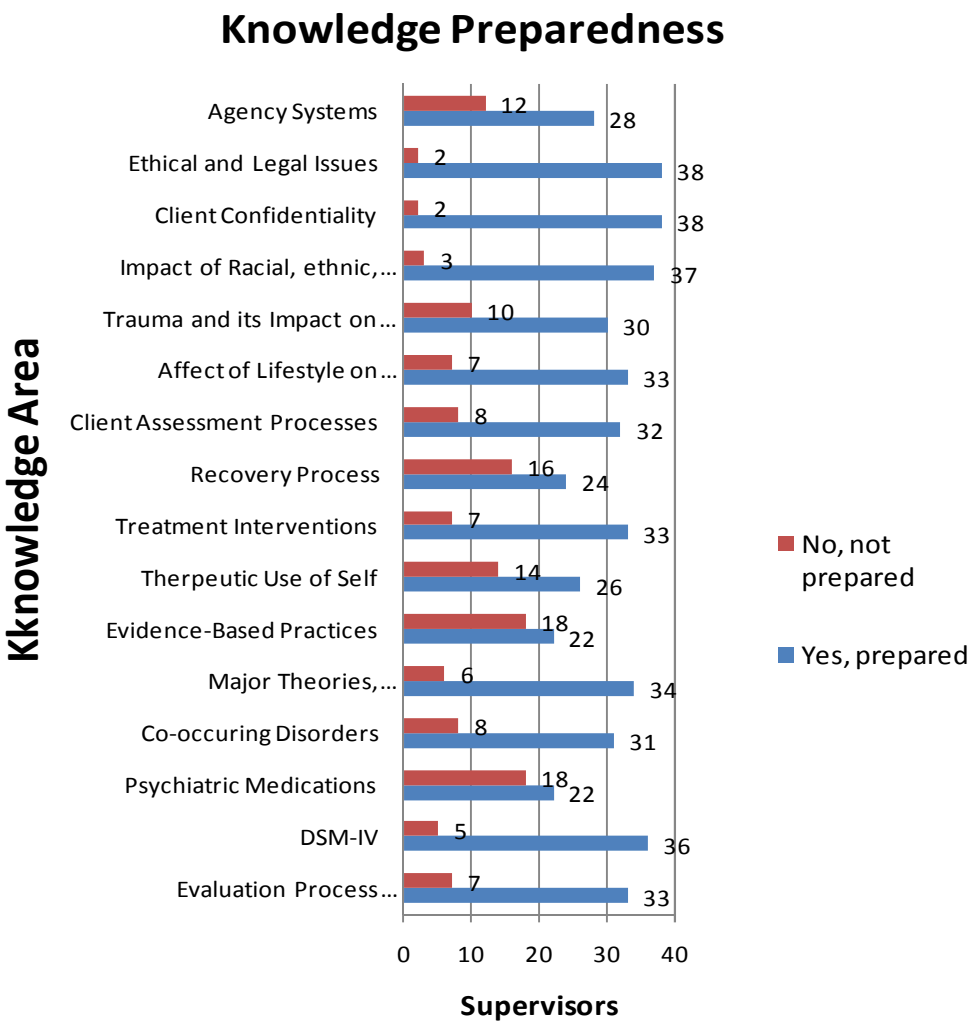
Provision of knowledge by year of graduation was rated with relative consistency across all years; however, those graduating in 2006 reported receiving the least amount for each knowledge area, with the exception of Therapeutic Use of Self. Notable discrepancies in the perceived level of importance assigned to a certain knowledge area and its provision in the classroom and/or through fieldwork experiences were reported in Evaluation Process Leading to a DSM-IV Diagnosis (-1.9), Ethical and Legal Issues (-1.4), and in Recovery Process (-1.1). Evaluation Process Leading to a DSM-IV diagnosis was rated between slightly and moderately provided- the lowest rating in this series. Importance of knowledge by year of graduation was rated with relative consistency across all years as all areas were deemed "important" to "very important" with the exception of Psychiatric Meds, which fell slightly below the important marker. We also analyzed importance of knowledge areas was tabulated as a function of years of supervisory experience. The chart is relatively consistent across all areas as those with '7 to 10' years experience rated knowledge areas as lowest in all categories with the exception of Affect of Lifestyle on Mood and Behavior, Therapeutic Use of Self, and Major Theories, Categories, Models Used to Explain Mental Illness. Moreover, with the exception of Major Theories, etc., and Therapeutic Use of Self, supervisors reporting 7 to 10 years experience rated all areas lowest in comparison to other supervisor experience groups.

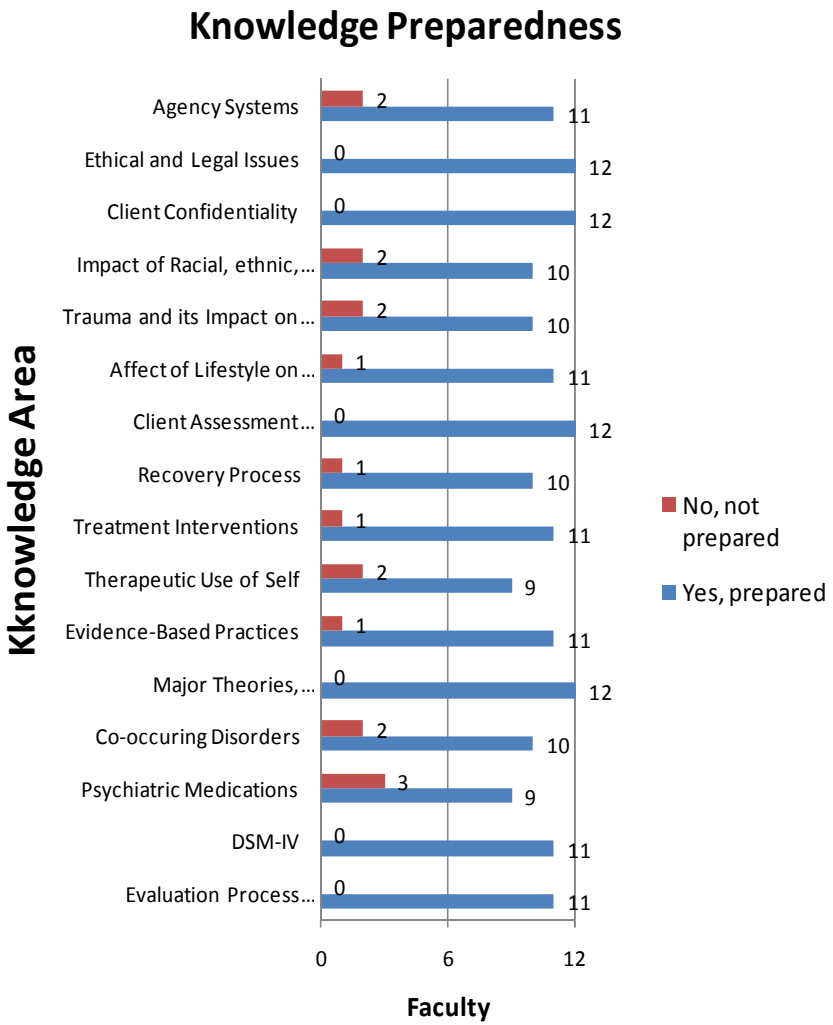

Perceived Importance of Knowledge- Graduates
0 = Unimportant to 4 = Very Important
4.0
3.0
2.0
1.0
0.0
3.3
3.7
3.8
3.6
3.6
3.4
3.6
3.4
3.6
3.4
3.2
3.1
3.5
3.1
3.4
3.5
Agency Systems
Ethical and Legal Issues
Client Confidentiality
Impact of Racial, ethnic, age, etc.
Trauma and its Impact on a Person
Affect of Lifestyle on Mood & Behavior
Client Assessment Processes
Recovery Process
Treatment Interventions
Therpeutic Use of Self
Evidence-Based Practices
Major Theories, Categories, Models...
Co-occuring Disorders
Psychiatric Medications
DSM-IV
Evaluation Process Leading to a DSM-IV ...
Knowledge Areas


Importance of Knowledge- Faculty
0 = Unimportant to 4 = Very Important
4
3
2
1
0
3
3.9
3.9
3.8
3.6
3.1
3.4
3.5
3.3
3.4
2.9
3.2
3.7
3.1
3.1
3.3
Agency Systems
Ethical and Legal Issues
Client Confidentiality
Impact of Racial, ethnic, age, etc.
Trauma and its Impact on a Person
Affect of Lifestyle on Mood & Behavior
Client Assessment Processes
Recovery Process
Treatment Interventions
Therpeutic Use of Self
Evidence-Based Practices
Major Theories, Categories, Models Used to...
Co-occuring Disorders
Psychiatric Medications
DSM-IV
Evaluation Process Leading to a DSM-IV Diagnosis
Knowledge Areas

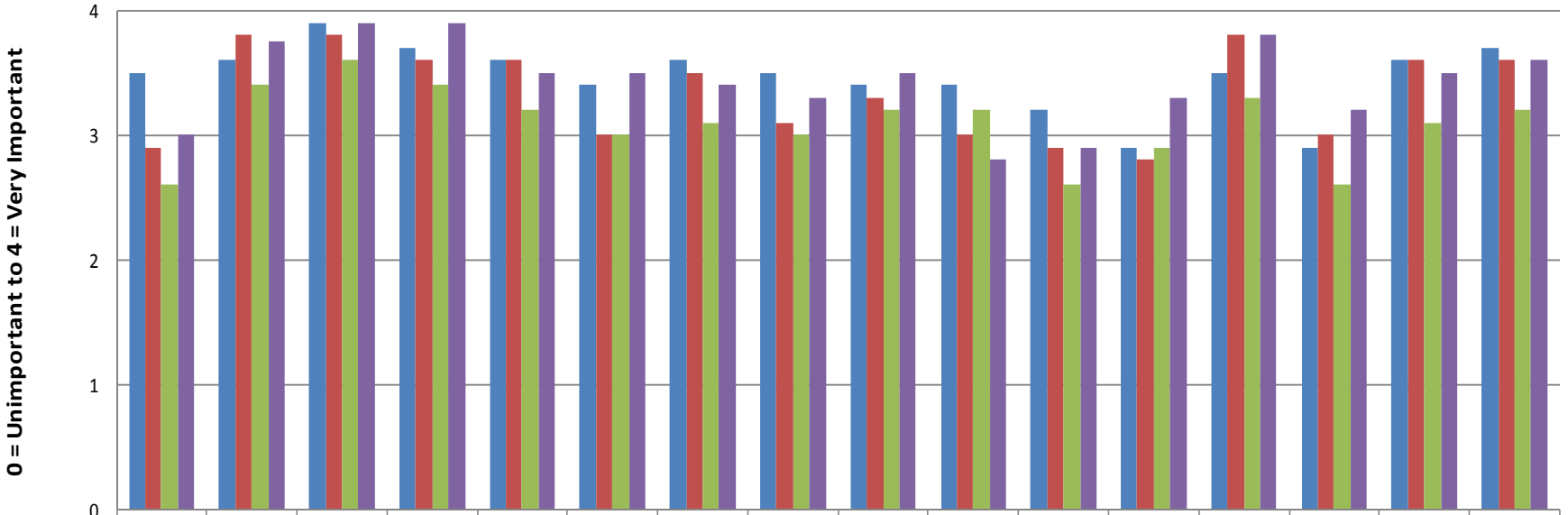

Importance of Knowledge- Supervisors
0 = Unimportant to 4 = Very Important
4
3
2
1
0
3
3.6
3.8
3.6
3.5
3.2
3.4
3.3
3.3
3.1
2.9
3
3.5
2.9
3.5
3.5
Agency Systems
Ethical and Legal Issues
Client Confidentiality
Impact of Racial, ethnic, age, etc.
Trauma and its Impact on a Person
Affect of Lifestyle on Mood & Behavior
Client Assessment Processes
Recovery Process
Treatment Interventions
Therpeutic Use of Self
Evidence-Based Practices
Major Theories, Categories, Models Used to...
Co-occuring Disorders
Psychiatric Medications
DSM-IV
Evaluation Process Leading to a DSM-IV Diagnosis
Knowledge Areas


% Differences: Knowledge
0 = Unimportant to 4 = Very Important
4
3
2
1
0
0
7.5
2.5
5
2.5
2.5
5
7.5
0
5
5
5
10
5
Agency Systems
Ethical and Legal Issues
Client Confidentiality
Impact of Racial, ethnic, age, etc.
Trauma and its Impact on a Person
Affect of Lifestyle on Mood & Behavior
Client Assessment Processes
Recovery Process
Treatment Interventions
Therpeutic Use of Self
Evidence-Based Practices
Major Theories, Categories, Models Used to ...
Co-occuring Disorders
Psychiatric Medications
DSM-IV
Evaluation Process Leading to a DSM-IV Diagnosis
Supervisors
Faculty

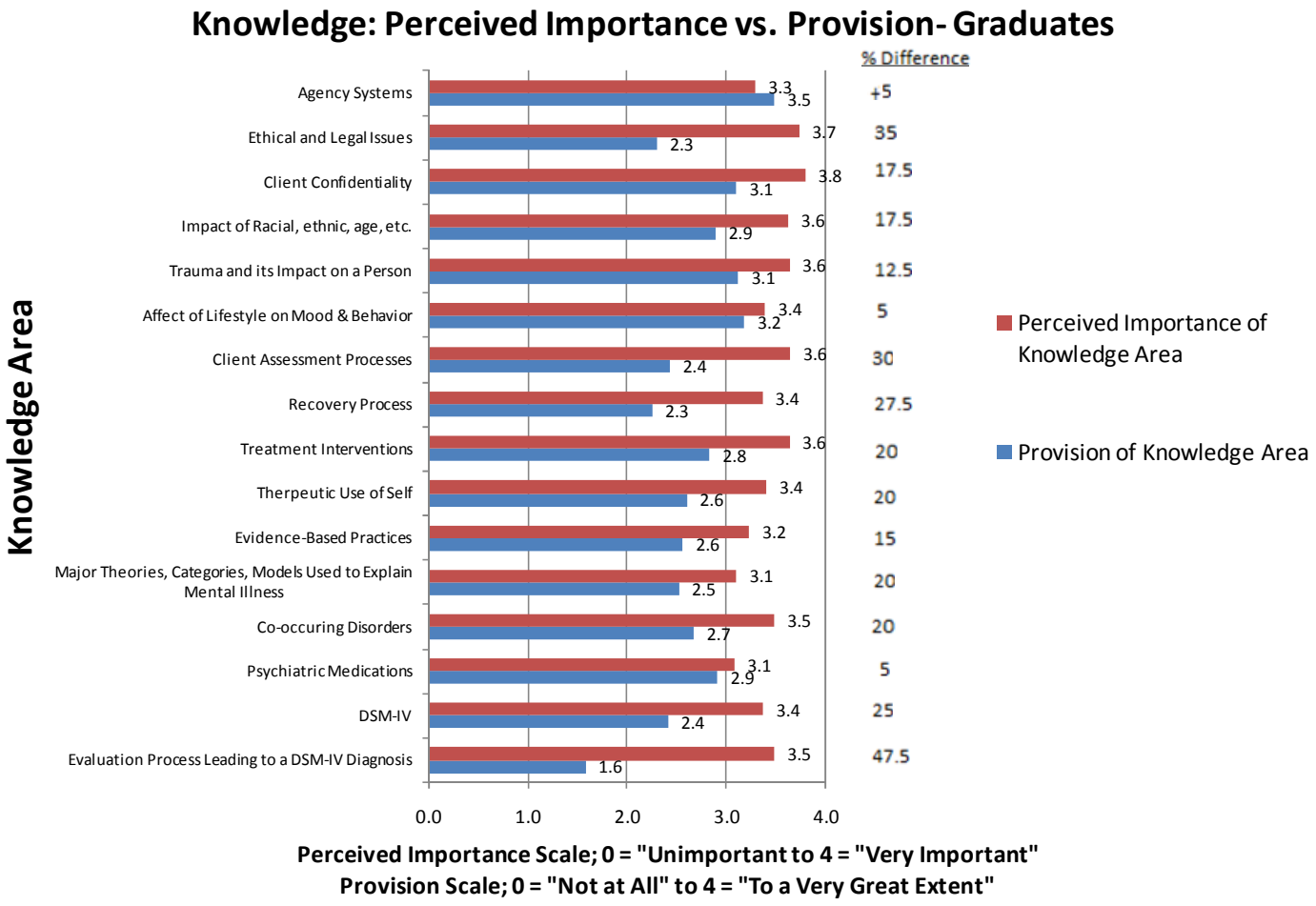

Knowledge Preparedness
Kknowledge Area
Agency Systems
Ethical and Legal Issues
Client Confidentiality
Impact of Racial, ethnic,...
Trauma and its Impact on...
Affect of Lifestyle on...
Client Assessment Processes
Recovery Process
Treatment Interventions
Therpeutic Use of Self
Evidence-Based Practices
Major Theories,...
Co-occuring Disorders
Psychiatric Medications
DSM-IV
Evaluation Process...
12
28
2
38
2
38
3
37
10
30
7
33
8
32
16
24
7
33
14
26
18
22
6
34
8
31
18
22
5
36
7
33
0
10
20
30
40
Supervisors
No, not prepared
Yes, prepared

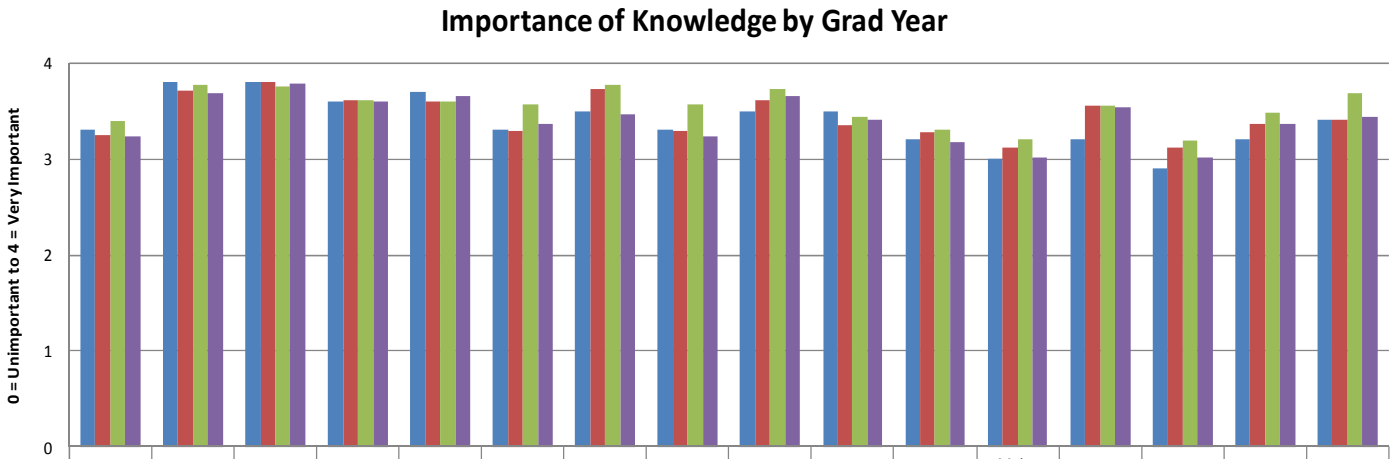

Knowledge Preparedness
Kknowledge Area
Agency Systems
Ethical and Legal Issues
Client Confidentiality
Impact of Racial, ethnic,...
Trauma and its Impact on...
Affect of Lifestyle on...
Client Assessment...
Recovery Process
Treatment Interventions
Therapeutic Use of Self
Evidence-Based Practices
Major Theories,...
Co-occuring Disorders
Psychiatric Medications
DSM-IV
Evaluation Process...
2
11
0
12
0
12
2
10
2
10
1
11
0
12
1
10
1
11
2
9
1
11
0
12
2
10
3
9
0
11
0
11
0
6
12
Faculty
No, not prepared
Yes, prepared

Importance of Knowledge by Years of Supervisory Service

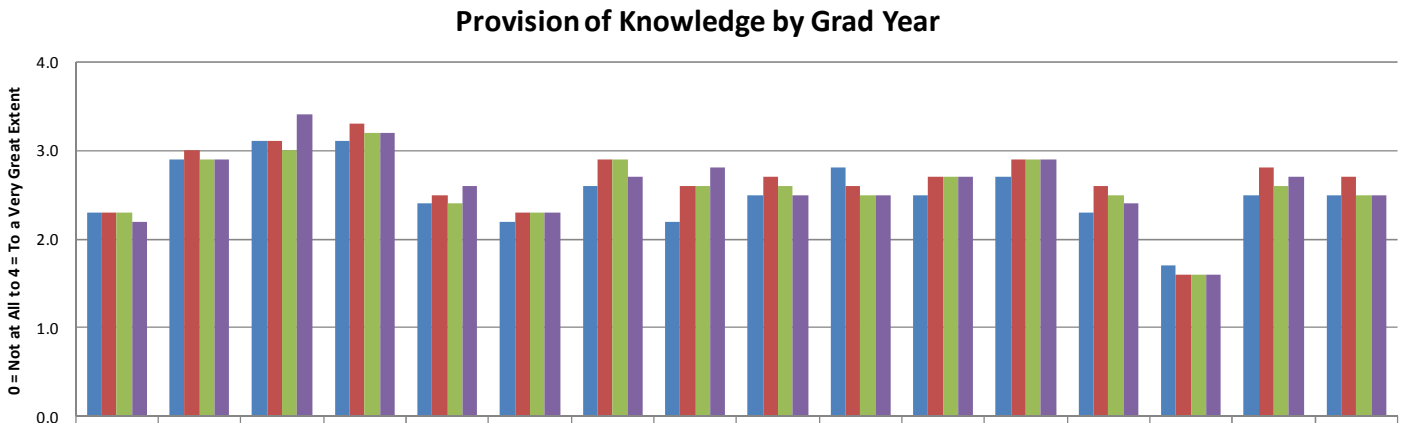


	Agency Systems	Ethical and Legal Issues	Client Confid.	Impact of racial, ethnic, age, etc.	Trauma and its Impact on a Person	Affect of Lifestyle on Mood & Behavior	Client Assmt. Processes	Recovery Process	Tx Interventions	Therpeutic Use of Self	EBPs	Major Theories, Categories, Models Used to Explain Mental Illness	Co-occuring Disorders	Psychiatric Meds	DSM-IV	Eval Process Leading to a DSM-IV Diagnosis
≤1 to 3 yrs	3.5	3.6	3.9	3.7	3.6	3.4	3.6	3.5	3.4	3.4	3.2	2.9	3.5	2.9	3.6	3.7
4 to 6 yrs	2.9	3.8	3.8	3.6	3.6	3	3.5	3.1	3.3	3	2.9	2.8	3.8	3	3.6	3.6
7 to 10 yrs	2.6	3.4	3.6	3.4	3.2	3	3.1	3	3.2	3.2	2.6	2.9	3.3	2.6	3.1	3.2
≥11 yrs	3	3.75	3.9	3.9	3.5	3.5	3.4	3.3	3.5	2.8	2.9	3.3	3.8	3.2	3.5	3.6





	Agency Systems	Ethical and Legal Issues	Client Confid.	Impact of Racial, ethnic, age, etc.	Trauma and its Impact on a Person	Affect of Lifestyle on Mood & Behavior	Client Asessment Proc.	Recovery Process	Tx Intvns.	Therpeutic Use of Self	Evidence-Based Practices	Major Theories, Categories, Models Used to Explain Mental Illness	Co-occuring Disorders	Psychiatric Meds	DSM-IV	Eval Process Leading to a DSM-IV Diagnosis
2006	3.3	3.8	3.8	3.6	3.7	3.3	3.5	3.3	3.5	3.5	3.2	3	3.2	2.9	3.2	3.4
2007	3.3	3.7	3.8	3.6	3.6	3.3	3.7	3.3	3.6	3.4	3.3	3.1	3.6	3.1	3.4	3.4
2008	3.4	3.8	3.8	3.6	3.6	3.6	3.8	3.6	3.7	3.4	3.3	3.2	3.6	3.2	3.5	3.7
2009	3.2	3.7	3.8	3.6	3.7	3.4	3.5	3.2	3.7	3.4	3.2	3.0	3.5	3.0	3.4	3.4



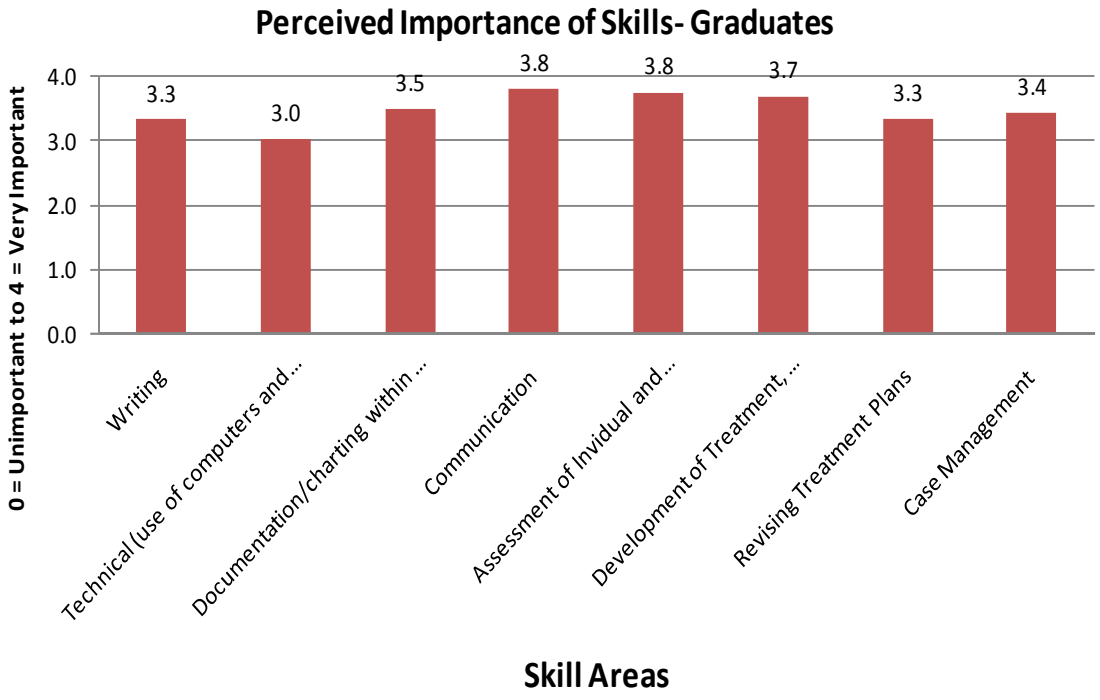
	Agency Systems	Ethical and Legal Issues	Client Confid.	Impact of Racial, ethnic, age, etc.	Trauma and its Impact on a Person	Affect of Lifestyle on Mood & Behavior	Client Asessment Proc.	Recovery Process	Tx Intvns.	Ther-peutic Use of Self	Evidence-Based Practices	Major Theories, Categories, Models Used to Explain Mental Illness	Co-occuring Disorders	Psychiatric Meds	DSM-IV	Eval Process Leading to a DSM-IV Diagnosis
2006	2.3	2.9	3.1	3.1	2.4	2.2	2.6	2.2	2.5	2.8	2.5	2.7	2.3	1.7	2.5	2.5
2007	2.3	3	3.1	3.3	2.5	2.3	2.9	2.6	2.7	2.6	2.7	2.9	2.6	1.6	2.8	2.7
2008	2.3	2.9	3	3.2	2.4	2.3	2.9	2.6	2.6	2.5	2.7	2.9	2.5	1.6	2.6	2.5
2009	2.2	2.9	3.4	3.2	2.6	2.3	2.7	2.8	2.5	2.5	2.7	2.9	2.4	1.6	2.7	2.5

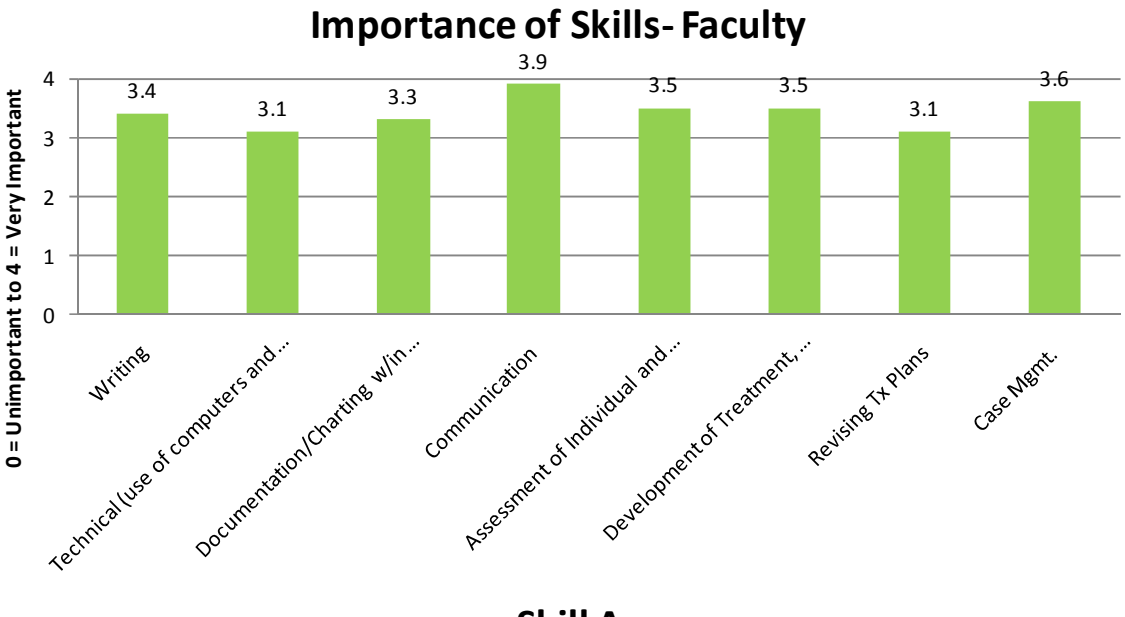
Perceived Importance, Provision, and Preparedness of Skills: Graduates, Faculty, and Supervisors

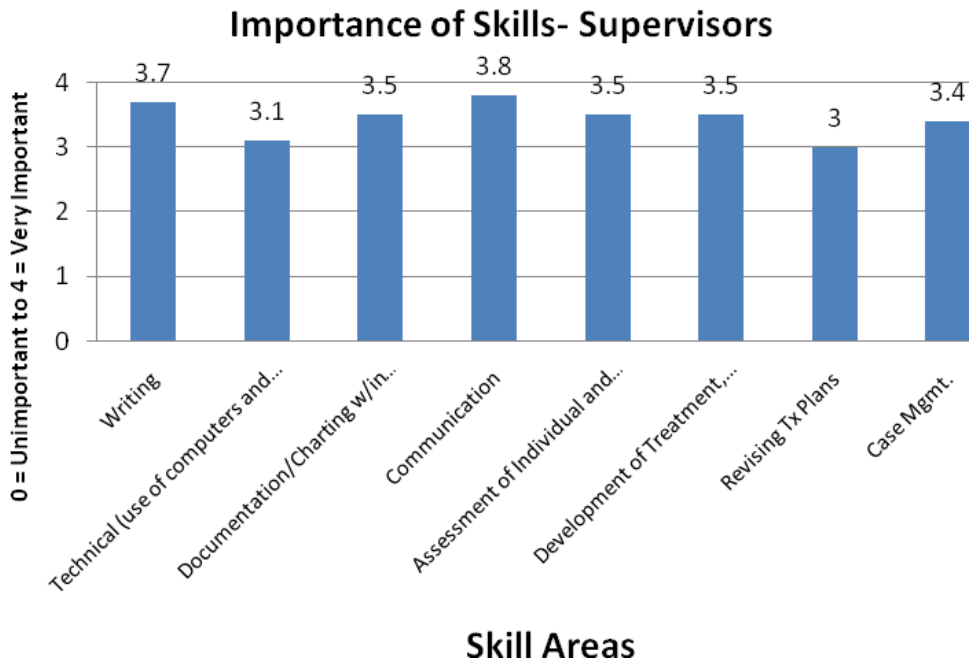
On average, graduates rated all types of skills above '3' indicating that they are all "important." The highest rated type of skill in terms of its importance was Communication (*M* = 3.8). The lowest rated skill area was Technical (Use of Computers and Various Programs Including the Internet) (*M* = 3.0). On average supervisors and faculty rated all skill areas as "important" with Communication (M = 3.8) being rated highest, showing consistency with faculty reports. On average faculty rated all skill areas as "important" with Communication rating closest to very important (*M* = 3.9). The skill area supervisors identified most as grads not being prepared for was Documentation/charting within Medi-Cal Guidelines (*N* = 18); This was followd by eleven supervisors reported both Revising Treatment Plans and Development of Treatment, Intervention, and Discharge Plans as areas in which Grads were not prepared for. Of approximately 11 to 12 faculty who responded to this question, the skill area that faculty idenitified most with respect to grads not being prepared for was Documentation/Charting within Medi-Cal Guidelines (*N* = 3) and Revising Treatment Plans (*N* = 3). A majority of skill areas were unanimously rated as 'prepared.' The ability area that supervisors identified most as grads not being prepared for was Stess Management (N = 16); followed by Handling Non-Compliance/Resistance to Treatment (N = 15); thirdly, 13 supervisors reported Conflict Resolution along with 13 also citing Crisis Intervention as skills that grads were not prepared for.

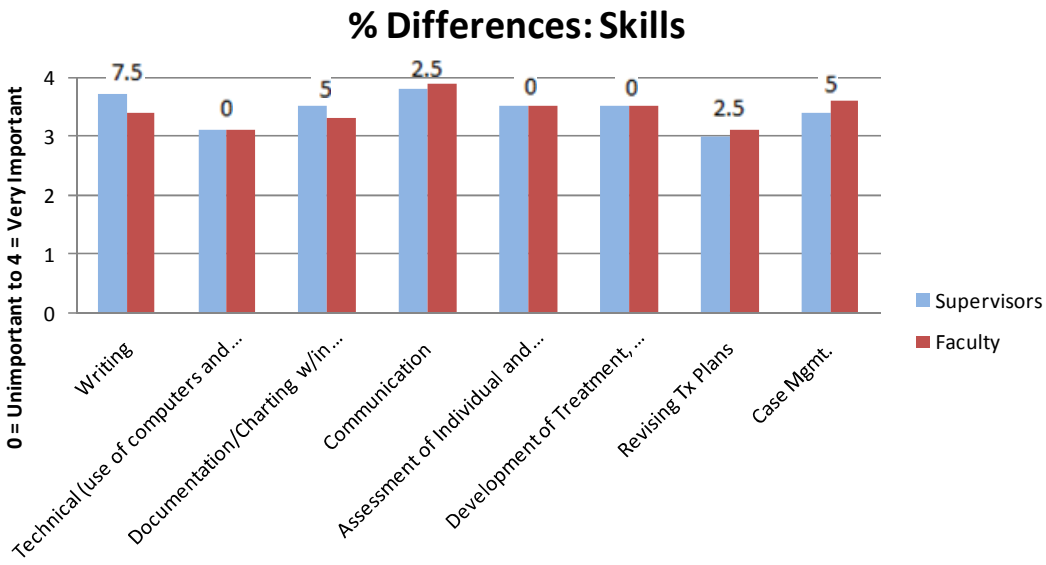
Of approximately 11 to 12 faculty who responded to this question, the ability areas that faculty idenitified most with respect to grads not being prepared for were Facilitating Self-Help/Peer Support Groups (*N* = 5); which was closely followed by Conflict Resolution (*N* = 4). A majority of skill areas were unanimously rated as 'prepared.' The perceived importance of skill areas was tabulated as a function of years of supervisory experience. The chart is relatively consistent across all areas with the exception of Revising Treatment Plans as it was given the lowest rating by those with equal to or more than 11 years experience (M = 2.6).

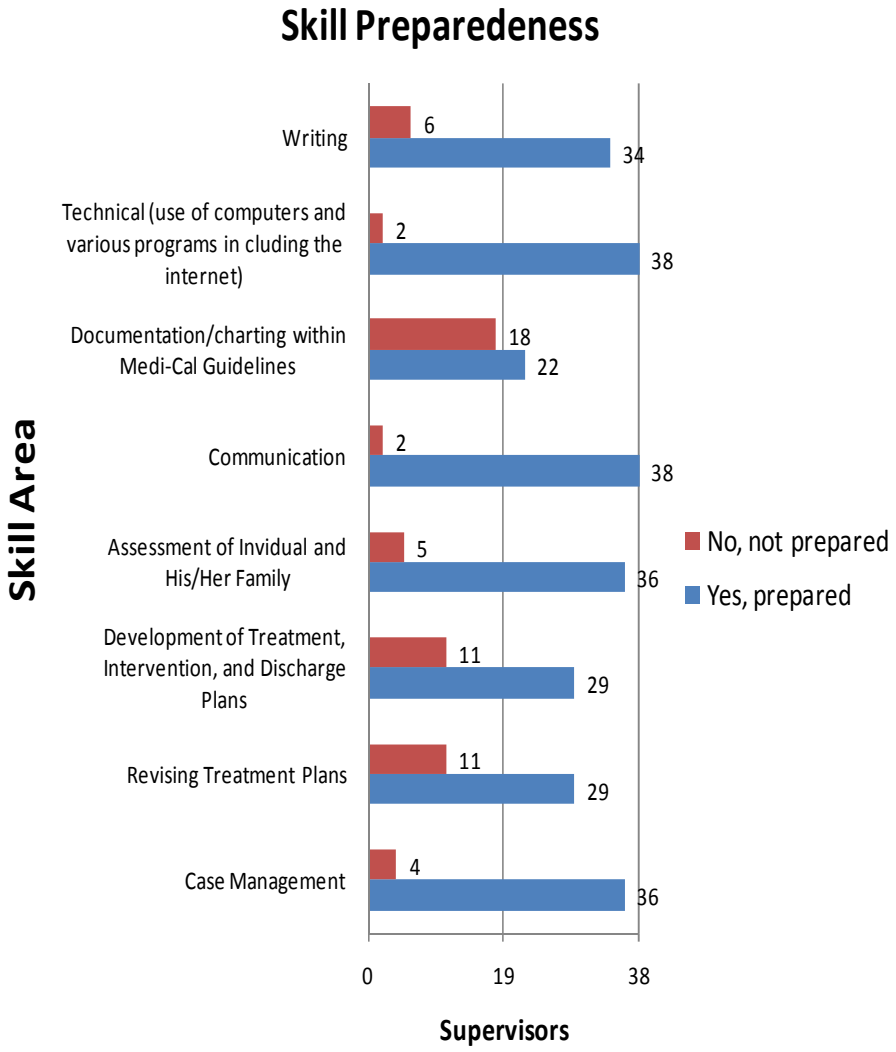
Notable discrepancies in the perceived level of importance assigned to a certain skill area and its provision in the classroom and/or through fieldwork experiences was reported in Documentation/Charting within Medi-Cal Guidelines (-1.9), Revising Treatment Plans (-1.4), and Case Management (-1.3). Such areas fall between slightly to moderately provided. Importance of skills by year of graduation was rated with relative consistency across all years; however, 2009 graduates rated Writing and Technical slightly less than important. Communication was rated highest among all years. Provision skills also showed consistency in terms of various areas such that Documentation/Charting With-in Medi-Cal Guidelines was rated as slightly to moderately offered by all years while communication was rated as offered the most.

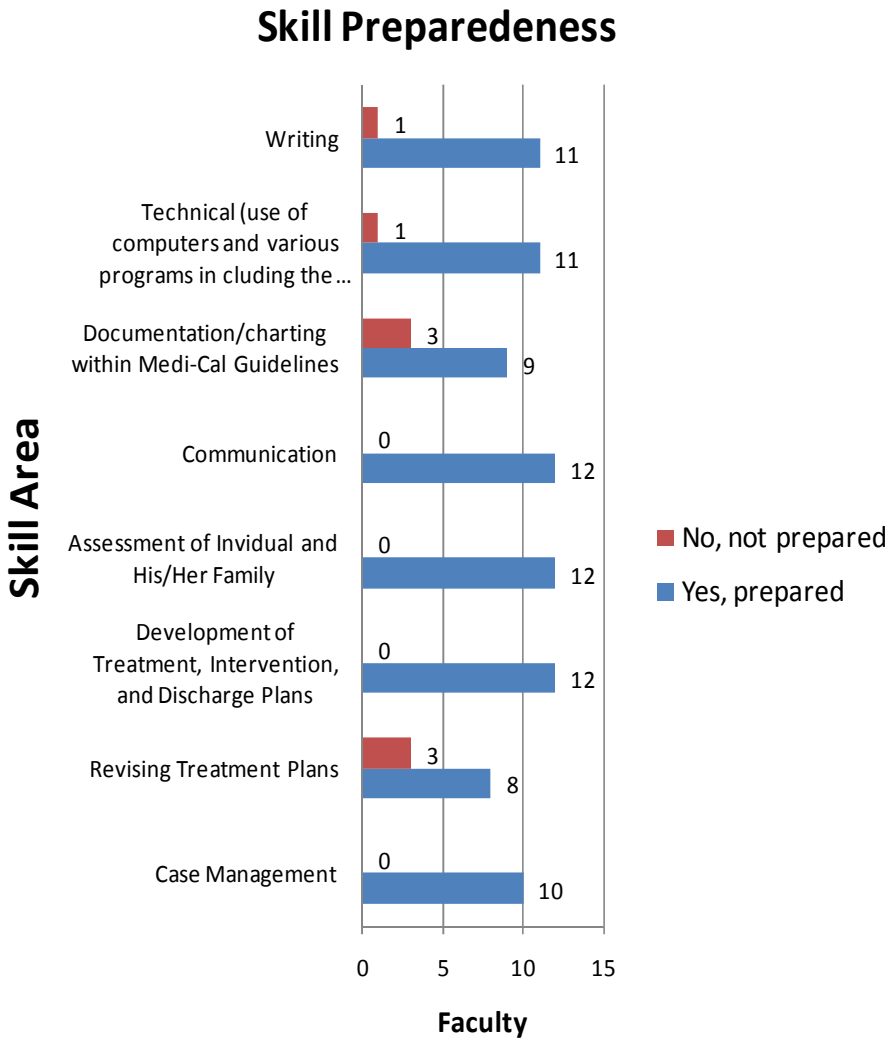



Importance of Skills- Faculty
0 = Unimportant to 4 = Very Important
4
3
2
1
0
3.4
3.1
3.3
3.9
3.5
3.5
3.1
3.6
Writing
Technical (use of computers and ...
Documentation/Charting w/in ...
Communication
Assessment of Individual and ...
Development of Treatment, ...
Revising Tx Plans
Case Mgmt.
Skill Area

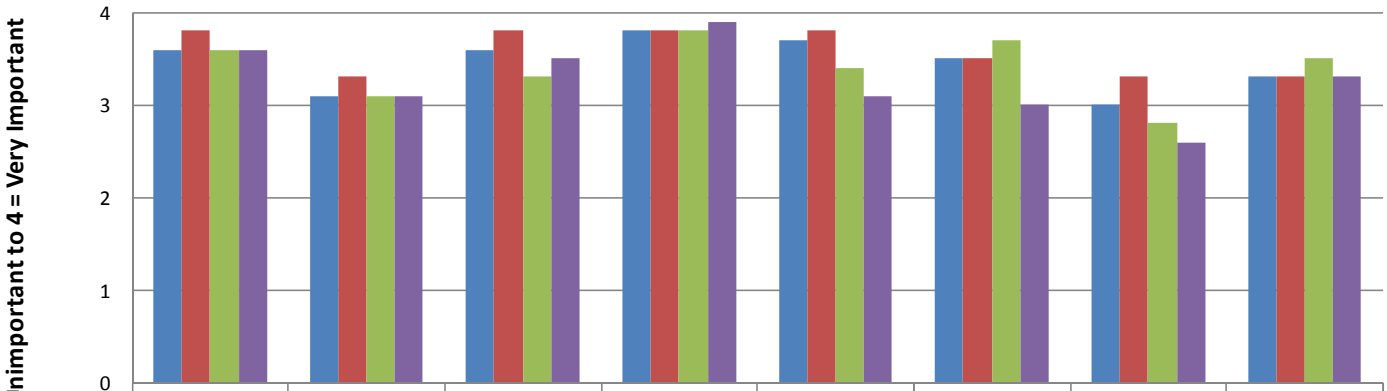

Importance of Skills- Supervisors
0 = Unimportant to 4 = Very Important
4
3
2
1
0
3.7
3.1
3.5
3.8
3.5
3.5
3
3.4
Writing
Technical (use of computers and...
Documentation/Charting w/in...
Communication
Assessment of Individual and...
Development of Treatment,...
Revising Tx Plans
Case Mgmt.
Skill Areas


% Differences: Skills
0 = Unimportant to 4 = Very Important
4
3
2
1
0
7.5
0
5
2.5
0
0
2.5
5
Writing
Technical (use of computers and…
Documentation/Charting w/in…
Communication
Assessment of Individual and…
Development of Treatment, …
Revising Tx Plans
Case Mgmt.
Supervisors
Faculty


Skill Preparedeness
Skill Area
Writing
Technical (use of computers and various programs in cluding the internet)
Documentation/charting within Medi-Cal Guidelines
Communication
Assessment of Invidual and His/Her Family
Development of Treatment, Intervention, and Discharge Plans
Revising Treatment Plans
Case Management
6
34
2
38
18
22
2
38
5
36
11
29
11
29
4
36
No, not prepared
Yes, prepared
0
19
38
Supervisors

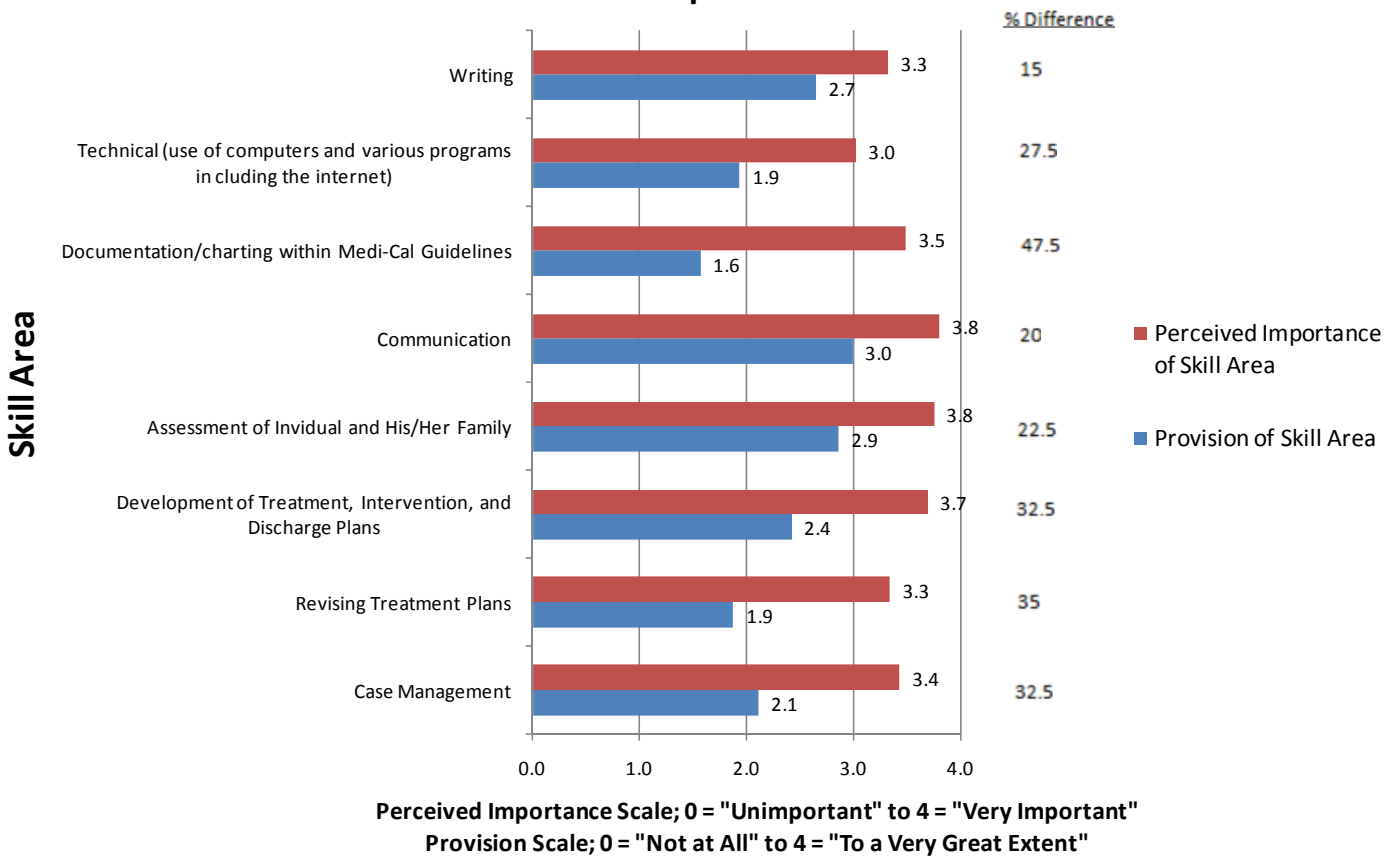

Skill Preparedeness
Skill Area
Writing
Technical (use of computers and various programs in cluding the…
Documentation/charting within Medi-Cal Guidelines
Communication
Assessment of Invidual and His/Her Family
Development of Treatment, Intervention, and Discharge Plans
Revising Treatment Plans
Case Management
1
11
1
11
3
9
0
12
0
12
0
12
3
8
0
10
No, not prepared
Yes, prepared
0
5
10
15
Faculty

Importance of Skills by Years of Supervisory Service



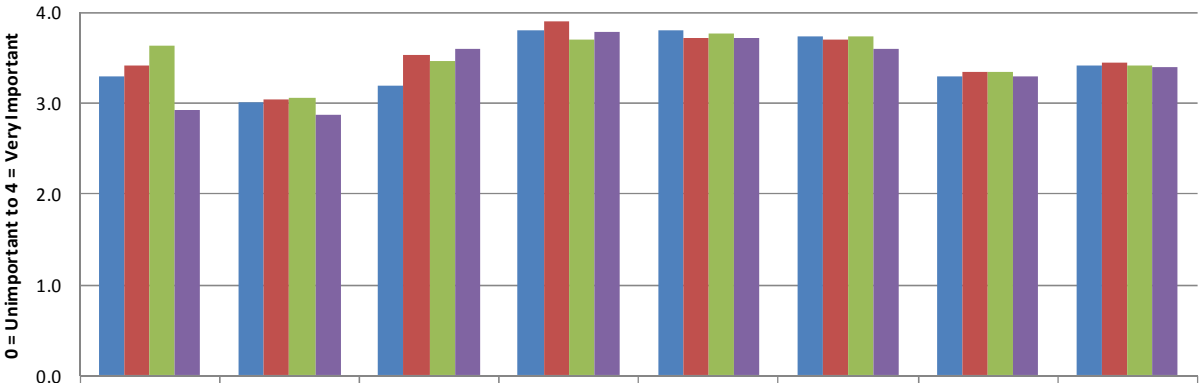
	Writing	Technical (use of computers and various programs including the internet)	Documentation /Charting w/in Medi-Cal Guidelines	Communication	Assessment of Individual and His/Her Family	Development of Treatment, Intervention, and Discharge Plans	Revising Tx Plans	Case Mgmt.
≤1 to 3 yrs	3.6	3.1	3.6	3.8	3.7	3.5	3	3.3
4 to 6 yrs	3.8	3.3	3.8	3.8	3.8	3.5	3.3	3.3
7 to 10 yrs	3.6	3.1	3.3	3.8	3.4	3.7	2.8	3.5
≥11 yrs	3.6	3.1	3.5	3.9	3.1	3	2.6	3.3

Skills: Perceived Importance vs. Provision- Graduates



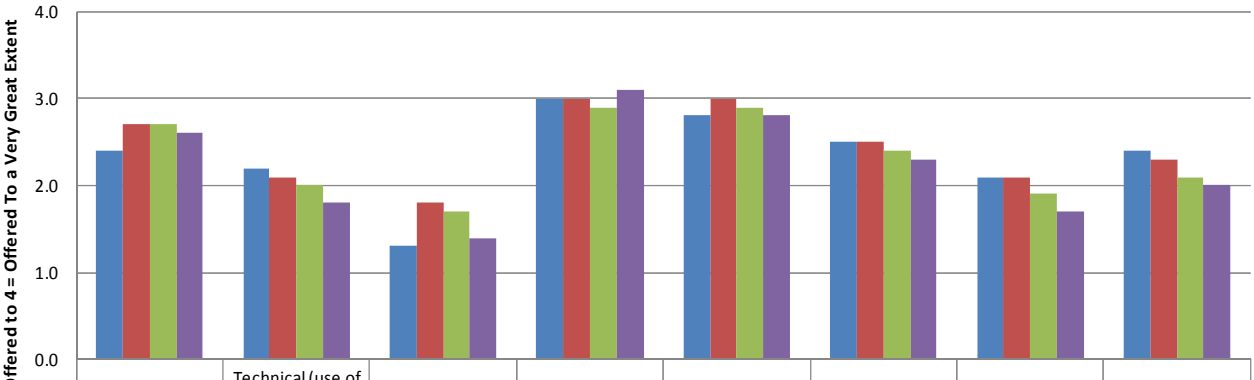
Perceived Importance Scale; 0 = "Unimportant" to 4 = "Very Important"
Provision Scale; 0 = "Not at All" to 4 = "To a Very Great Extent"

Importance of Skills by Grad Year



	Writing	Technical (use of computers and various programs including the internet)	Documentation /Charting within Medi-Cal Guidelines	Communication	Assessment of Individual and His/Her Family	Development of Treatment, Intervention, and Discharge Plans	Revising Treatment Plans	Case Management
2006	3.3	3.0	3.2	3.8	3.8	3.7	3.3	3.4
2007	3.4	3.0	3.5	3.9	3.7	3.7	3.4	3.5
2008	3.6	3.1	3.5	3.7	3.8	3.7	3.4	3.4
2009	2.9	2.9	3.6	3.8	3.7	3.6	3.3	3.4

Provision of Skills by Grad Year



	Writing	Technical (use of computers and various programs including the internet)	Documentation/ Charting within Medi-Cal Guidelines	Communication	Assessment of Individual and His/Her Family	Development of Treatment, Intervention, and Discharge Plans	Revising Treatment Plans	Case Management
2006	2.4	2.2	1.3	3	2.8	2.5	2.1	2.4
2007	2.7	2.1	1.8	3	3	2.5	2.1	2.3
2008	2.7	2	1.7	2.9	2.9	2.4	1.9	2.1
2009	2.6	1.8	1.4	3.1	2.8	2.3	1.7	2

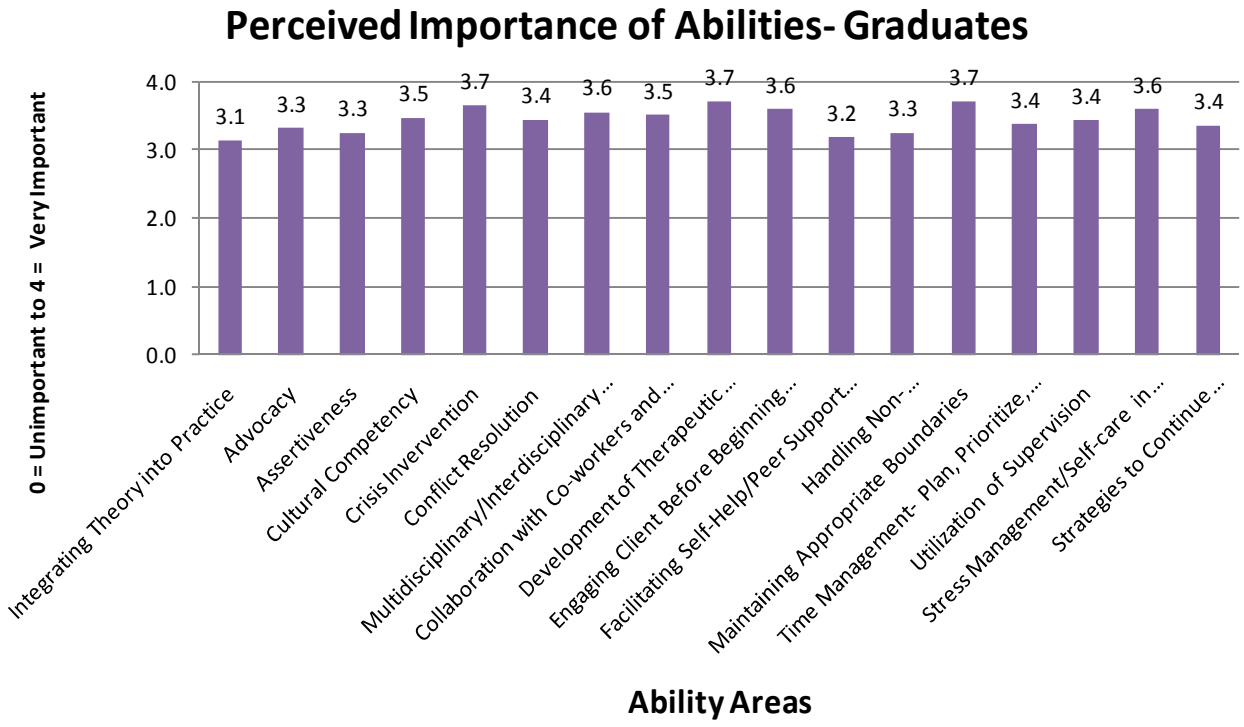
Perceived Importance, Provision, and Preparedness of Abilities: Graduates, Faculty, and Supervisors

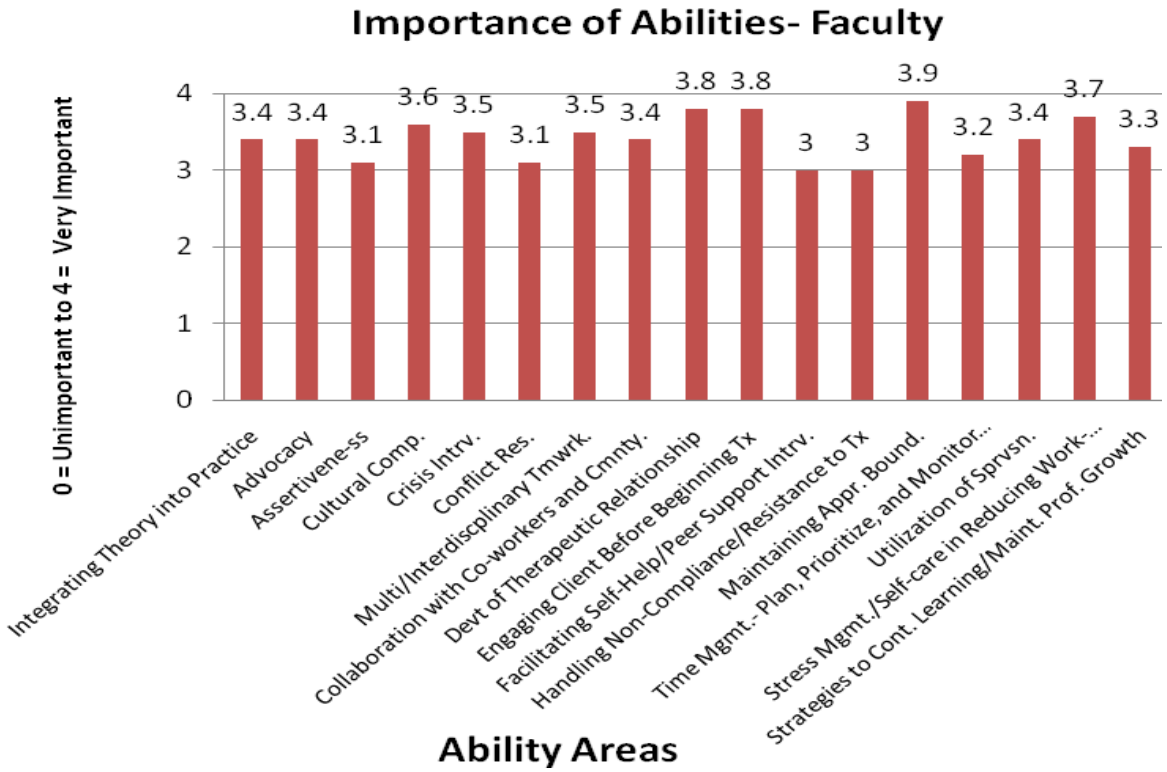
On average, all 163 grads who answered this question rated all types of abilities above '3' indicating that they are all "important." The highest rated types of abilities in terms of its importance were Crisis Intervention (*M* = 3.7), Development of Therapeutic Relationship (*M* = 3.7), and Maintaining Appropriate Boundaries (*M* = 3.7). The lowest rated ability area was Facilitating Self-Help/Peer-Support Interventions (*M* = 3.18). On average supervisors and faculty rated all ability areas as "important." Supervisors rated several ability areas with equal importance, e.g. Cultural Competency, Collaboration with Co-workers and Community, Development of Therapeutic Relationship, Maintaining Appropriate Boundaries, and Stress Management/Self-care in Reducing Work Related Stress with a rating of 3.7. Faculty reported Maintaining Appropriate Boundaries as closest to "very important" with a mean rating of 3.9. The lowest rated ability areas reported by faculty were Facilitating Self-Help/Peer Support Interventions (equal to the supervisor rating) and Handling Non-Compliance/Resistance to Treatment (M = 3), which was significantly lower than supervisors' rating of this area.

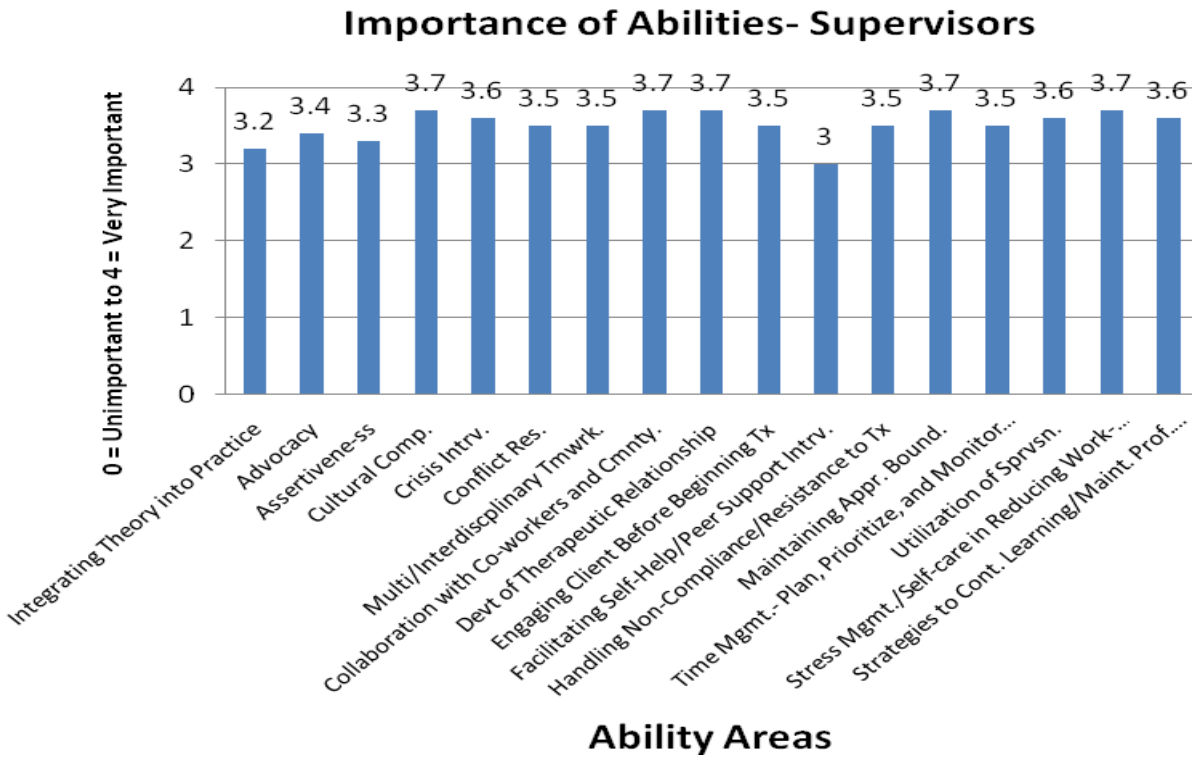
The ability area that supervisors identified most as grads not being prepared for was Stess Management (N = 16); followed by Handling Non-Compliance/Resistance to Treatment (N = 15); thirdly, 13 supervisors reported Conflict Resolution along with 13 also citing Crisis Intervention as skills that grads were not prepared for. Of approximately 11 to 12 faculty who responded to this question, the ability areas that faculty idenitified most with respect to grads not being prepared for were Facilitating Self-Help/Peer Support Groups (*N* = 5); which was closely followed by Conflict Resolution (*N* = 4). A majority of skill areas were unanimously rated as 'prepared.'

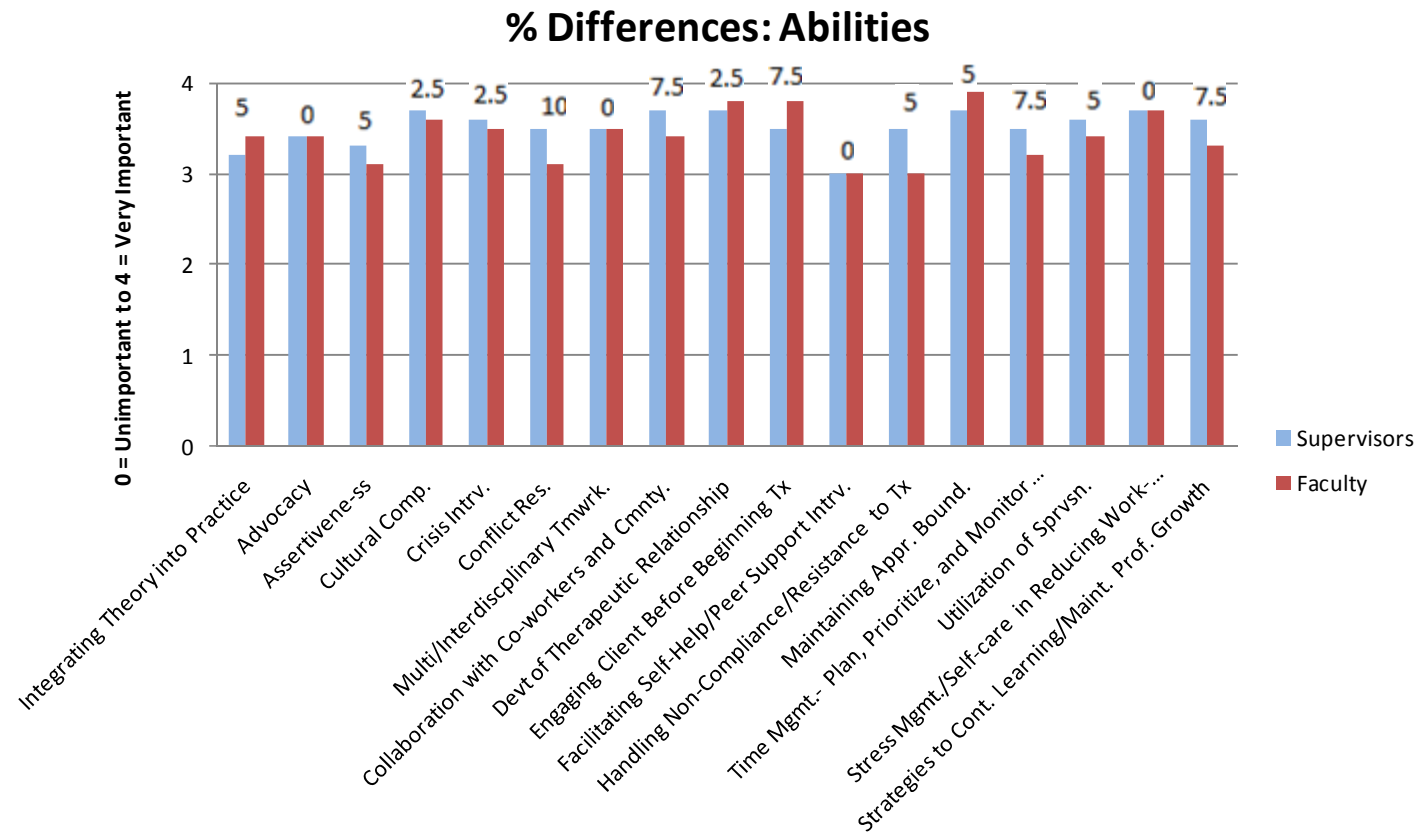
The perceived importance of ability areas was tabulated as a function of years of supervisory experience. Similar to the knowledge and skill areas above, this chart is relatively consistent across all areas with the exception of Facilitating Self-Help Peer Support Groups- which was rated lowest among those with equal to or more than 11 years of supervisor experience. Notable is the fact that those reporting less than 1 to 3 years experience provided relatively high ratings ("important" to "very important") for all ability areas.

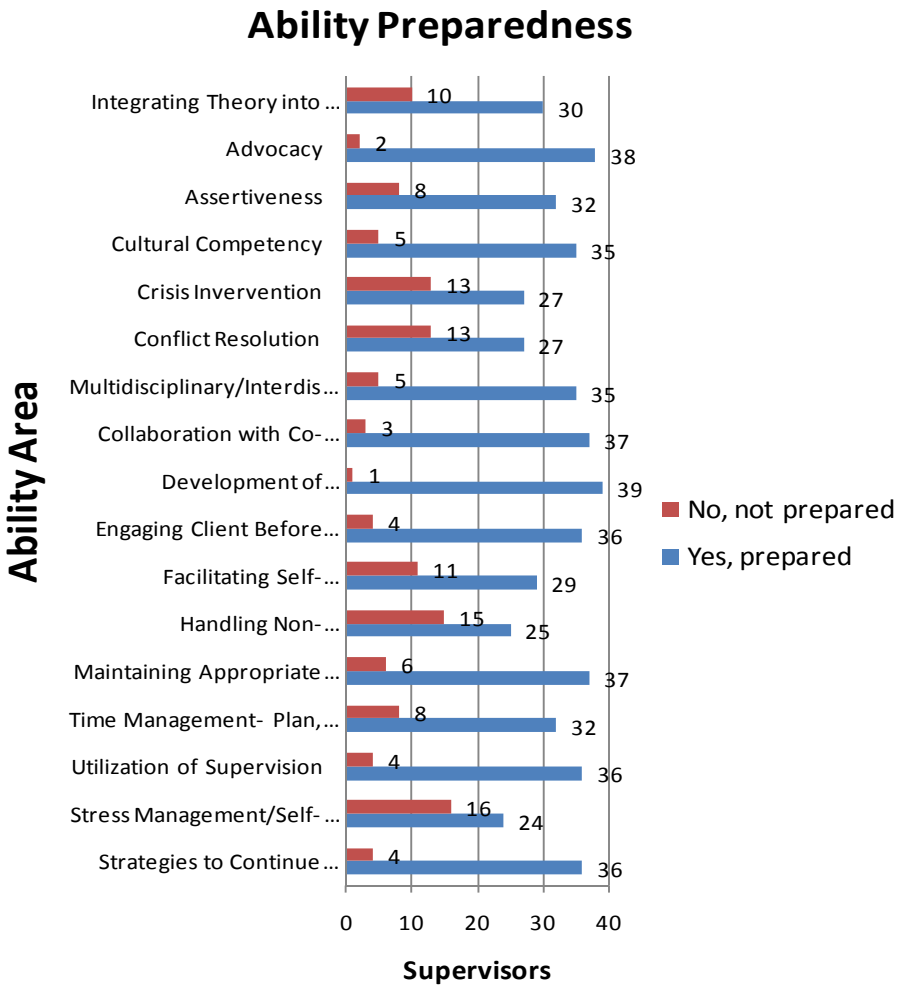
Notable discrepancies in the perceived level of importance assigned to a certain ability area and its provision in the classroom and/or through fieldwork experiences were reported in Crisis Management (-1.3) and Conflict Resolution (-1.2). Also, with the exception of Development of Therapetic Relationship, all ability areas were ranked slightly above '2' but under '3'- rendering nearly all ability areas as "moderately provided." Importance of abilities by year of graduation was rated with no significant deviations between groups as each ability area was rated as "important" to "very important." Provision of abilities revealed some variation between ability areas. Notable is the fact that only Cultural Competency and the 2007-2009 grads for Development of Therapeutic Relationship were rated above '3' or as "offered to a great extent" while all others were rated below this marker.

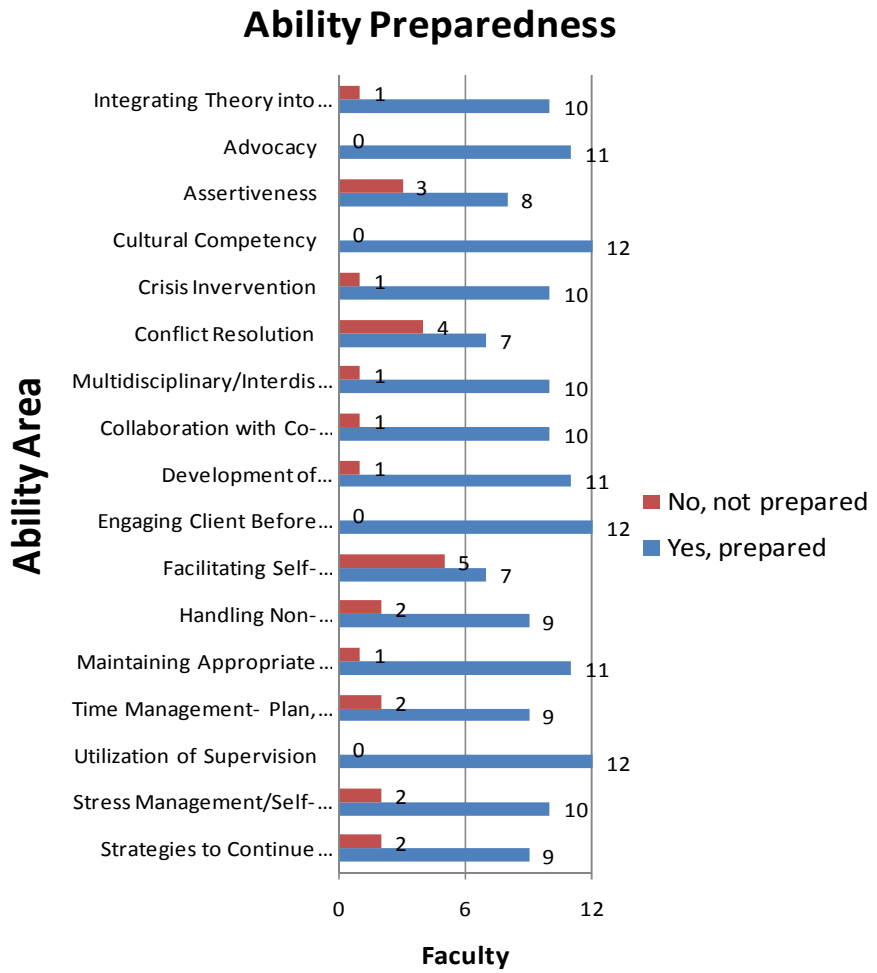

Perceived Importance of Abilities- Graduates
0 = Unimportant to 4 = Very Important
4.0
3.0
2.0
1.0
0.0
3.1
3.3
3.3
3.5
3.7
3.4
3.6
3.5
3.7
3.6
3.2
3.3
3.7
3.4
3.4
3.6
3.4
Integrating Theory into Practice
Advocacy
Assertiveness
Cultural Competency
Crisis Inervention
Conflict Resolution
Multidisciplinary/Interdisciplinary...
Collaboration with Co-workers and...
Development of Therapeutic...
Engaging Client Before Beginning...
Facilitating Self-Help/Peer Support...
Handling Non-...
Maintaining Appropriate Boundaries
Time Management- Plan, Prioritize,...
Utilization of Supervision
Stress Management/Self-care in...
Strategies to Continue...
Ability Areas


Importance of Abilities- Faculty
0 = Unimportant to 4 = Very Important
4
3
2
1
0
3.4
3.4
3.1
3.6
3.5
3.1
3.5
3.4
3.8
3.8
3
3
3.9
3.2
3.4
3.7
3.3
Integrating Theory into Practice
Advocacy
Assertivene-ss
Cultural Comp.
Crisis Intrv.
Conflict Res.
Multi/Interdisciplinary Tmwrk.
Collaboration with Co-workers and Cmnty.
Devt of Therapeutic Relationship
Engaging Client Before Beginning Tx
Facilitating Self-Help/Peer Support Intrv.
Handling Non-Compliance/Resistance to Tx
Maintaining Appr. Bound.
Time Mgmt.- Plan, Prioritize, and Monitor...
Utilization of Sprvsn.
Stress Mgmt./Self-care in Reducing Work-...
Strategies to Cont. Learning/Maint. Prof. Growth
Ability Areas

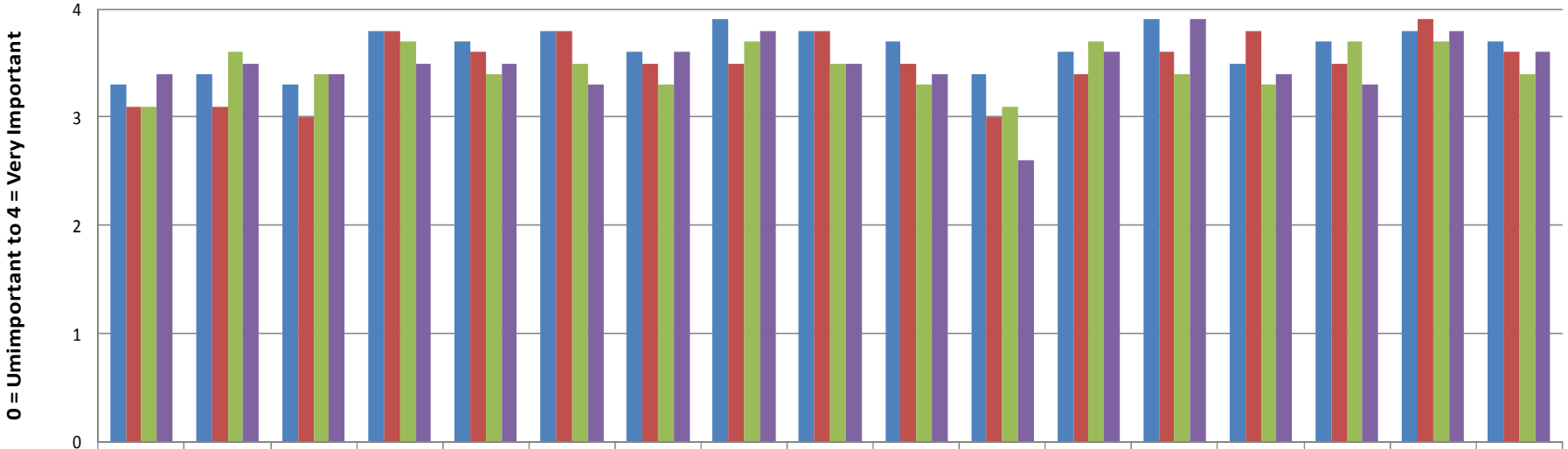

Importance of Abilities- Supervisors
0 = Unimportant to 4 = Very Important
4
3
2
1
0
3.2
3.4
3.3
3.7
3.6
3.5
3.5
3.7
3.7
3.5
3
3.5
3.7
3.5
3.6
3.7
3.6
Integrating Theory into Practice
Advocacy
Assertivene-ss
Cultural Comp.
Crisis Intrv.
Conflict Res.
Multi/Interdiscplinary Tmwrk.
Collaboration with Co-workers and Cmnty.
Devt of Therapeutic Relationship
Engaging Client Before Beginning Tx
Facilitating Self-Help/Peer Support Intrv.
Handling Non-Compliance/Resistance to Tx
Maintaining Appr. Bound.
Time Mgmt.- Plan, Prioritize, and Monitor...
Utilization of Sprvsn.
Stress Mgmt./Self-care in Reducing Work-...
Strategies to Cont. Learning/Maint. Prof....
Ability Areas


% Differences: Abilities
0 = Unimportant to 4 = Very Important
4
3
2
1
0
5
0
5
2.5
2.5
10
0
7.5
2.5
7.5
0
5
5
7.5
5
0
7.5
Integrating Theory into Practice
Advocacy
Assertivene-ss
Cultural Comp.
Crisis Intrv.
Conflict Res.
Multi/Interdiscplinary Tmwrk.
Collaboration with Co-workers and Cmnty.
Devt of Therapeutic Relationship
Engaging Client Before Beginning Tx
Facilitating Self-Help/Peer Support Intrv.
Handling Non-Compliance/Resistance to Tx
Maintaining Appr. Bound.
Time Mgmt.- Plan, Prioritize, and Monitor ...
Utilization of Sprvsn.
Stress Mgmt./Self-care in Reducing Work-...
Strategies to Cont. Learning/Maint. Prof. Growth
Supervisors
Faculty


Ability Preparedness
Ability Area
Integrating Theory into ...
Advocacy
Assertiveness
Cultural Competency
Crisis Invervention
Conflict Resolution
Multidisciplinary/Interdis...
Collaboration with Co-...
Development of...
Engaging Client Before...
Facilitating Self-...
Handling Non-...
Maintaining Appropriate...
Time Management- Plan,...
Utilization of Supervision
Stress Management/Self-...
Strategies to Continue...
10 30
2 38
8 32
5 35
13 27
13 27
5 35
3 37
1 39
4 36
11 29
15 25
6 37
8 32
4 36
16 24
4 36
0 10 20 30 40
Supervisors
No, not prepared
Yes, prepared

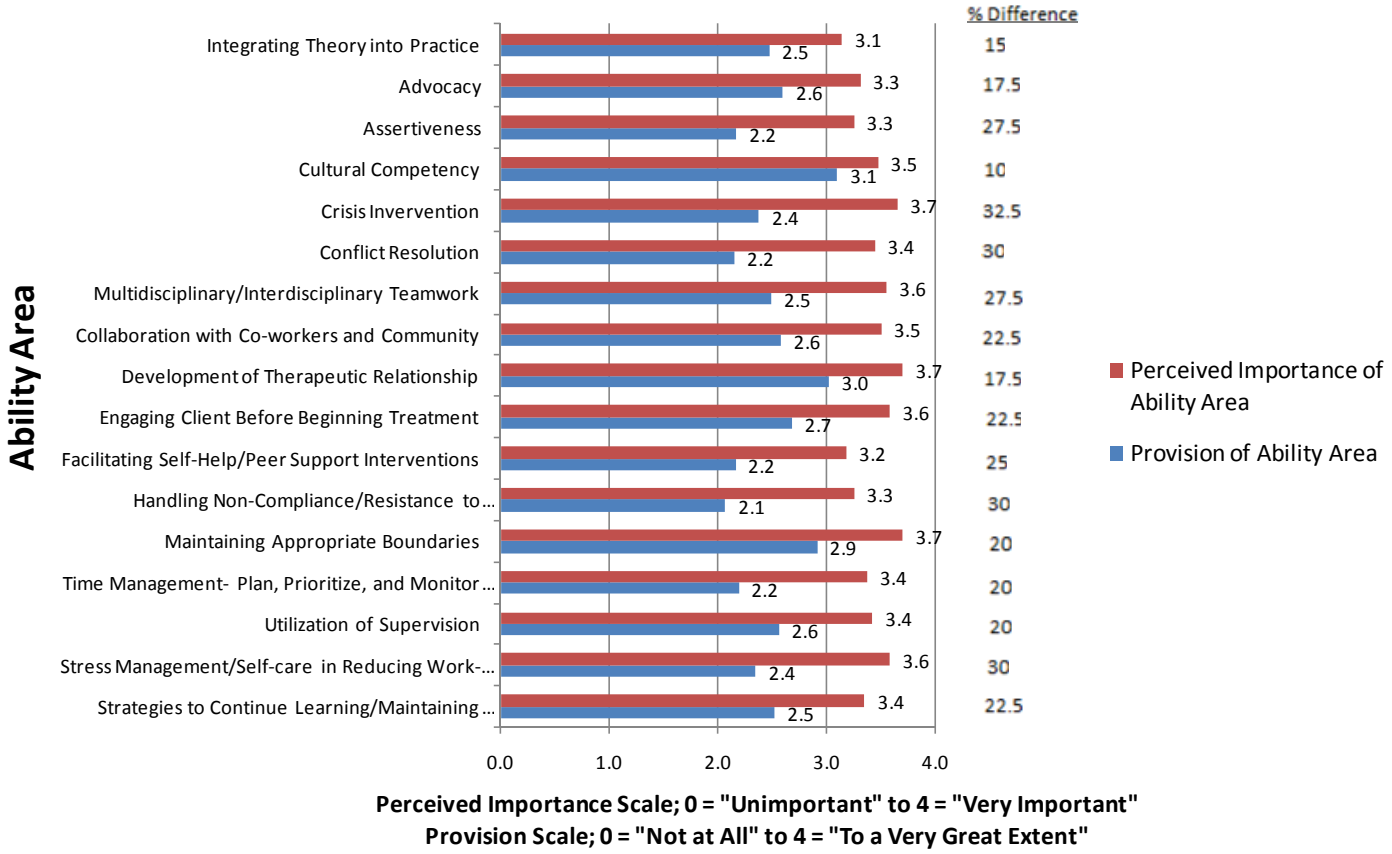

Ability Preparedness
Ability Area
Integrating Theory into ...
Advocacy
Assertiveness
Cultural Competency
Crisis Invervention
Conflict Resolution
Multidisciplinary/Interdis...
Collaboration with Co-...
Development of...
Engaging Client Before...
Facilitating Self-...
Handling Non-...
Maintaining Appropriate...
Time Management- Plan,...
Utilization of Supervision
Stress Management/Self-...
Strategies to Continue...
1 10
0 11
3 8
0 12
1 10
4 7
1 10
1 10
1 11
0 12
5 7
2 9
1 11
2 9
0 12
2 10
2 9
0 6 12
Faculty
No, not prepared
Yes, prepared

Importance of Abilities by Years of Supervisory Service



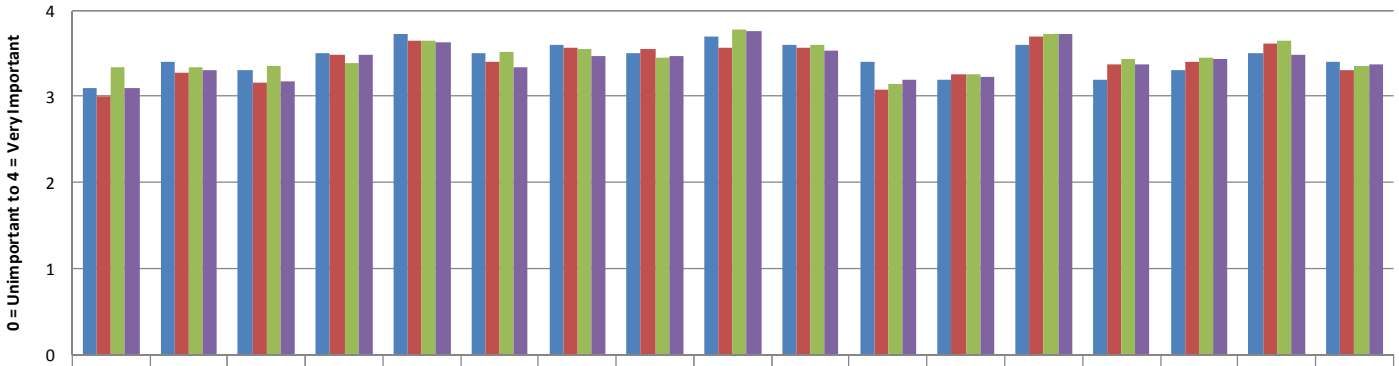
	Integrating Theory into Practice	Advocacy	Assertivene-ss	Cultural Comp.	Crisis Intrv.	Conflict Res.	Multi/Interd iscplinary Tmwrk.	Collaboratio n with Co-workers and Cmnty.	Devt of Therapeutic Relationship	Engaging Client Before Beginning Tx	Facilitating Self-Help/Peer Support Intrv.	Handling Non-Compliance /Resistance to Tx	Maintaining Appr. Bound.	Time Mgmt.-Plan, Prioritize, and Monitor Completion of Assigned Activities	Utilization of Sprvsn.	Stress Mgmt./Self-care in Reducing Work-Related Stress Factors	Strategies to Cont. Learning/M aint. Prof. Growth
≤1 to 3 yrs	3.3	3.4	3.3	3.8	3.7	3.8	3.6	3.9	3.8	3.7	3.4	3.6	3.9	3.5	3.7	3.8	3.7
4 to 6 yrs	3.1	3.1	3	3.8	3.6	3.8	3.5	3.5	3.8	3.5	3	3.4	3.6	3.8	3.5	3.9	3.6
7 to 10 yrs	3.1	3.6	3.4	3.7	3.4	3.5	3.3	3.7	3.5	3.3	3.1	3.7	3.4	3.3	3.7	3.7	3.4
≥11 yrs	3.4	3.5	3.4	3.5	3.5	3.3	3.6	3.8	3.5	3.4	2.6	3.6	3.9	3.4	3.3	3.8	3.6

Abilities: Perceived Importance vs. Provision- Graduates



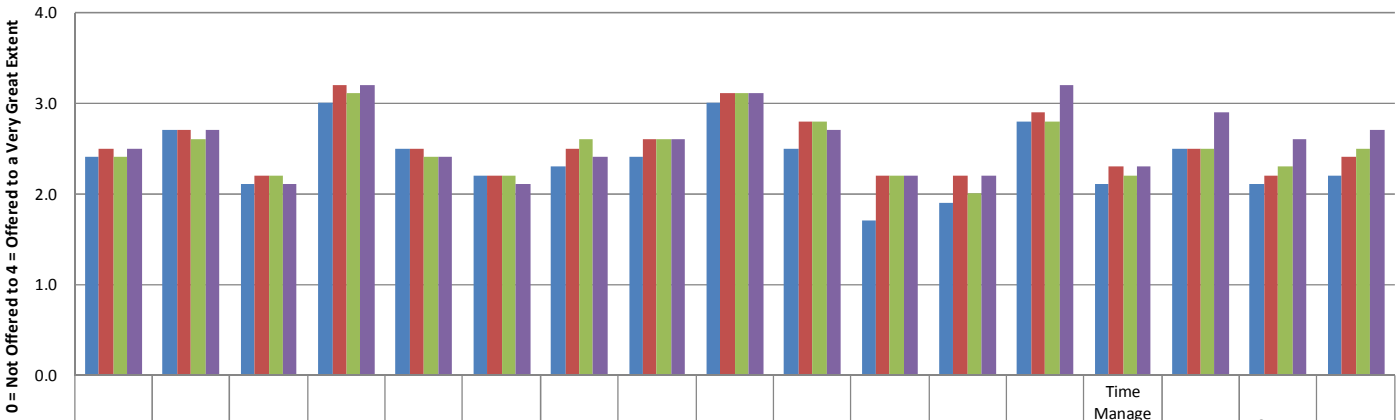
Perceived Importance Scale; 0 = "Unimportant" to 4 = "Very Important"
Provision Scale; 0 = "Not at All" to 4 = "To a Very Great Extent"

Importance of Abilities by Grad Year



	Integ. Theory into Practice	Advocacy	Assertive-ness	Cultural Comp.	Crisis Int.	Conflict Res.	Multi/Interdi-sciplinary Team-work	Clbrtn. with Co-workers and Cmnty.	Dev't of Therapeu-tic Relation-ship	Engaging Client Before Begin-ning Treatment	Facilita-ting Self-Help/Pe-er Support Intvns.	Handling Non-Compli-ance/Res ist-ance to Tx	Maint. Approp. Bounda-ries	Time Manage ment-Plan, Prioritize, and Monitor Completi on of Assigned Activities	Util-ization of Supervi-sion	Stress Mgmt/Se lf-care in Reducing Work-Related Stress Factors	Strate-gies to Continue Learning/ Maint. Personal Growth
2006	3.1	3.4	3.3	3.5	3.7	3.5	3.6	3.5	3.7	3.6	3.4	3.2	3.6	3.2	3.3	3.5	3.4
2007	3	3.3	3.2	3.5	3.7	3.4	3.6	3.6	3.6	3.6	3.1	3.3	3.7	3.4	3.4	3.6	3.3
2008	3.3	3.3	3.4	3.4	3.6	3.5	3.6	3.5	3.8	3.6	3.1	3.3	3.7	3.4	3.5	3.6	3.4
2009	3.1	3.3	3.2	3.5	3.6	3.3	3.5	3.5	3.8	3.5	3.2	3.2	3.7	3.4	3.4	3.5	3.4

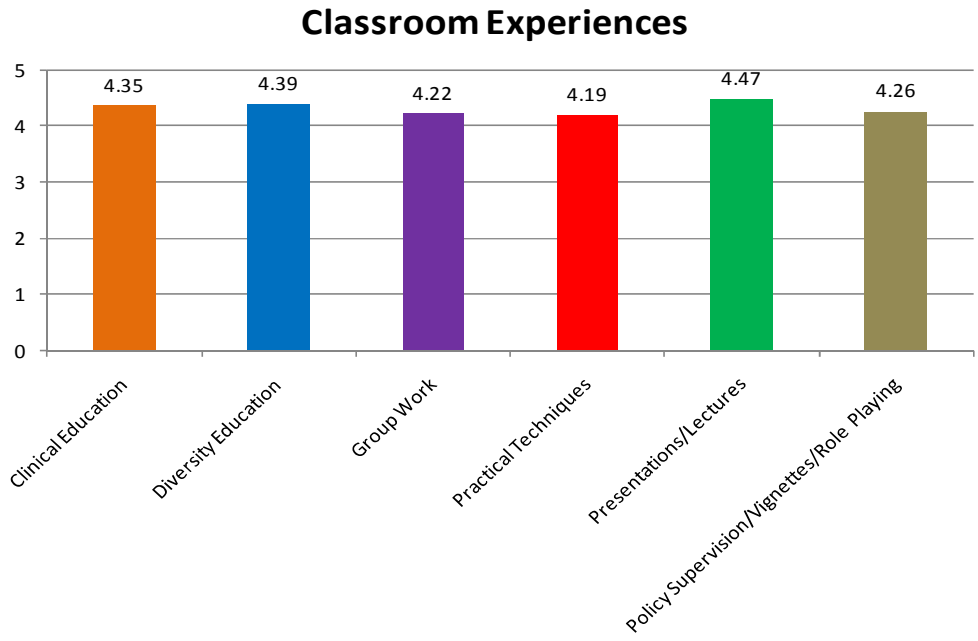
Provision of Abilities by Grad Year

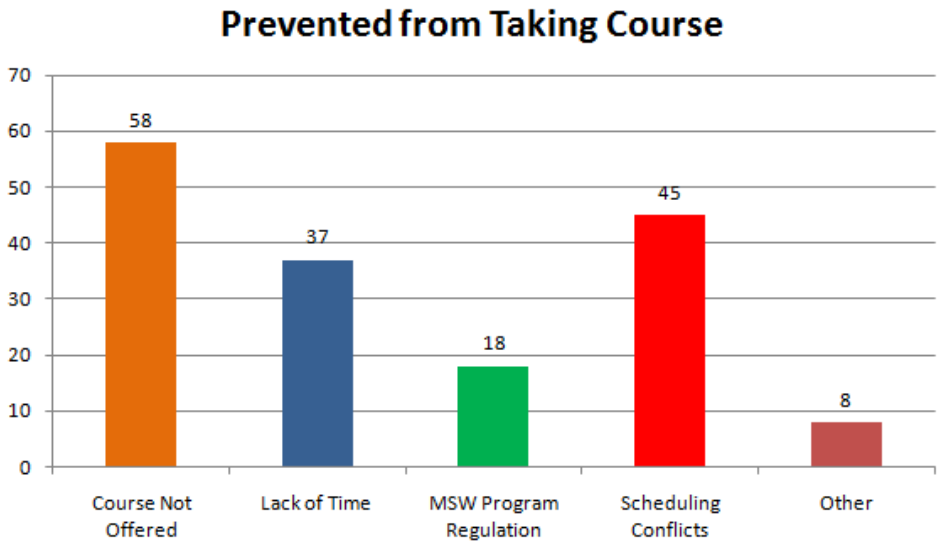


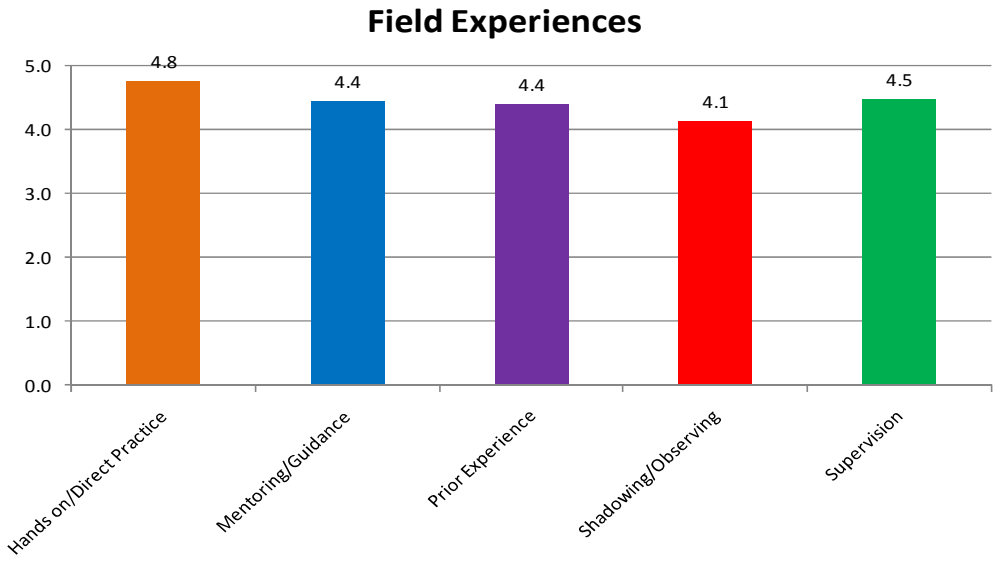
	Integ. Theory into Practice	Advocacy	Assertive-ness	Cultural Comp.	Crisis Int.	Conflict Res.	Multi/Interdi-sciplinary Team-work	Clbrtn. with Co-workers and Cmnty.	Dev't of Therapeu-tic Relation-ship	Engaging Client Before Begin-ning Tx	Facilita-ting Self-Help/Pe-er Support Intvns.	Handling Non-Compli-ance/Resi st-ance to Tx	Maint. Approp. Bounda-ries	Time Manage ment-Plan, Prioritize, and Monitor Completi on of Assigned Activities	Util-ization of Supervi-sion	Stress Mgmt/Se lf-care in Reducing Work-Related Stress Factors	Strate-gies to Continue Learning/ Maint. Personal Growth
2006	2.4	2.7	2.1	3	2.5	2.2	2.3	2.4	3	2.5	1.7	1.9	2.8	2.1	2.5	2.1	2.2
2007	2.5	2.7	2.2	3.2	2.5	2.2	2.5	2.6	3.1	2.8	2.2	2.2	2.9	2.3	2.5	2.2	2.4
2008	2.4	2.6	2.2	3.1	2.4	2.2	2.6	2.6	3.1	2.8	2.2	2	2.8	2.2	2.5	2.3	2.5
2009	2.5	2.7	2.1	3.2	2.4	2.1	2.4	2.6	3.1	2.7	2.2	2.2	3.2	2.3	2.9	2.6	2.7

Learning Experiences & Opportunities

Grads rated the following classroom and field experiences in terms of each items helpfulness on a scale of 0 to 5 where '0' = "Not Offered" to '5' = "Very Helpful." The highest rated classroom experience helpful in preparing graduates for the field of public mental health was *Presentations/lectures* (*M = 4.47*). Additional classroom experiences that grads felt were helpful in preparing them for the field of public mental health included therapeutic interventions in practice, guest speakers, mental health and the law, DSM-IV courses, cultural competence, visiting community mental health centers, and family therapy reenactments. The highest rated field experience helpful in preparing graduates for the field of public mental health was *Hands on/Direct practice* (*M = 4.75*). In terms of issues preventing students from taking a certain course, of the 101 graduates who responded to this question, 58 reported that the course was not offered, 44 reported scheduling conflicts, which was followed closely by 37 who reported a lack of time, and 18 reported MSW program regulations as a deterrent in taking courses.

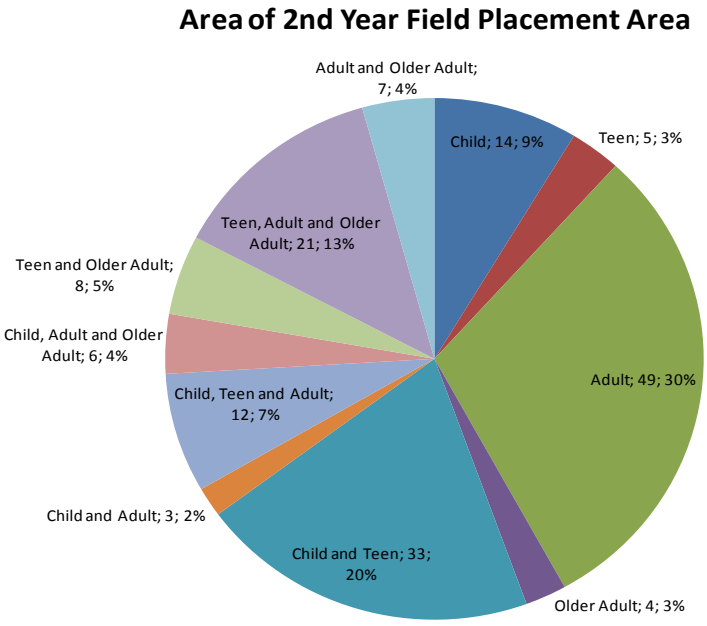


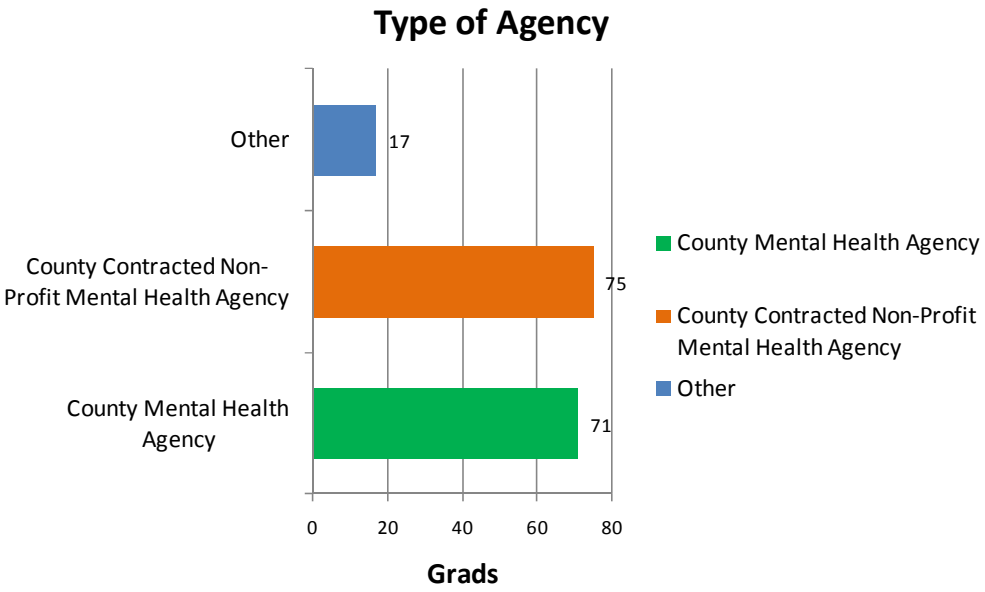


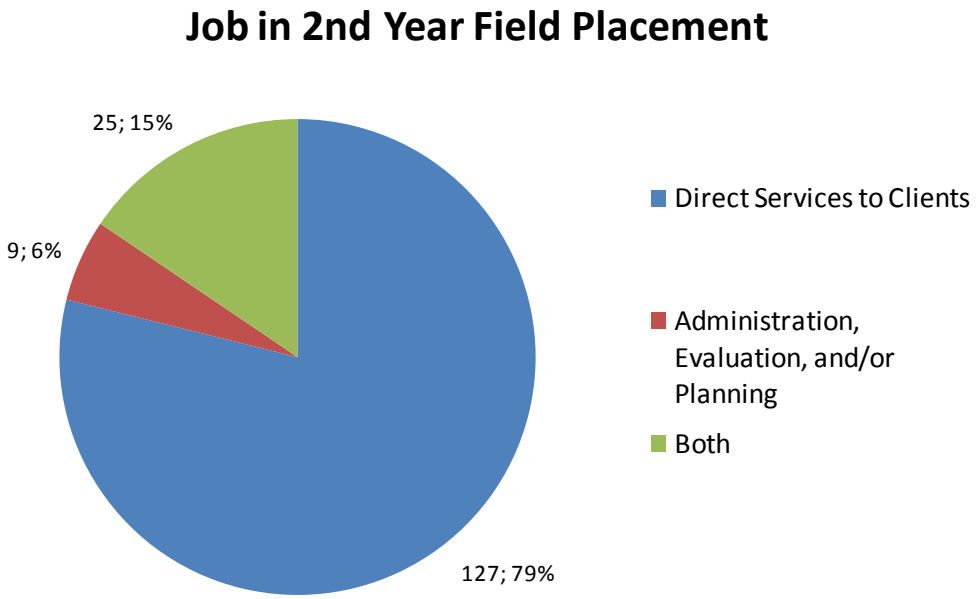


Second Year Field Placements

A majority of grads reported working for County Contracted Non-Profit Mental Health Agencies (N = 75) and County Mental Health Agencies (*N = 71*). Seventeen (*N = 17*) grads reported working for other types of agencies. A majority of the 161 grads cited working with more than one type of population during their second year field placements. The single highest area reported was *Adult* (*N* = 49), followed by *Child and Teen* (*N* = 33). Only four grads reported working in the area of *Older Adult*. Of the 159 grads who responded to this question, a majority (*N* = 127) reported working in the area of *Direct Services to Clients* during their 2nd year field placements.



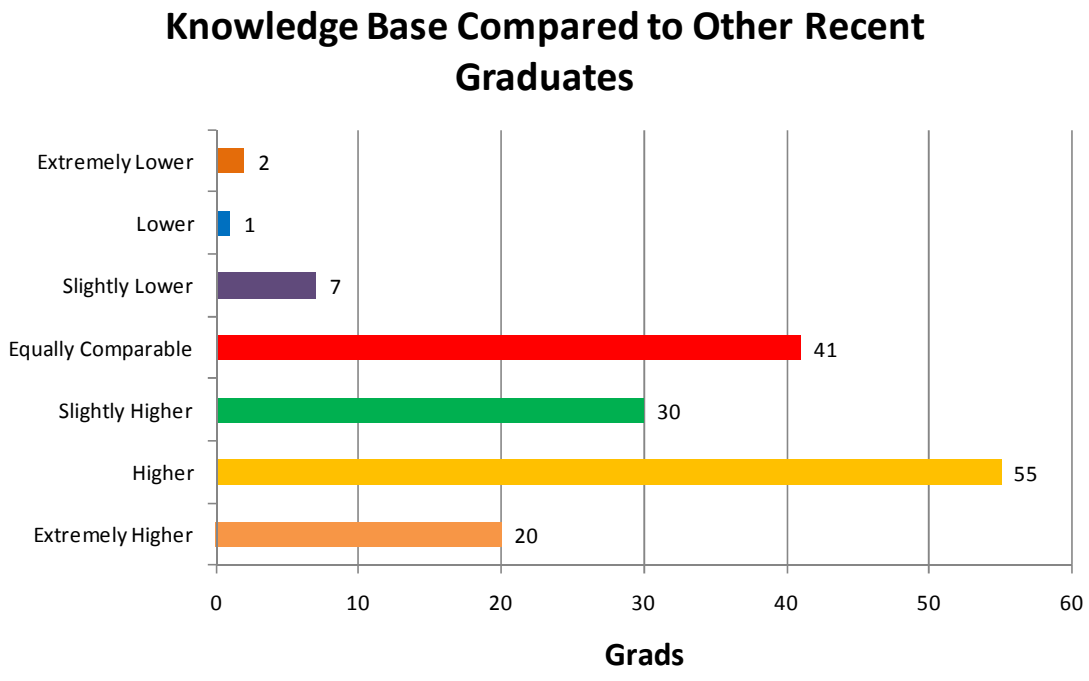

Type of Agency
Other
17
County Contracted Non-Profit Mental Health Agency
75
County Mental Health Agency
71
0
20
40
60
80
Grads
County Mental Health Agency
County Contracted Non-Profit Mental Health Agency
Other

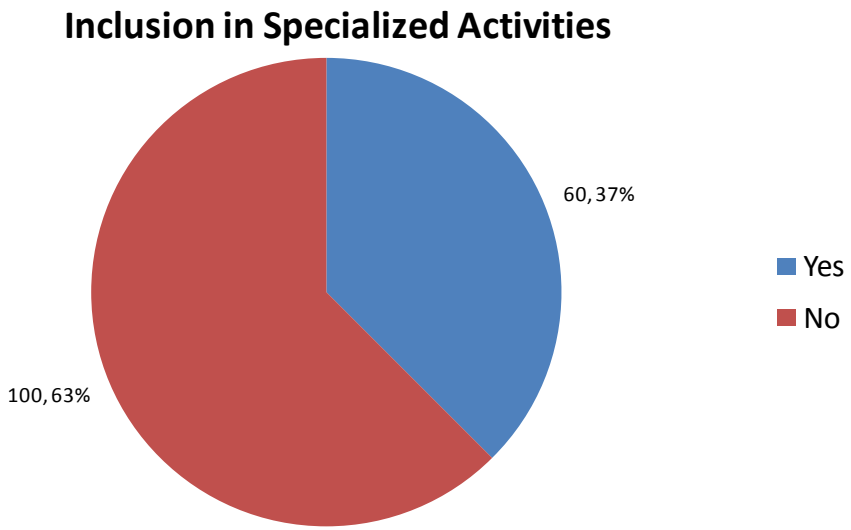

Job in 2nd Year Field Placement
25; 15%
9; 6%
127; 79%
Direct Services to Clients
Administration, Evaluation, and/or Planning
Both

Opinions on Mental Health Work

We solicited opinions on mental health field work with respect to the facets that graduates find satisfying ad challenging. Graduates related their satisfaction to working in the field, working with families and children, autonomy, empowering clients, building rapport with clients, diagnosing, inspiring hope, professional self development, supporting change and growth, helping people, and making a positive impact on the client. Challenges included dealing with clients' resistance to treatment, creating service plans, Medi-Cal billing, completion and handling of paperwork, knowing policies, time management, low pay, diagnosis and use of DSM-IV, bureaucracy, encountering insurance coverage restrictions, lethargy of co-workers, working collaboratively with people, and working with co-occurring disorders as some challenging aspects of public mental health work. Graduates were also asked to suggest a new course or content area to better prepare MSW students for work in mental health. Grads offered the following courses/content areas: drug and alcohol classes, pharmacology and psychotropic medications, medical billing, self care, clinical note writing, Medi-Cal documentation, motivational interviewing, grant writing, DSM-IV classes, geriatric social work, stress management/burn-out prevention, and Evidence-Based Practices and practical interventions.

Furthermore, graduates were asked to rate their Knowledge Base in Comparison to Other Recent Graduates: Of the 155 graduates who responded to this question, the majority (*N = 55*) reported their knowledge being *Higher* in comparison to other recent graduates. This was followed by 41 individuals who thought their knowledge was equally comparable. Only two graduates reported their knowledge base as *Extremely lower* in comparison to other recent graduates. Finally we asked graduates to provide a response with regard to whether or not they have been included in special projects as a result of their education. The vast majority of graduates, 100 (61.3%) of the 160 who responded to this question reported that they have not been included in specialized activities in the workplace as a result of their specialized knowledge from their MSW curriculum. The remaining 60 graduates who reported being included in specialized activities cited some of the following activities: developing support groups, DBT oriented therapy, group therapy, illness management and recovery task groups, program evaluation, chemical dependency and dual diagnosis programs, utilization review, planning commission meetings, and special research projects.




Inclusion in Specialized Activities
60, 37%
100, 63%
Yes
No

Curriculum Development

When the Mental Health Social Work Stipend Program was launched in 2005, priority was given to ensuring that the curricular offerings provided at the participating schools were compatible with the Mental Health Services Act and that an appropriate emphasis was placed on recovery and resilience. The importance of students being prepared to practice in community mental health settings and to serve the neediest groups of people facing the most serious challenges has not only been recognized but is a prime commitment of the program.

While the overall management of the stipend program was assumed by CalSWEC at the School of Social Welfare at UC Berkeley, responsibility for curriculum development was contracted out to Loma Linda University, under the leadership of Dr. Beverly Buckles, the principal investigator. With the assistance of Mr. John Ryan and Ms. Jan Black, a core training curriculum has been developed. In addition, standardized curriculum competencies have been identified, numerous workshops and conferences on curriculum issues have been organized, and ongoing technical advice to the participating schools on curriculum issues has been provided.

In 2005, a series of technical assistance meetings were held with faculty and agency representatives to ensure that curriculum development proceeded efficiently and met the expectations of stakeholders such as the Department of Mental Health, the county mental health agencies, and advocacy and consumer groups. These meetings also provided resources to assist faculty in the development of appropriate curricular offerings. Particular emphasis was placed on agency field work to ensure that students were being given the best opportunities to apply their academic knowledge to practice situations. Syllabi from courses that incorporate the Mental Health Curriculum Competencies offered at MSW programs in California were collected and posted on the CalSWEC Mental Health website to support curriculum development efforts. Specialized meetings and curriculum resource development activities continued throughout the 2006–2007 academic year, and efforts were made to identify innovative strategies and teaching and learning collaboratives.

Meetings with Department of Mental Health and other relevant stakeholder groups were also held to keep them apprised of the curriculum development activities and to disseminate the work of the CalSWEC Mental Health Initiative. Participation in these meetings provided an opportunity to learn about the needs of specific stakeholder groups such as the small/rural counties, and to identify strategies that can address their needs.

In July 2006, a survey concerning the implementation of the Mental Health Competencies, the Curriculum Competency Implementation Survey, was sent to all participating schools. The survey showed that 7 (41%) of the participating schools had a concentration in mental health prior to passage of the Mental Health Services Act and were easily able to incorporate the competencies into current curricular offerings. Several curriculum strategies were adopted by the schools that did not have a mental health concentration to ensure that these competencies are incorporated into the curriculum. The three most widely used strategies were the development of specialized seminars for mental health stipend students, the development of a required mental health elective for stipend students, and regular meetings with the school curriculum committee to discuss the progress and next steps in strengthening the mental health curriculum.

Schools also reported on their efforts to infuse evidence-based information into coursework and fieldwork learning. Several innovative strategies were adopted including the development of a website for one school's stipend program. In addition, planning for regional and sub-regional meetings with schools and county mental

health and contract agencies was also underway. One school reported offering coursework to stipend students at the local county mental health site.

In the survey, the schools communicated future plans and strategies for implementing the curriculum competencies in the academic 2006–2007 year. These strategies included additional specialized seminars for mental health stipend students, increased involvement of agency-based field instructors in curriculum development, further participation of consumers and families in curriculum development and the delivery of content, and increased regional partnerships. In addition, all the schools were interested in having technical assistance meetings with university faculty, agency field instructors, and professional staff to foster closer collaboration between the schools and county agencies. Such meetings also help future curriculum implementation efforts. An additional finding was that all the schools expressed interest in CalSWEC developing and providing specialized training in recovery for university faculty and agency field instructors.

The results of the completed Curriculum Competency Implementation Survey were compiled and distributed to the CalSWEC Mental Health Committee, the CalSWEC Executive Committee, and the CalSWEC Board of Directors. A presentation of the survey results was made to the California Mental Health Directors in January 2007 by Mr. Ryan and Ms. Black.

Efforts to further develop the mental health social work curriculum and competencies have continued. Reports are disseminated to schools of social work, county mental health agencies, and non-profit mental health
contract agencies, and others in the public mental health community in several ways. First, as noted in the March 2007 report, interested parties were invited to sign up for the Mental Health Initiative Google Listserv, where promising practices at each of the consortium schools are e-mailed to subscribers. Second, the Mental Health Curriculum Resources website was launched which serves as a clearinghouse for a variety of reports, academic papers, and presentations related to curriculum and program resources.

In addition to the implementation of the mental health competencies, the schools have developed evaluation tools to assess the level of integration of the competencies into their curriculum as well as evaluation of the students' understanding of the curriculum skills and knowledge. In order to identify courses in which the competencies were offered, schools implemented a matrix listing CalSWEC's curriculum competencies and the courses in which these competencies were being covered. Outcome surveys were utilized to assess the students' grasp of the mental health competency content. Efforts to further develop evaluation tools continue.

To assess the development of faculty and field instructors, a second survey, the Mental Health Curriculum Implementation Survey, was conducted in summer 2007. This survey built on the original information collected during the first year (2005–2006) of the Mental Health Social Work Stipend Program.

The CalSWEC Mental Health Committee received funding from the Zellerbach Family Foundation in 2007 for a project entitled "A Model for Implementation of the Mental Health Competency Curriculum." The activities and projects under this grant support critically needed curriculum development and implementation activities, as identified in the 2006 Curriculum Competency Implementation Survey. The five main work areas are as follows:

1. Collaboration and System Sustainability Activities
2. Regional, Statewide, and National Collaboration Activities
3. Curriculum Development and Infusion Activities

4. Curriculum Related Development Activities
5. Evaluation Activities

Zellerbach Family Foundation also supported the development of four Mental Health Curriculum Modules during 2008. The four new modules will be posted on the CalSWEC and Loma Linda University Mental Health Curriculum Resource website. The modules are:
• *Recovery* by Betty Dahlquist, MSW, Executive Director, CASRA;
• *Co-Occurring Disorders* by Dr. Sally Mathiesen, Professor, San Diego State University, School of Social Work;
• *Specialized Interventions for Older Adults with Mental Illness* by Dr. Michael Johnson, Professor, California State University, Stanislaus, Department of Social Work
• *Specialized Interventions for Children and Transitional Aged Youth with SED* by Dr. Sigrid James, Professor, Loma Linda University, Department of Social Work and Social Ecology.

Each of the modules contains nine hours of lecture content, with accompanying exercises and reference materials, and can be used as a total course or as "drop-in" lectures in a variety of courses.

A series of three Curriculum Infusion Seminars have been held. The first focused on recovery, with presenters Mr. Chad Costello, MSW, director of Public Policy, Mental Health America, Los Angeles, and Ms. Heather Martin, consumer and member of MHALA's innovative program The Village. The second seminar was on co-occurring disorders, with presenter Dr. Tom Freese, UCLA, Integrated Substance Abuse Programs and Pacific Southwest Addiction Technology. The third seminar focused on specialized interventions with children with SED, transitional age youth, and older adults with mental illness. The presenters included Dr. Sigrid James, Loma Linda University, and Dr. Michael Johnson, California State University, Stanislaus. This seminar was repeated to provide access for individuals from the Central and Northern portions of the state.

In summer 2008, an in-depth discussion was held regarding the strategies that schools were using to implement the current Mental Health Curriculum Competencies. The following areas and strategies were identified:
1) challenges of offering specialized electives, 2) utilization of specialized seminars for students, 3) utilization of extra hours of field seminar/seminars to ensure delivery of all relevant content areas, and 4) the role of weekly support groups. Ongoing depth and breadth issues in social work education were also discussed. The question arose about how to ensure the fit with Council on Social Work Education (CSWE) requirements and specialization areas in the curriculum. The context for the discussion was that while all the participating schools meet CSWE requirements, some programs have a specialization in mental health and others do not. For the schools with a specialization, the infusion and implementation of the mental health competency curriculum is easier than in schools without a specialization, since the latter group must either develop specialized courses for the stipend students, utilize elective courses for the content, or infuse the content throughout the social work curriculum. As the mental health competency curriculum enters its fourth year, all of the schools are actively engaged in implementing the offerings and are using innovative strategies to do so.

The Statewide Mental Health Summit, held on September 24, 2008, in Sacramento, was very successful. Over 120 participants representing academic, community practice, county mental health, and a variety of stakeholders in the mental health field came together to share national and statewide trends and issues. Keynote speakers included John Morris of the Annapolis Coalition, Dr. Stephen Mayberg, director of the California Department of Mental Health, and Dr. Beverly Buckles, director of the Department of Social Work

and Social Ecology at Loma Linda University. The summit was underwritten by the grant funded by the Zellerbach Family Foundation.

The competencies approved by the CalSWEC Board of Directors in May 2005 have been in place for six years now. Curriculum implementation surveys have provided basic information on the implementation strategies being utilized by the schools. The last Mental Health Initiative Committee meeting in September 2008 included an in-depth review of these competencies. Discussions have begun in those areas which need revision, and a process is currently being established to involve the participating schools in a full review of these competencies and their implementation.

REFERENCES

Adam et al. (2004). Improving the research climate in social work curricula: Clarifying learning expectations across BSW and MSW research courses. *Journal of Teaching in Social Work, 24*(3/4).

Bronstein et al. (2007). Goodness of fit: Social work education and practice in health care. *Social Work Health Care, 45(*2), 59-76.

Bureau of Labor Statistics. (2011). Occupational outlook handbook, 2010-11 edition. Retreived on May 10, 2011 from: http://www.bls.gov/oco/ocos060.htm

Campbell et al. (2008). The real world of the ivory tower: Linking Classroom and Practice via Pedagogical Modeling. *Journal of Teaching in Social Work, 28* (1/2).

Council of Social Work Education. (2008). *Educational policy and accreditation standards.* Retrieved on May 9, 2011 from: www.cswe.org/Accredifation/48165.aspx

Frysztacki, K. (2008). Social science and/or social work: Do we (should we) teach them both? *Journal of Teaching in Social Work, 28*(3-4).

Harlen, W., & James, M. (1997). Assessment and learning: Differences and relationships between formative and summativee assessment. *Assessment in Education, 4,* 365–379.

Kealey, E. Assessment and Evaluation in Social Work Education: Formative and Summative Approaches. *Journal of Teaching In Social Work, 30,* 64–74.

LeCroy, Craig W., & Ryan, L. (1993). Designing a model curriculum for children's mental health. *Journal of Social Work Education*, 318-327.

Lesser and Cooper (2007). Theory and practice: An integrative model linking class and field. *Journal of Teaching in Social Work, 26* (3/4).

US Office of Personnel Management. (2011). General policies: explanation of terms. Retrieved on May 9, 2011 from: http://www.opm.gov/qualifications/policy/Terms.asp

Yankeelov et al. (2010). From “producing” to “consuming” research: Incorporating evidence-based practice into advanced research courses in a master of social work program. *Journal of Teaching in Social Work, 30*(4), 367-384.

APPENDIX B

Student Ratings of Knowledge, Skills, & Abilities

Knowledge

Knowledge Factors

Pattern Matrix[a]

	Factor		
	1	2	3
Imp_Recovery_Process	**.826**	-.175	-.076
Imp_Cooccuring_ Disorders	**.612**	.126	-.151
Imp_Affect_Lifestyle_ Mood	**.598**	-.029	.231
Imp_Psychiatric_Meds	**.490**	.321	-.208
Imp_Tx_Interventions	**.485**	.213	-.148
Imp_Trauma_Impact	**.481**	.018	.039
Imp_Major_Theories	**.404**	.327	.121
Imp_Therapeutic_Use_ Self	**.364**	.086	.274
Imp_EBPs	**.361**	.349	.069
Imp_Agency_Systems_ Resources	.273	.011	.043
Imp_DSM_IV	-.163	**.937**	-.009
Imp_Evaluation_Process	.079	**.785**	.056
Imp_Client_ Assessment_Processes	.178	**.335**	.152
Imp_Client_ Confidentiality	-.159	.039	**.887**
Imp_Ethical_Legal_ Issues_Tx	-.105	.105	**.825**
Imp_Impact_Racial_ Ethnic	.431	-.219	**.529**

Extraction Method: Principal Axis Factoring.
Rotation Method: Promax with Kaiser Normalization.

a. Rotation converged in 6 iterations.

Professional Practice

Evaluation & Assessment

Ethics & Ethnic/ Gender Issues

Agency Resources

Correlation of Knowledge Factors

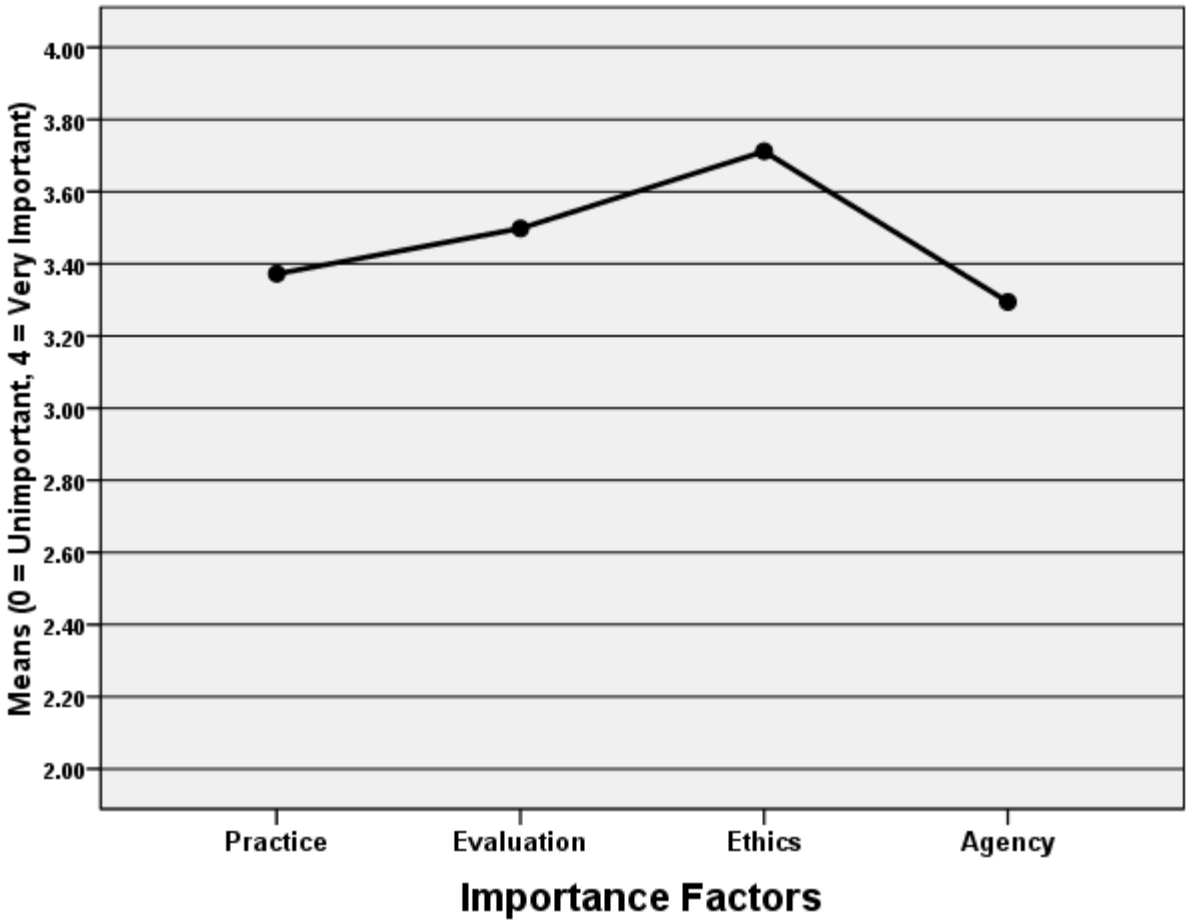
Correlations

		Professional Practice (Importanct)	DSM, Evaluation, & Assessment (Importance)	Ethics & Ethnic/Gender Sensitivity (Importance)	Agency System/Resources (Importance)
Professional Practice (Importanct)	Pearson Correlation	1	.605**	.400**	.266**
	Sig. (2-tailed)		.000	.000	.001
	N	163	163	163	163
DSM, Evaluation, & Assessment (Importance)	Pearson Correlation	.605**	1	.237**	.148
	Sig. (2-tailed)	.000		.002	.059
	N	163	163	163	163
Ethics & Ethnic/Gender Sensitivity (Importance)	Pearson Correlation	.400**	.237**	1	.184*
	Sig. (2-tailed)	.000	.002		.018
	N	163	163	163	163
Agency System/Resources (Importance)	Pearson Correlation	.266**	.148	.184*	1
	Sig. (2-tailed)	.001	.059	.018	
	N	163	163	163	163

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Importance of Knowledge Factors

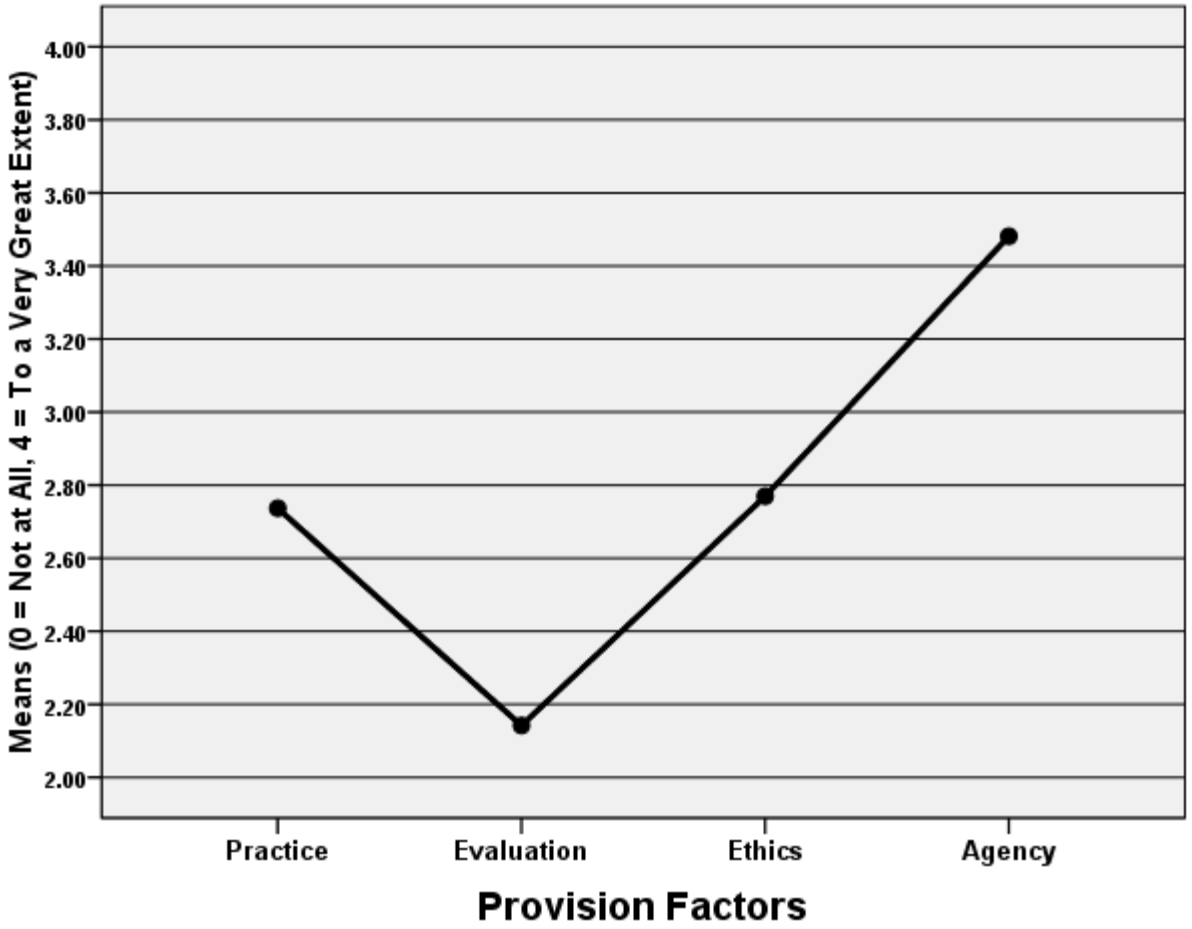


Stats for Importance of Knowledge Factors Repeated Measures ANOVA

- Within subjects Importance factor
  - $F(3,486) = 21.21$, $p < .001$, $eta^2 = .12$

    - Ethics > Evaluation, Practice, & Agency
    - Evaluation > Practice & Agency
    - Practice > Agency

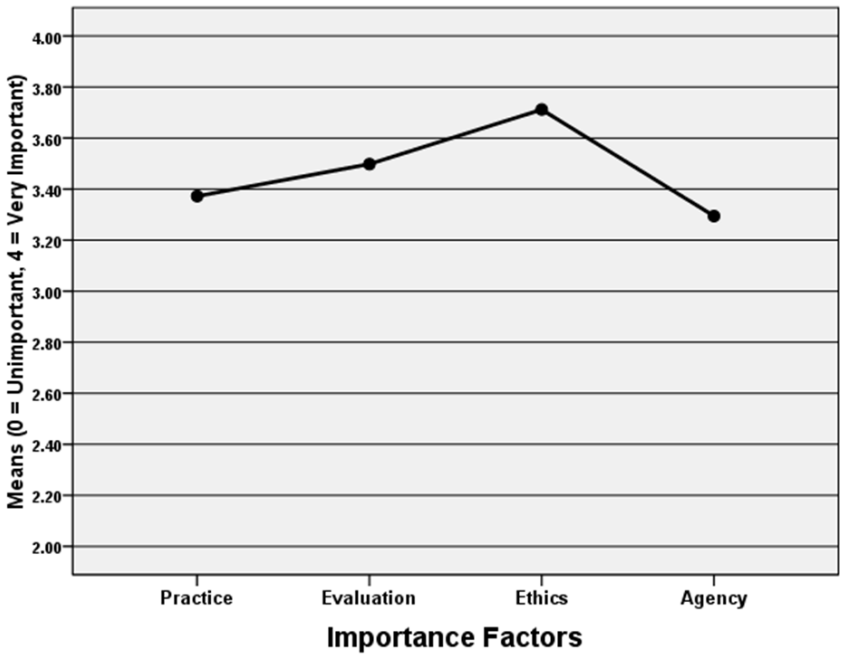
Provision of Knowledge Factors

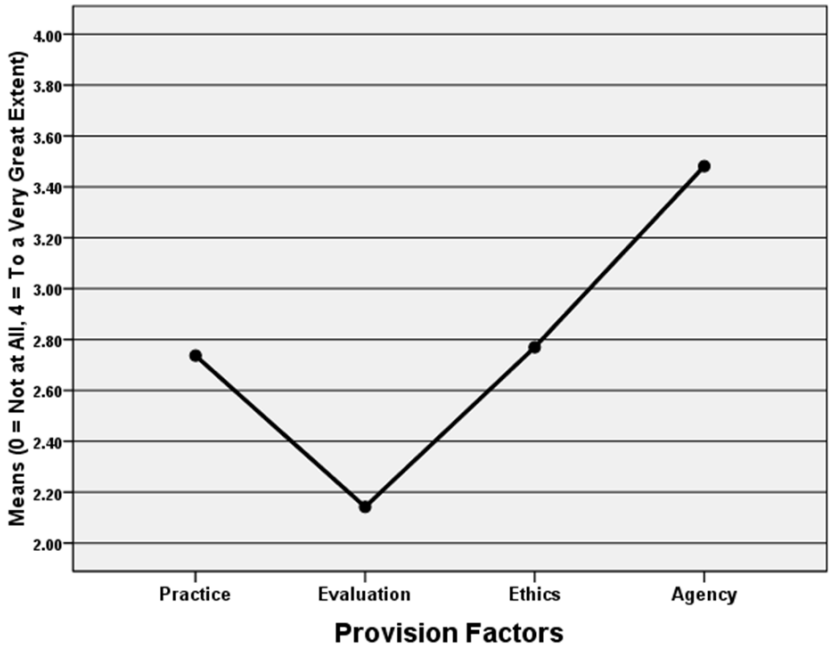


Stats for Provision of Knowledge Factors: Repeated Measures ANOVA

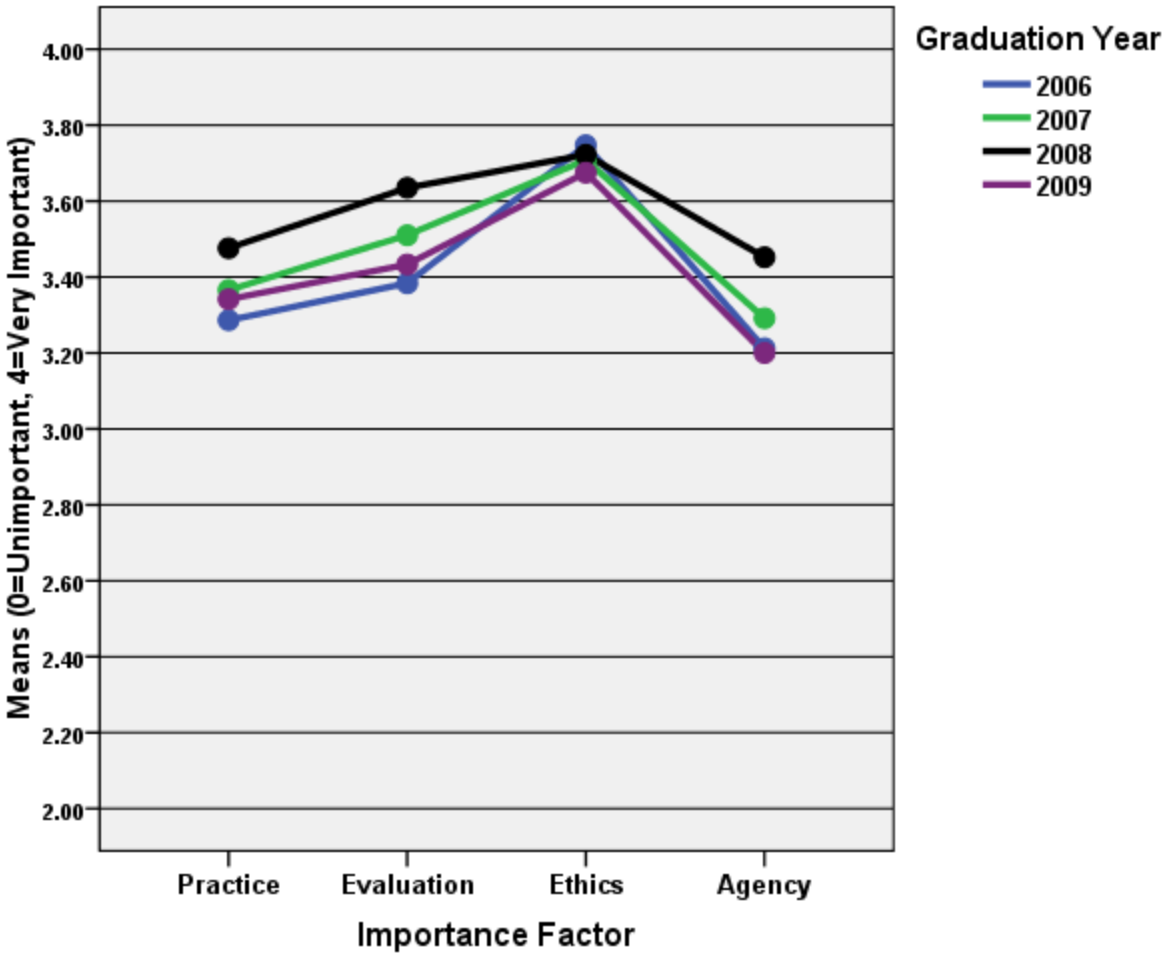
- Within subjects Provision factor
  - $F(3,486) = 147.12$, $p < .001$, $eta^2 = .48$
    - Only non-significant difference between Practice & Ethics

Importance to Provision Knowledge Factors





Importance of Knowledge Factors by Time



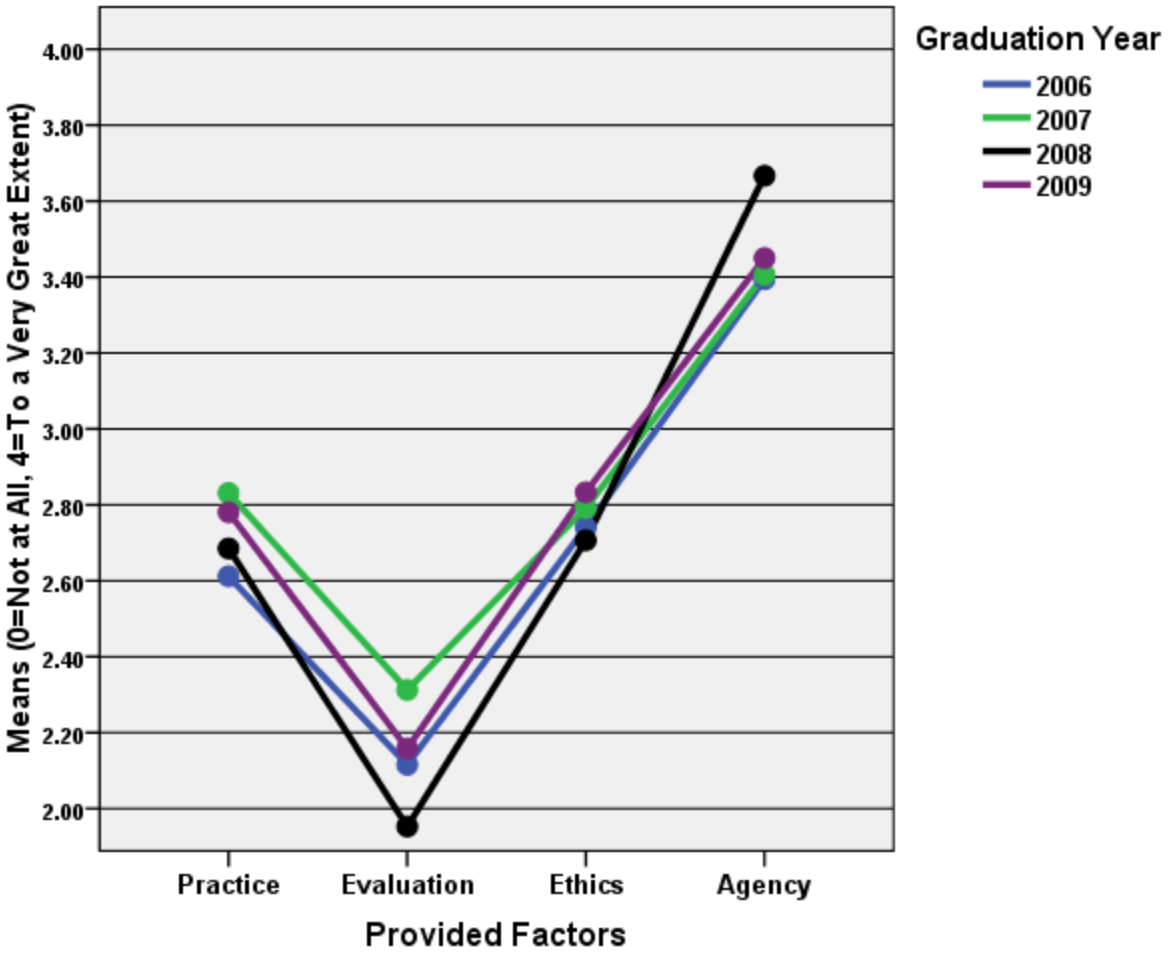
Stats for Importance of Knowledge by Time: Mixed B/W Factorial ANOVA

- Within subjects Importance factor
  - $F(3,477) = 21.29$, $p < .001$, $eta^2 = .12$
    - All different except Practice to Agency

- Importance by Year interaction
  - $F(9,477) = .47$, $p = .896$, $eta^2 = .01$

- Between subjects Year factor
  - $F(3,159) = 1.50$, $p = .217$, $eta^2 = .03$

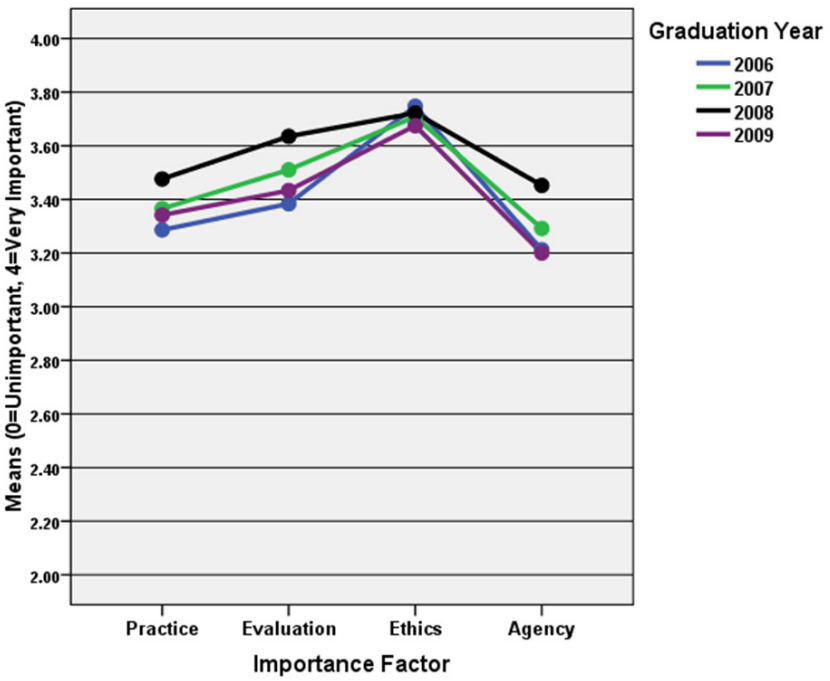
Provision of Knowledge Factors by Time

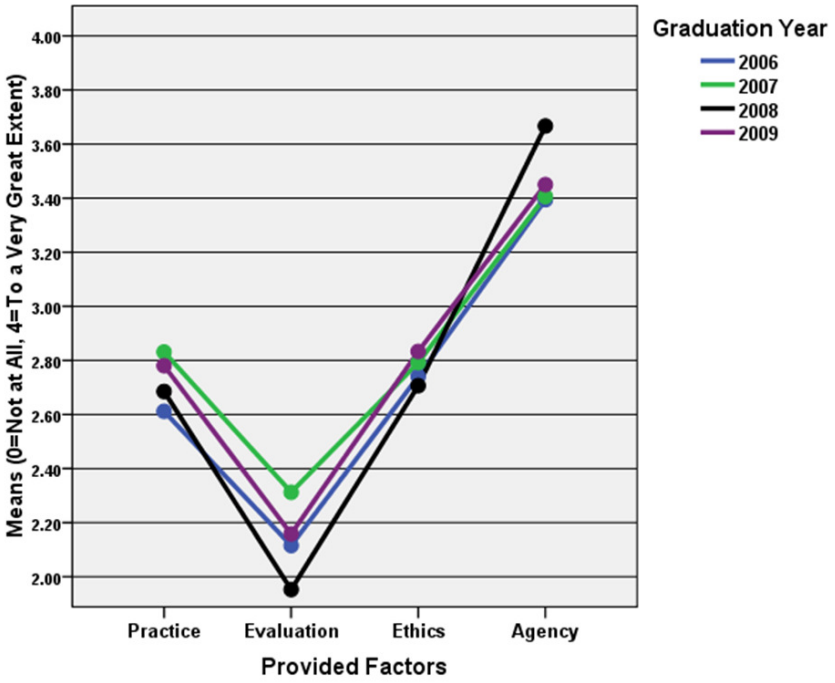


Stats for Provision of Knowledge by Time Mixed Between/Within Factorial ANOVA

- Within subjects Provision factor
  - $F(3,477) = 147.62$, $p < .001$, $eta^2 = .48$
    - All different except Practice to Ethics
- Provision by Year interaction
  - $F(9,477) = 1.73$, $p = .081$, $eta^2 = .03$
- Between subjects Year factor
  - $F(3,159) = .35$, $p = .786$, $eta^2 = .01$

Importance to Provision of Knowledge by Time





Further Factoring of Practice Construct (Factor 1 of the Knowledge Factors)

Pattern Matrix[a]

	Factor			
	1	2	3	4
Imp_Trauma_Impact	**.772**	.016	-.033	-.074
Imp_Affect_Lifestyle_ Mood	**.564**	-.079	.070	.242
Imp_Tx_Interventions	**.457**	.332	-.004	-.063
Imp_Recovery_Process	**.433**	-.035	.202	.137
Imp_EBPs	.168	**.779**	-.074	-.049
Imp_Major_Theories	-.180	**.686**	.145	.173
Imp_Cooccuring_ Disorders	-.009	-.017	.884	-.038
Imp_Psychiatric_Meds	.149	.148	.475	-.057
Imp_Therapeutic_Use_ Self	.020	.061	-.062	**.839**

Treatment

Theory

Use of Self

Extraction Method: Principal Axis Factoring.
Rotation Method: Promax with Kaiser Normalization.

a. Rotation converged in 7 iterations.

Decision made to analyze Co-occurring Disorders and Psychiatric Meds as separate variables.

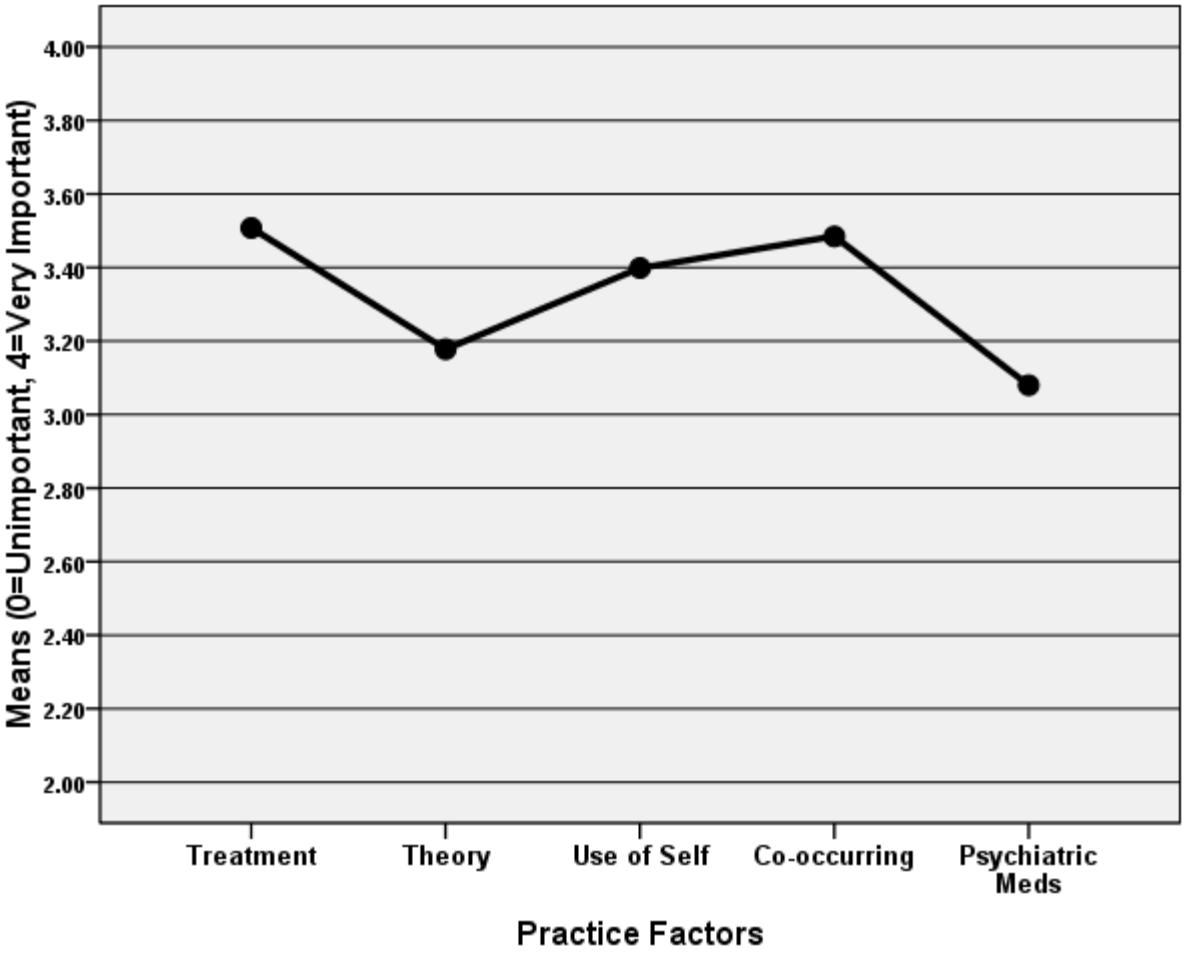
Correlation of Practice Factors

Correlations

		Treatment (Importance)	Theory (Importance)	Use of Self (Importance)	Co-occuring Disorders (Importance)	Psychiatric Meds (Importance)
Treatment (Importance)	Pearson Correlation	1	.532**	.474**	.479**	.441**
	Sig. (2-tailed)		.000	.000	.000	.000
	N	163	163	163	163	163
Theory (Importance)	Pearson Correlation	.532**	1	.416**	.506**	.461**
	Sig. (2-tailed)	.000		.000	.000	.000
	N	163	163	163	163	163
Use of Self (Importance)	Pearson Correlation	.474**	.416**	1	.291**	.319**
	Sig. (2-tailed)	.000	.000		.000	.000
	N	163	163	163	163	163
Co-occuring Disorders (Importance)	Pearson Correlation	.479**	.506**	.291**	1	.523**
	Sig. (2-tailed)	.000	.000	.000		.000
	N	163	163	163	163	163
Psychiatric Meds (Importance)	Pearson Correlation	.441**	.461**	.319**	.523**	1
	Sig. (2-tailed)	.000	.000	.000	.000	
	N	163	163	163	163	163

**. Correlation is significant at the 0.01 level (2-tailed).

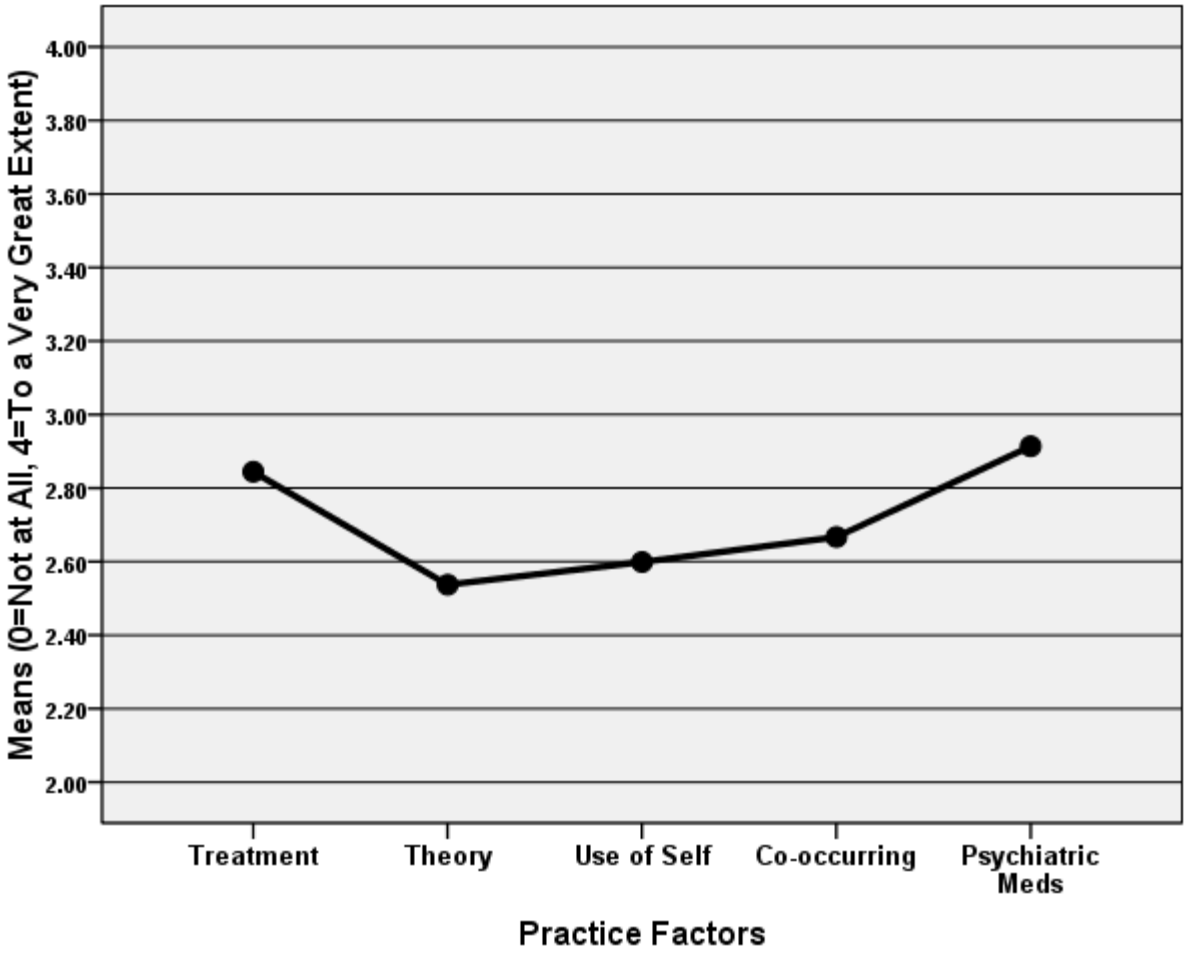
Importance of Practice Factors



Stats for Importance of Practice Factors: Repeated Measures ANOVA

- Within subjects Importance factor
  - $F(4,648) = 20.30$, $p < .001$, $eta^2 = .11$
    - Treatment, Use of Self, & Co-occurring Disorders > Theory & Psychiatric Meds

Provision of Practice Factors

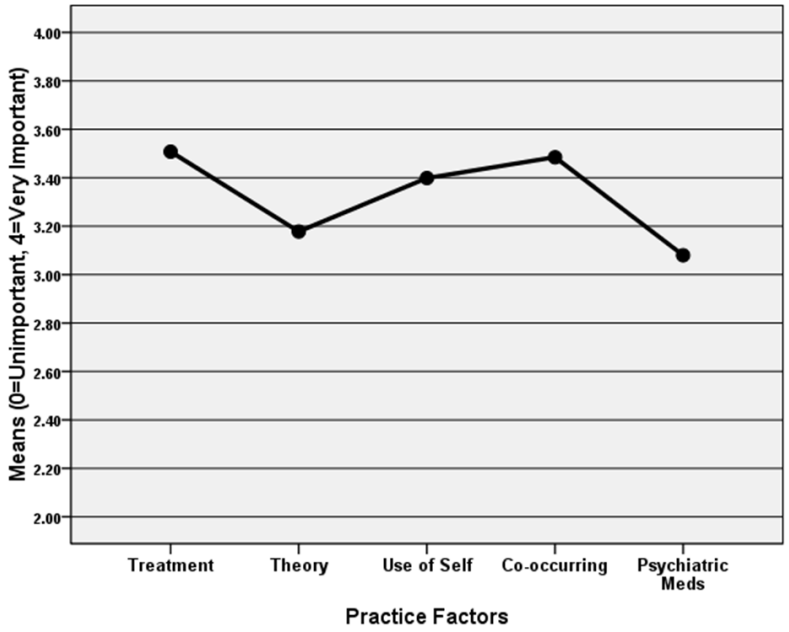


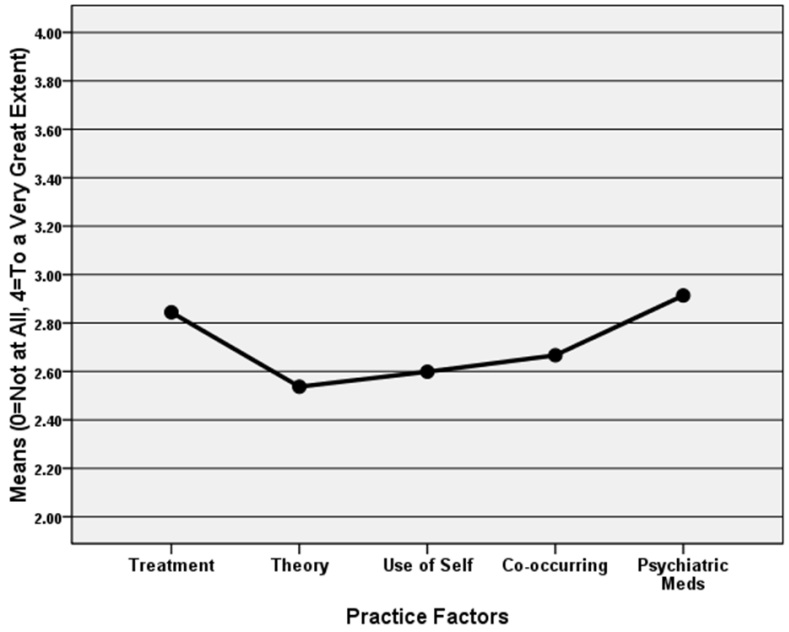
Stats for Provision of Practice Factors: Repeated Measures ANOVA

- Within subjects Importance factor
  - $F(4,648) = 9.80$, $p < .001$, $eta^2 = .06$

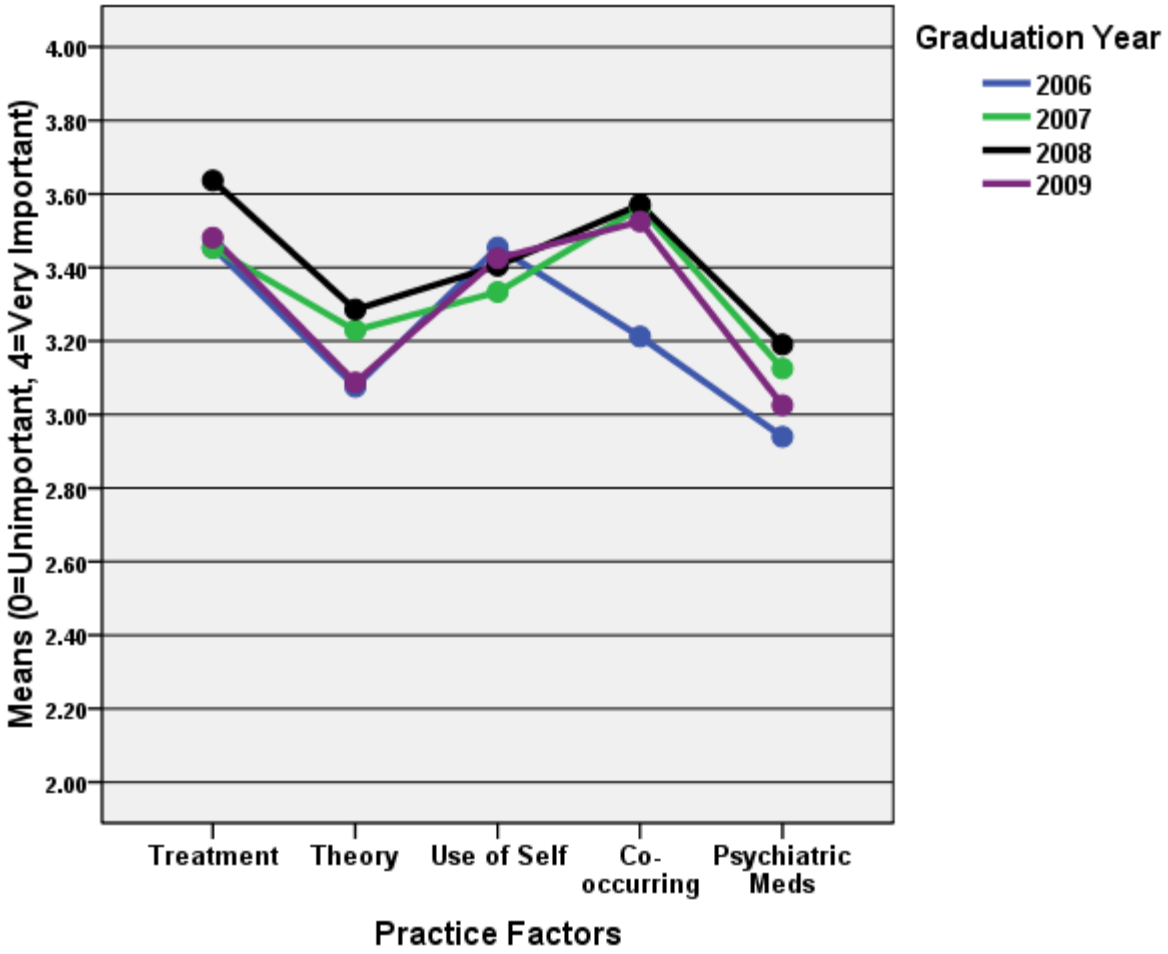
    - Treatment > Theory & Use of Self
    - Psychiatric Meds > Theory, Use of Self, & Co-Occurring Disorders

Importance to Provision of Practice Factors





Importance of Practice Factors by Time



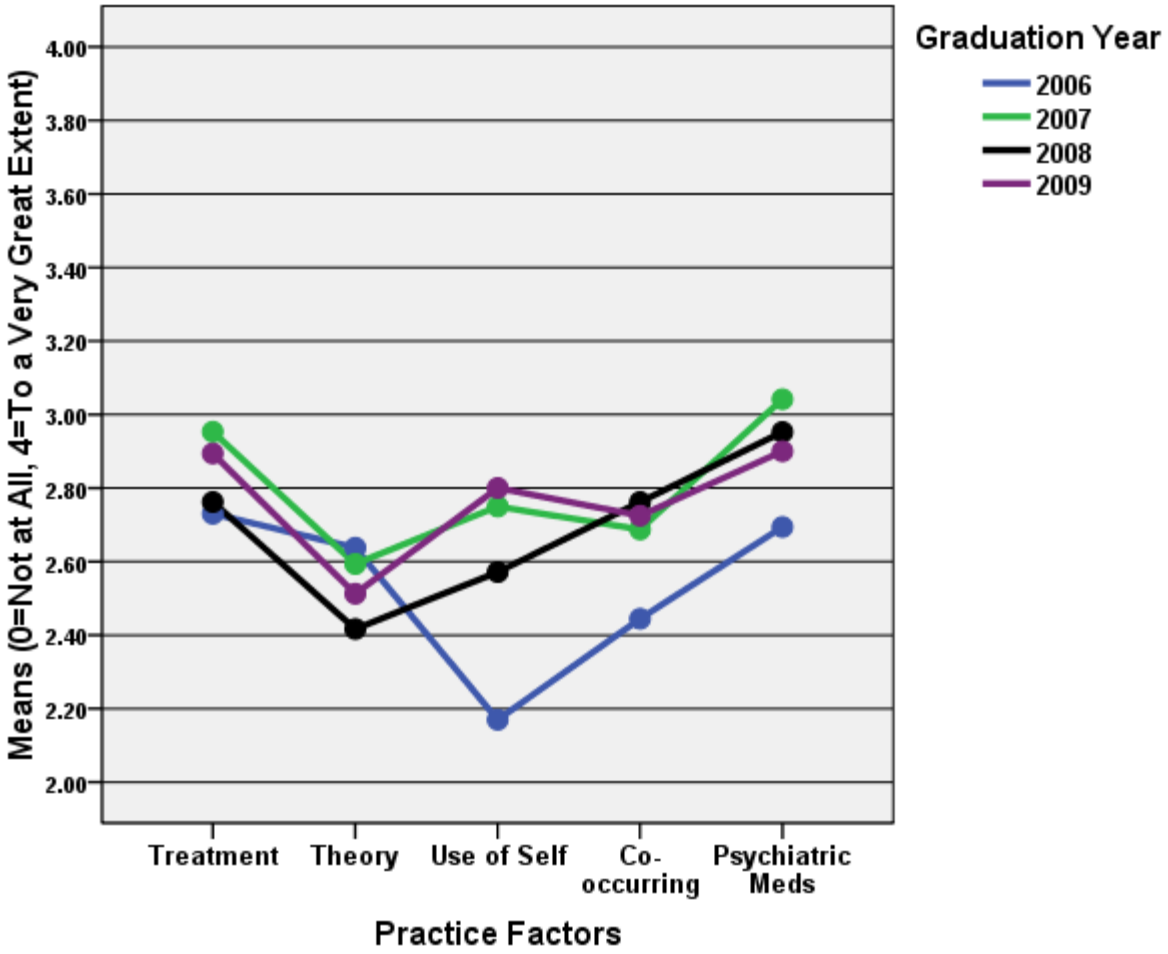
Stats for Importance of Practice Factors by Time Mixed B/W Factorial ANOVA

- Within subjects Importance factor
  - $F(4,636) = 20.33$, $p < .001$, $eta^2 = .11$
    - Treatment > Theory & Psychiatric Meds
    - Use of Self & Co-occurring Disorders > Theory & Psychiatric Meds

- Importance by Year interaction
  - $F(12,636) = 1.03$, $p = .420$, $eta^2 = .02$

- Between subjects Year factor
  - $F(3,159) = 0.87$, $p = .458$, $eta^2 = .02$

Provision of Practice Factors by Time



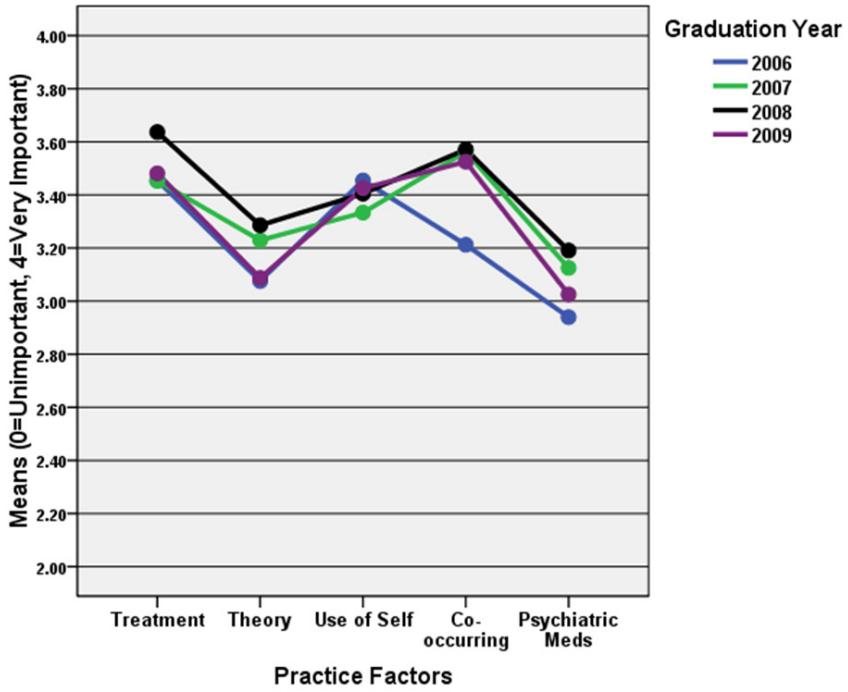
Stats for Provision of Practice Factors by Time Mixed B/W Factorial ANOVA

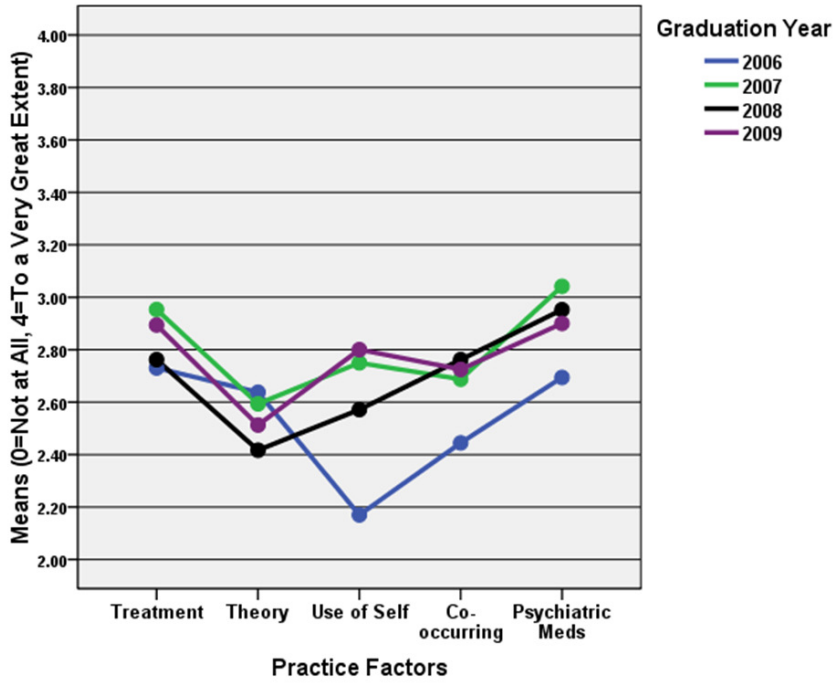
- Within subjects Importance factor
  - $F(4,636) = 9.48$, $p < .001$, $eta^2 = .06$
    - Treatment > Theory & Use of Self
    - Psychiatric Meds > Theory, Use of Self, & Co-occurring

- Importance by Year interaction
  - $F(12,636) = 1.57$, $p = .10$, $eta^2 = .03$
  - Marginal significance, Change in provision of Therapy, Co-occurring Disorders, & Psychiatric Meds from 2006 to 2007

- Between subjects Year factor
  - $F(3,159) = 0.93$, $p = .429$, $eta^2 = .02$

Importance to Provision of Practice Factors over Time





Student Ratings of Knowledge, Skills, & Abilities

Skills

Skill Factors

Treatment Planning

Writing & Tech

Pattern Matrix[a]

	Factor		
	1	2	3
Imp_Assessment_Indv_Fam	.902	-.010	.045
Imp_Communication	.604	-.010	-.023
Imp_Devt_Tx_Int_Dis_Plans	.527	.070	-.228
Imp_Technical	-.134	.732	-.107
Imp_Writing	.101	.596	.070
Imp_Case_Management	-.022	-.067	-.869
Imp_Documentation_MediCal	.009	.059	-.568
Imp_Revising_Tx_Plans	.249	.086	-.541

Extraction Method: Principal Axis Factoring.

Rotation Method: Oblimin with Kaiser Normalization.

a. Rotation converged in 7 iterations.

Decision made to add Revision of Treatment Plans to Treatment Planning factor, and to analyze Case Management & Documentation as separate variables.

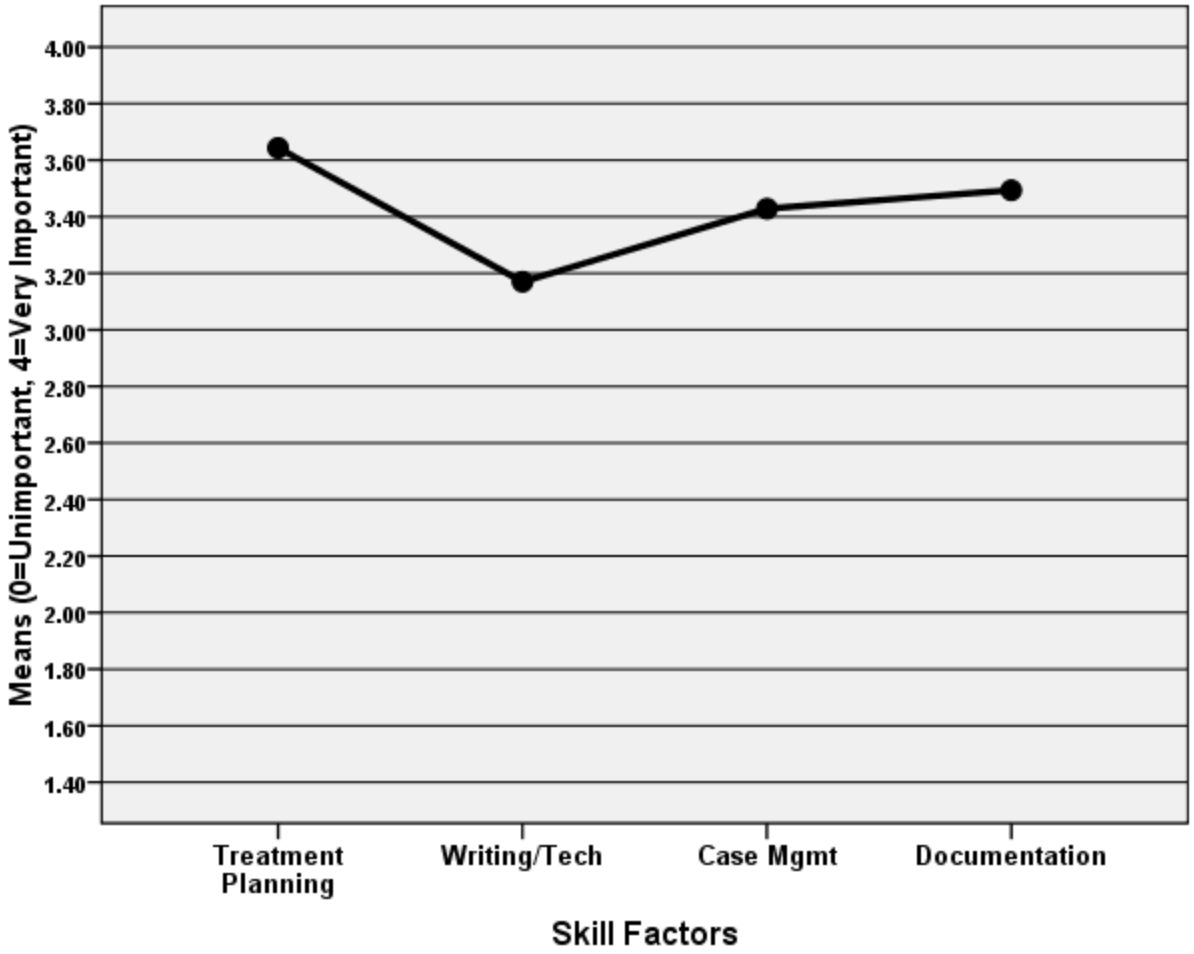
Correlation among Skill Factors

Correlations

		Treatment Planning (Importance)	Writing/Technical (Importance)	Case Management (Importance)	Documentation (Importance)
Treatment Planning (Importance)	Pearson Correlation	1	.262**	.548**	.401**
	Sig. (2-tailed)		.001	.000	.000
	N	163	163	163	163
Writing/Technical (Importance)	Pearson Correlation	.262**	1	.224**	.234**
	Sig. (2-tailed)	.001		.004	.003
	N	163	163	163	163
Case Management (Importance)	Pearson Correlation	.548**	.224**	1	.516**
	Sig. (2-tailed)	.000	.004		.000
	N	163	163	163	163
Documentation (Importance)	Pearson Correlation	.401**	.234**	.516**	1
	Sig. (2-tailed)	.000	.003	.000	
	N	163	163	163	163

**. Correlation is significant at the 0.01 level (2-tailed).

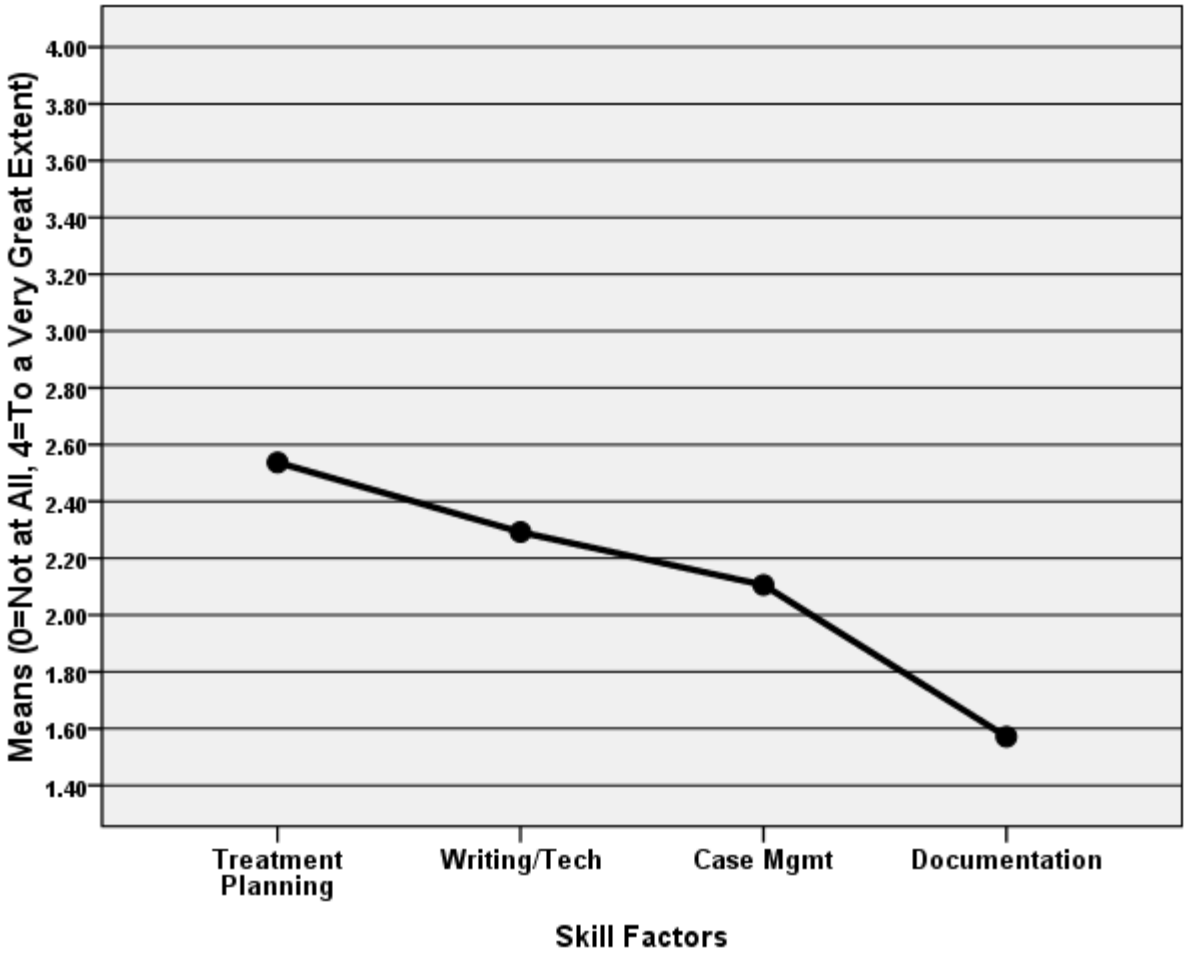
Importance of Skill Factors



Stats for Importance of Skill Factors: Repeated Measures ANOVA

- Within subjects Importance factor
  - $F(3,486) = 25.69$, $p < .001$, $eta^2 = .14$
    - Treatment Planning > Writing/Tech, Case Mgmt, & Documentation
    - Case Mgmt, & Documentation > Writing/Tech

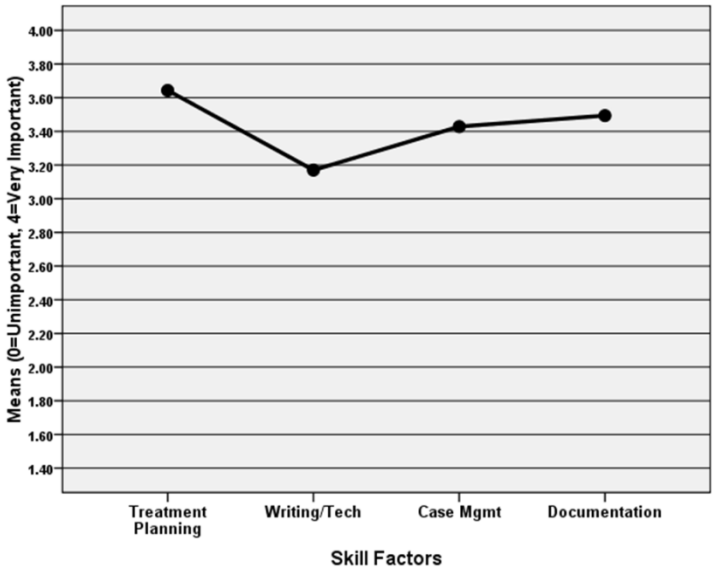
Provision of Skill Factors

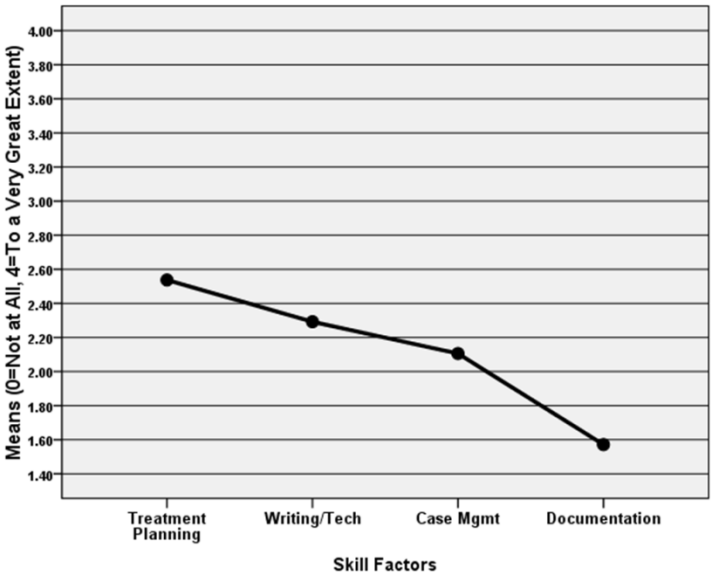


Stats for Provision of Skill Factors: Repeated Measures ANOVA

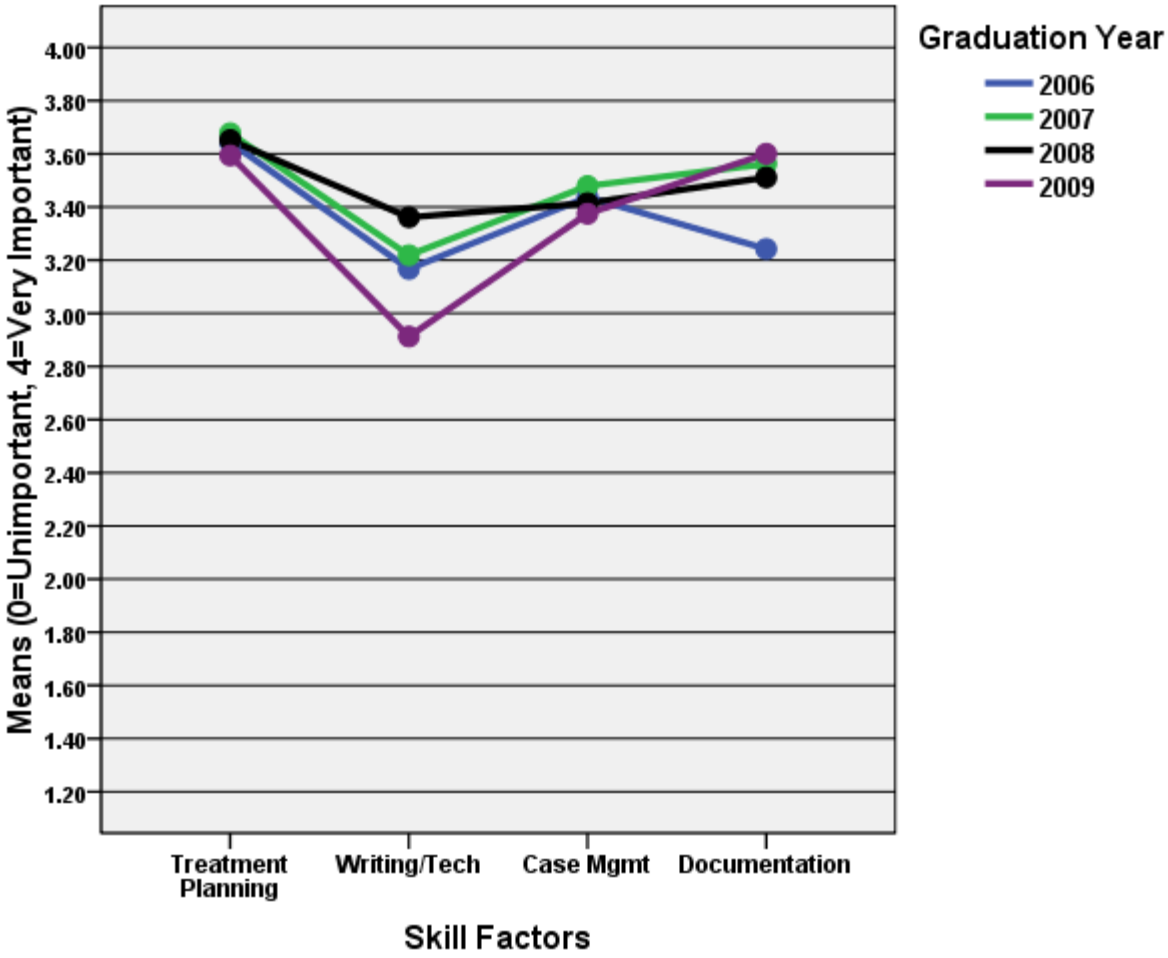
- Within subjects Importance factor
  - $F(3,486) = 39.67$, $p < .001$, $eta^2 = .20$
    - Treatment Planning > Writing/Tech, Case Mgmt, & Documentation
    - Writing/Tech & Case Mgmt > Documentation

Importance to Provision of Skill Factors





Importance of Skill Factors by Time



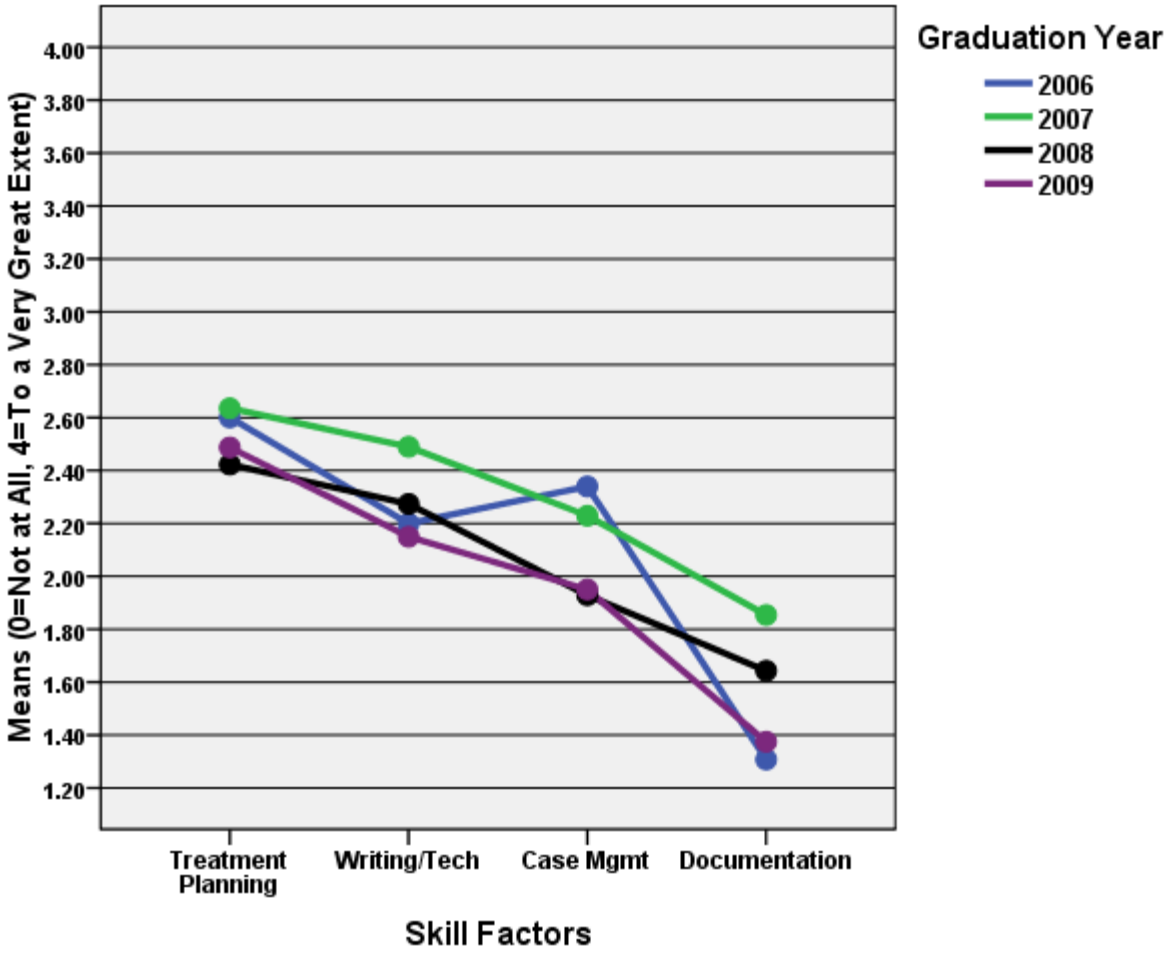
Stats for Importance of Skill Factors by Time: Mixed B/W Factorial ANOVA

- Within subjects Importance factor
  - $F(3,477) = 25.98$, $p < .001$, $eta^2 = .14$
    - Treatment Planning > Writing/Tech, Case Mgmt, & Documentation
    - Case Mgmt, & Documentation > Writing/Tech

- Importance by Year interaction
  - $F(9.477) = 2.49$, $p = .009$, $eta^2 = .05$
    - Increase in Documentation from 2006 to later years
    - Drop in Writing/Tech in 2009 compared to previous years

- Between subjects Year factor
  - $F(3,159) = 0.90$, $p = .444$, $eta^2 = .02$

Provision of Skill Factors by Time



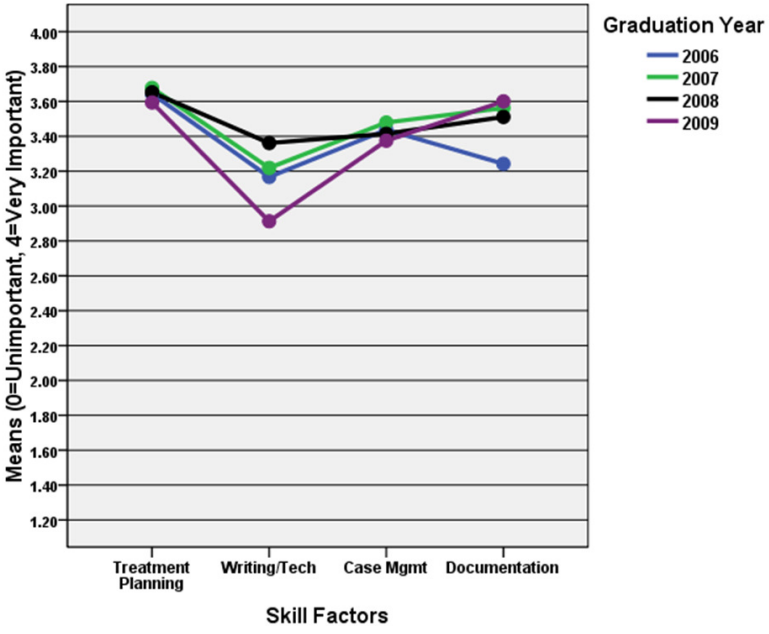
Stats for Provision of Skill Factors by Time: Mixed B/W Factorial ANOVA

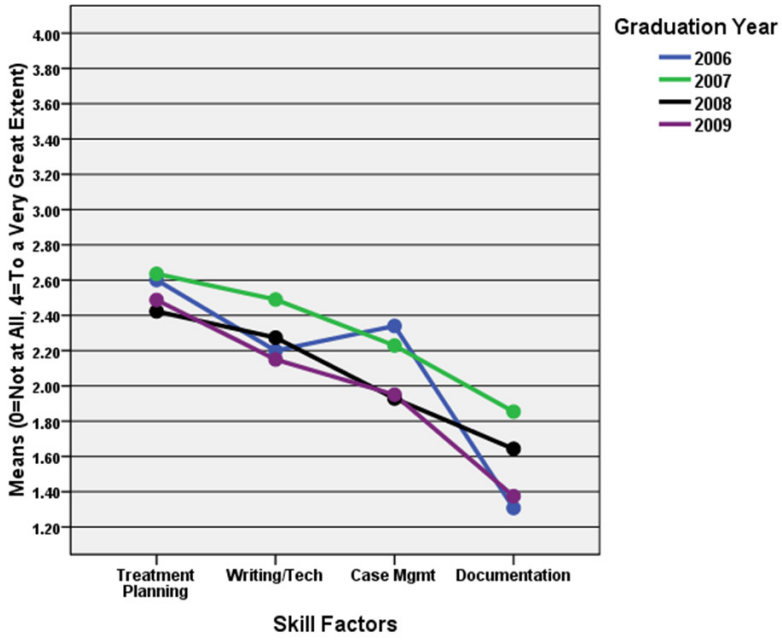
- Within subjects Importance factor
  - $F(3,477) = 41.03$, $p < .001$, $eta^2 = .21$
    - Treatment Planning > Writing/Tech, Case Mgmt, & Documentation
    - Writing/Tech & Case Mgmt > Documentation

- Importance by Year interaction
  - $F(9.477) = 1.20$, $p = .291$, $eta^2 = .02$

- Between subjects Year factor
  - $F(3,159) = 0.95$, $p = .418$, $eta^2 = .02$

Importance to Provision of Skill Factors over Time





Student Ratings of Knowledge, Skills, & Abilities

Ability

Ability Factors

Pattern Matrix[a]

	Factor			
	1	2	3	4
Imp_Utilization_Supervision	**.784**	-.012	-.084	-.022
Imp_Strategies_Learning	**.672**	.208	.022	.014
Imp_Time_Mgmt	**.604**	.142	-.016	.045
Imp_Stress_Mgmt	**.588**	-.194	-.256	.122
Imp_Maintaining_App_Bound	**.447**	.261	.115	.072
Imp_Advocacy	-.049	**.761**	-.054	-.040
Imp_Cultural_Competency	.089	**.552**	.006	.225
Imp_Assertiveness	.145	**.535**	-.015	.055
Imp_Mult_Int_Teamwork	.305	.142	**-.672**	.062
Imp_Collaboration	.182	.352	**-.385**	.135
Imp_Conflict_Resolution	-.136	.128	-.219	**.728**
Imp_Devt_Therapeutic_Rel	.004	.075	.142	**.588**
Imp_Engaging_Client	.139	-.075	.093	**.583**
Imp_Crisis_Intervention	-.041	.008	-.219	**.578**
Imp_Facilitating_Self_Help	.122	.268	-.013	**.457**
Imp_Handling_NonCompliance	.323	-.124	.017	**.440**
Imp_Integrating_Theory_Practice	.264	.150	.244	**.403**

Professional Behaviors

Advocacy

Teamwork

Interpersonal Interactions

Cultural Competence

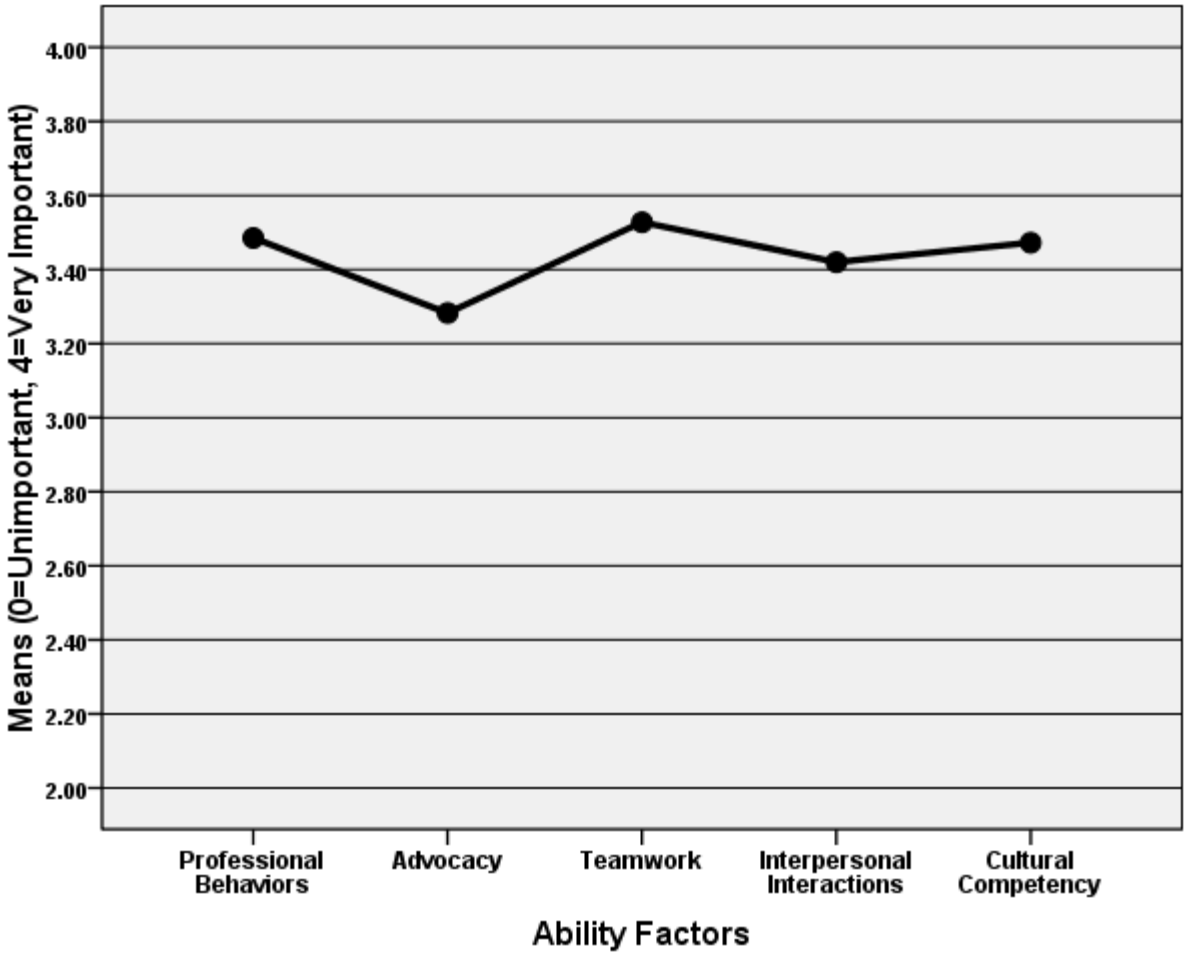
Correlations among Ability Factors

Correlations

		Professional Behaviors (Importance)	Advocacy (Importance)	Teamwork (Importance)	Interpersonal Interactions (Importance)	Cultural Competence (Importance)
Professional Behaviors (Importance)	Pearson Correlation	1	.394**	.562**	.633**	.468**
	Sig. (2-tailed)		.000	.000	.000	.000
	N	163	163	163	163	163
Advocacy (Importance)	Pearson Correlation	.394**	1	.399**	.411**	.524**
	Sig. (2-tailed)	.000		.000	.000	.000
	N	163	163	163	163	163
Teamwork (Importance)	Pearson Correlation	.562**	.399**	1	.488**	.440**
	Sig. (2-tailed)	.000	.000		.000	.000
	N	163	163	163	163	163
Interpersonal Interactions (Importance)	Pearson Correlation	.633**	.411**	.488**	1	.508**
	Sig. (2-tailed)	.000	.000	.000		.000
	N	163	163	163	163	163
Cultural Competence (Importance)	Pearson Correlation	.468**	.524**	.440**	.508**	1
	Sig. (2-tailed)	.000	.000	.000	.000	
	N	163	163	163	163	163

**. Correlation is significant at the 0.01 level (2-tailed).

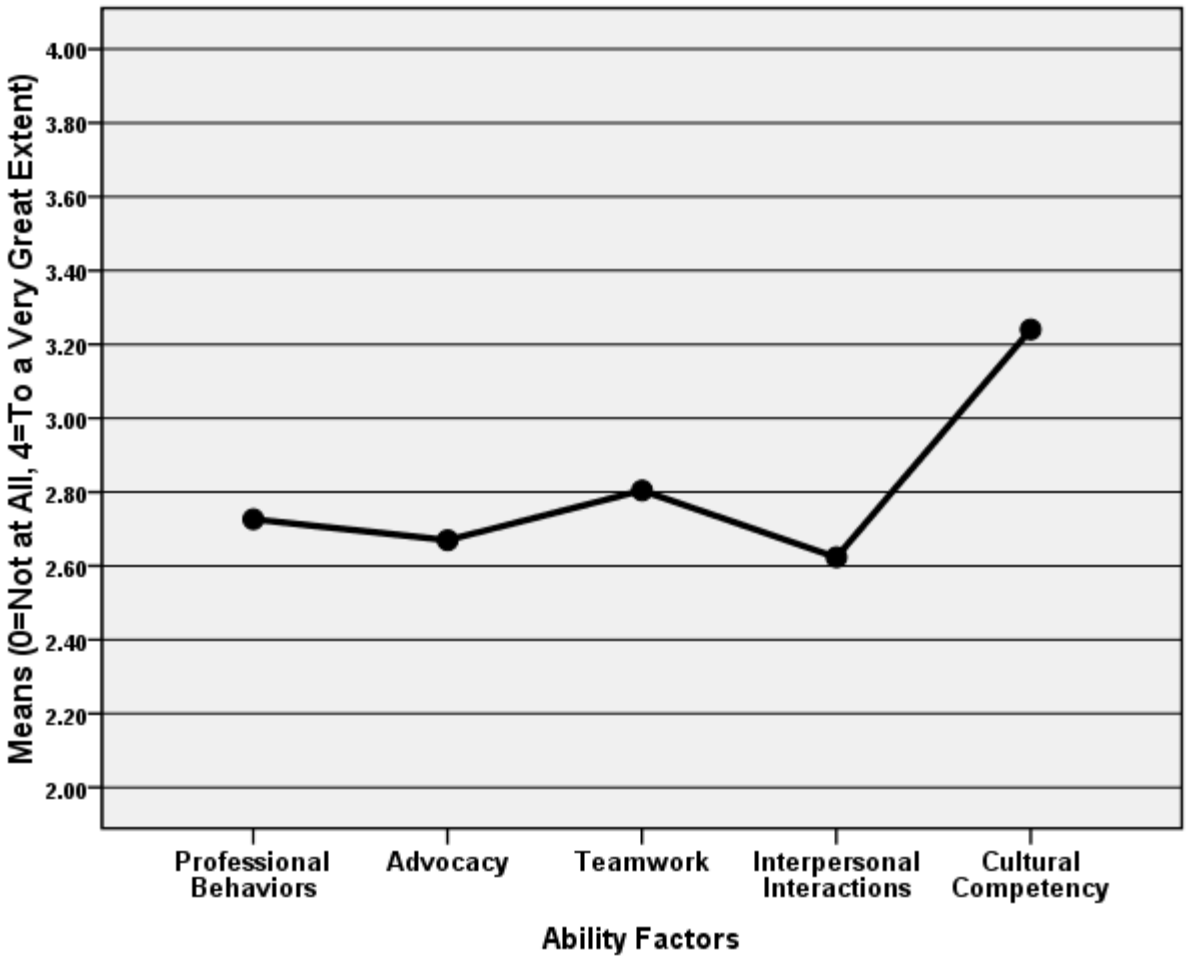
Importance of Ability Factors



Stats for Importance of Ability Factors: Repeated Measures ANOVA

- Within subjects Importance factor
  - $F(4,648) = 7.67$, $p < .001$, $eta^2 = .05$
    - Professional Behaviors, Teamwork, & Cultural Competency > Advocacy

Provision of Ability Factors

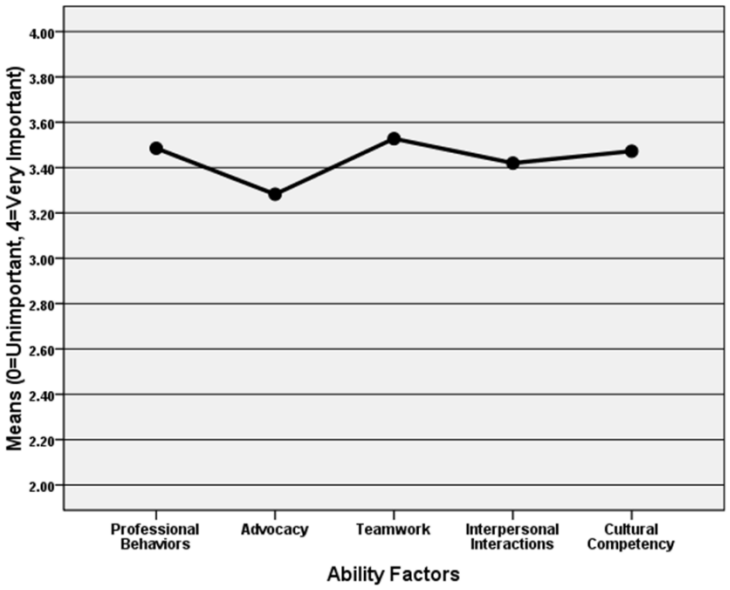


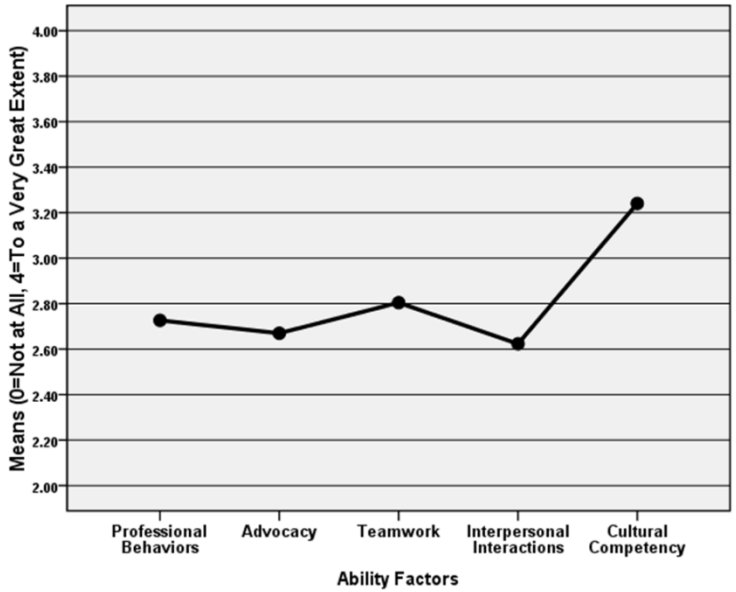
Stats for Provision of Ability Factors: Repeated Measures ANOVA

- Within subjects Importance factor
  - $F(4,844) = 34.00$, $p < .001$, $eta^2 = .14$

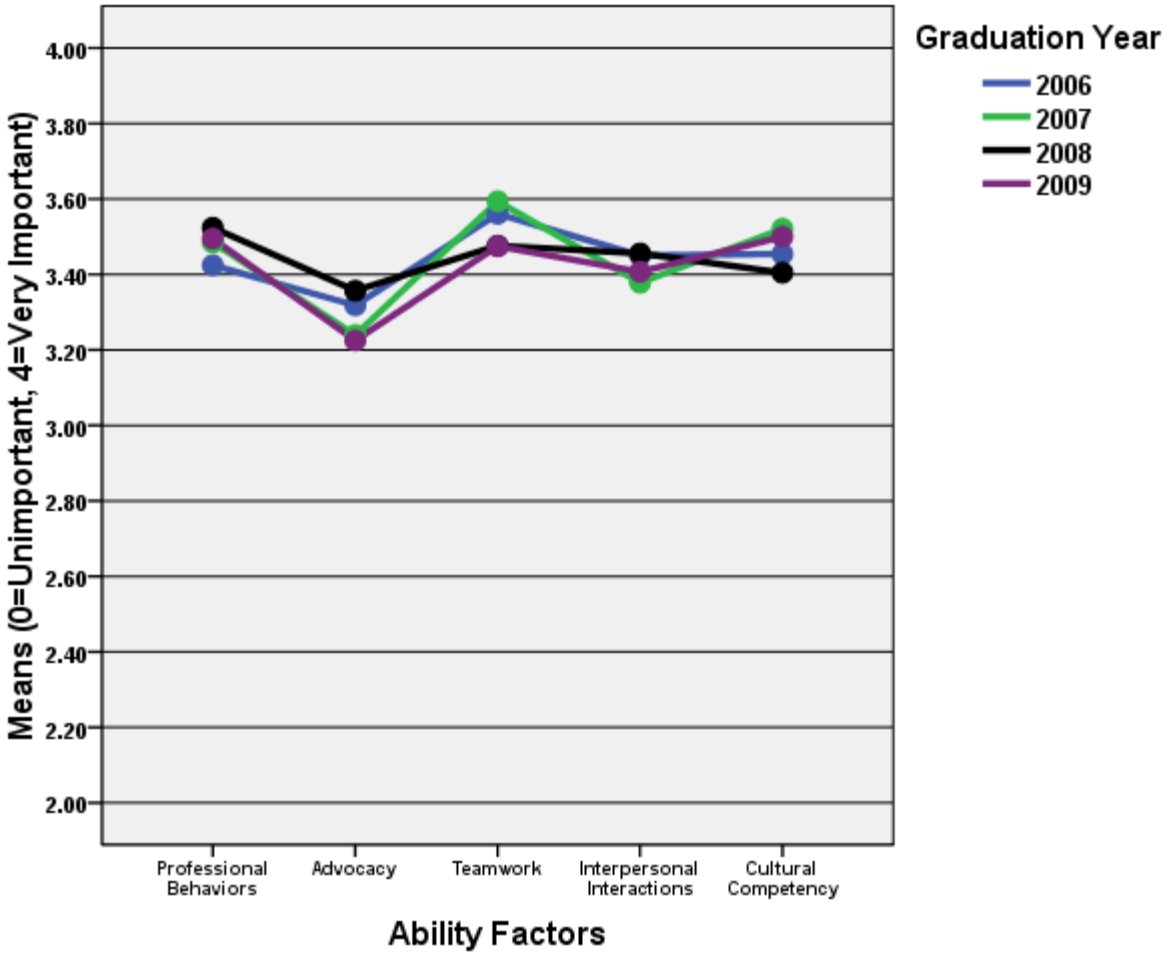
    - Cultural Competency > Professional Behaviors, Advocacy, Teamwork, & Interpersonal Interactions
    - Teamwork > Interpersonal Interactions

Importance to Provision of Ability Factors





Importance of Ability Factors by Time



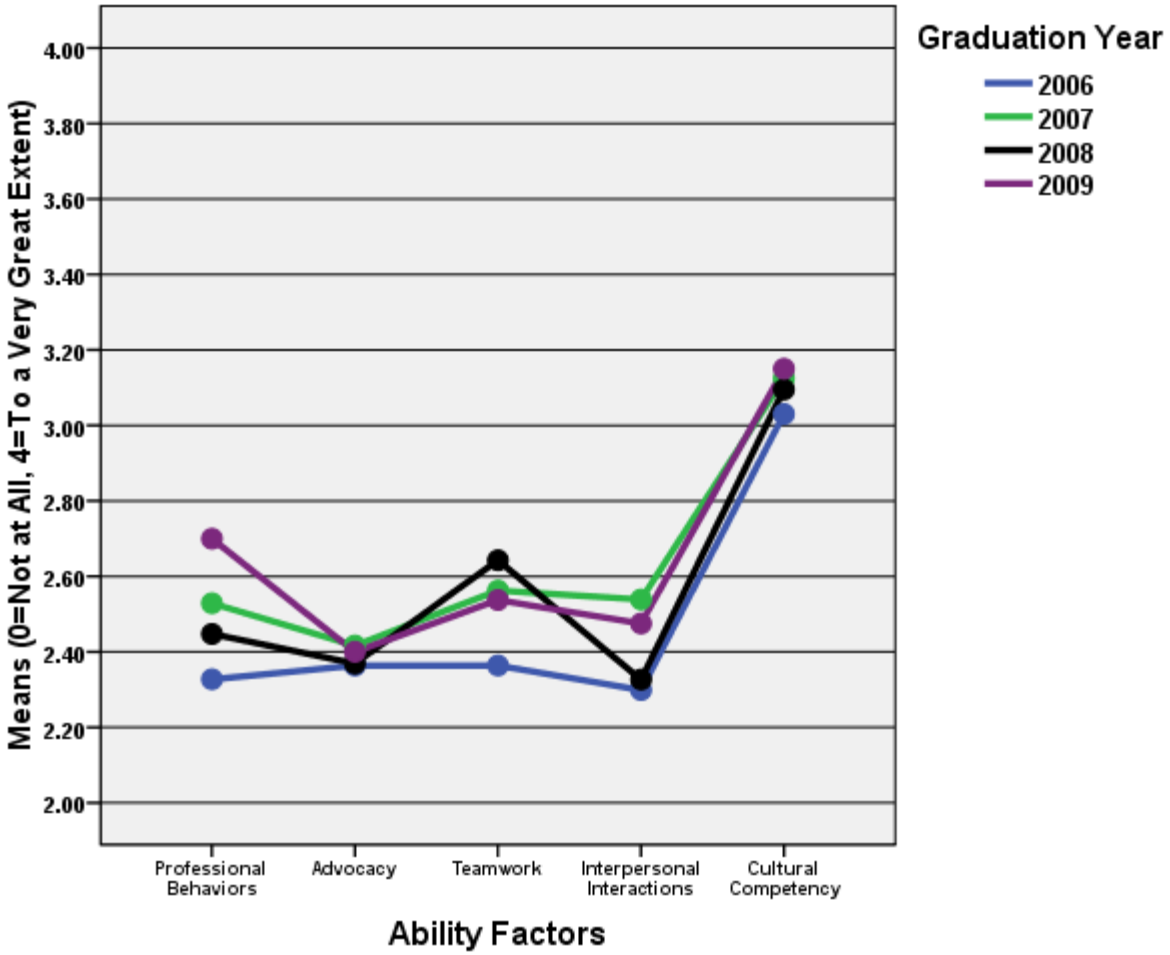
Stats for Importance of Ability Factors by Time: Mixed B/W Factorial ANOVA

- Within subjects Importance factor
  - $F(4,636) = 7.15$, $p < .001$, $eta^2 = .04$
    - Professional Behaviors, Teamwork, & Cultural Competency > Advocacy

- Importance by Year interaction
  - $F(12,636) = .69$, $p = .761$, $eta^2 = .01$

- Between subjects Year factor
  - $F(3,159) = 0.03$, $p = .995$, $eta^2 = .00$

Provision of Ability Factors by Time



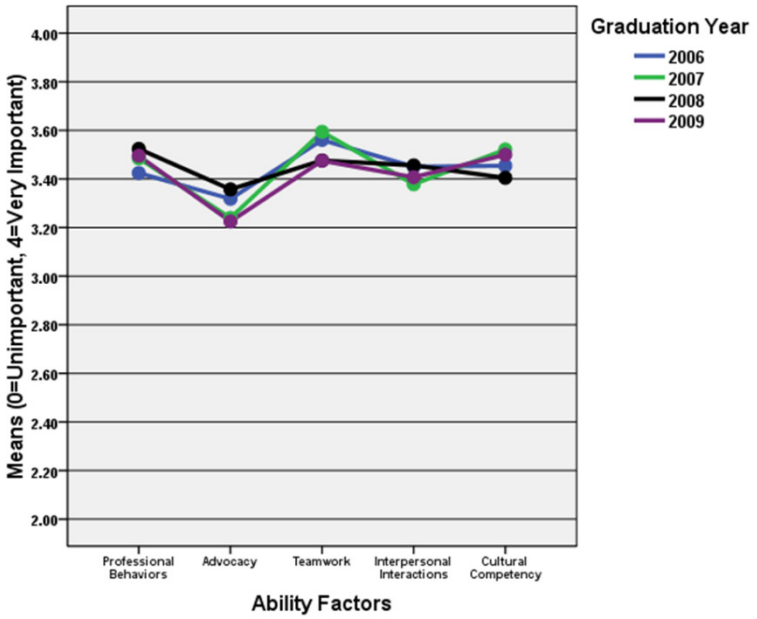
Stats for Provision of Ability Factors by Time: Mixed B/W Factorial ANOVA

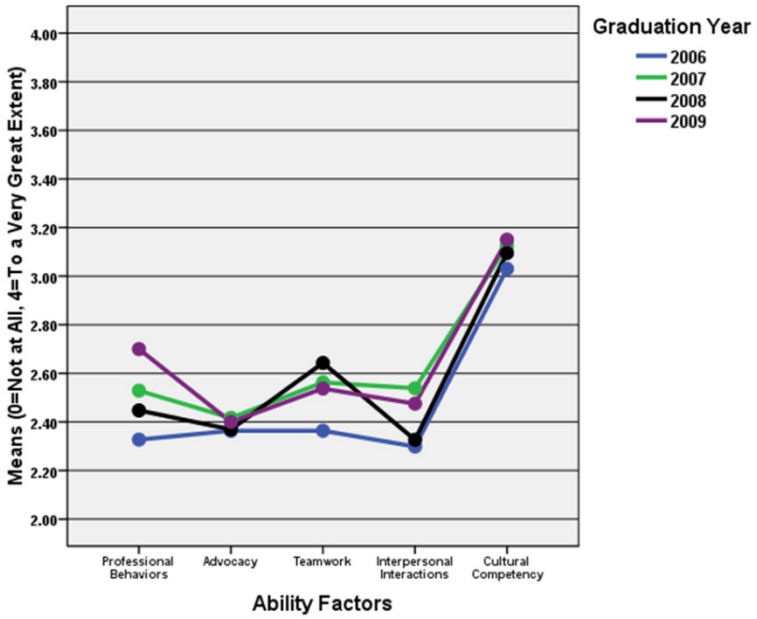
- Within subjects Importance factor
  - $F(4,636) = 37.53$, $p < .001$, $eta^2 = .19$
    - Cultural Competency > Professional Behaviors, Advocacy, Teamwork, & Interpersonal Interactions

- Importance by Year interaction
  - $F(12,636) = .64$, $p = .809$, $eta^2 = .01$

- Between subjects Year factor
  - $F(3,159) = 0.36$, $p = .781$, $eta^2 = .01$

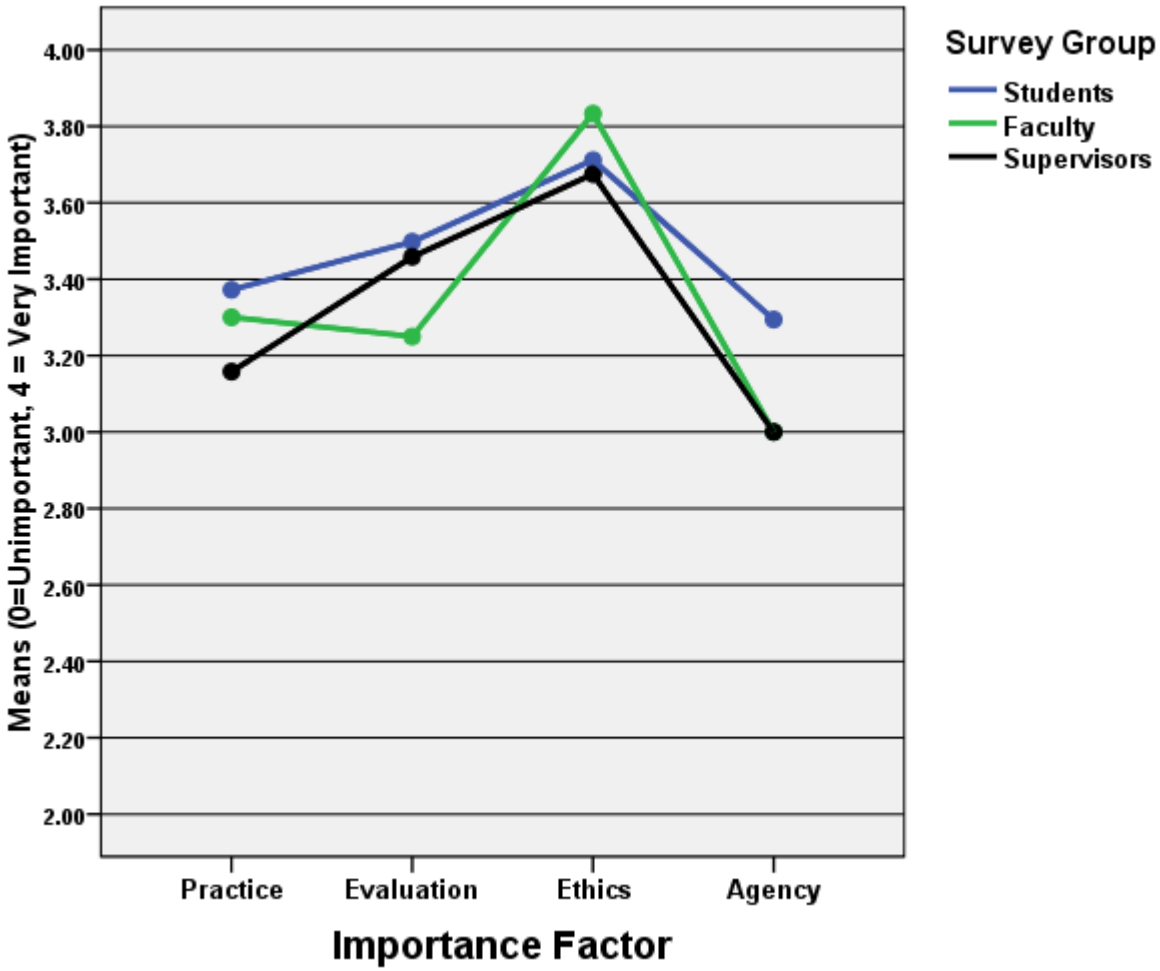
Importance to Provision of Ability Factors over Time





Student, Supervisor, & Faculty Ratings of Importance of Knowledge, Skills, & Abilities

Importance of Knowledge Factors by Group



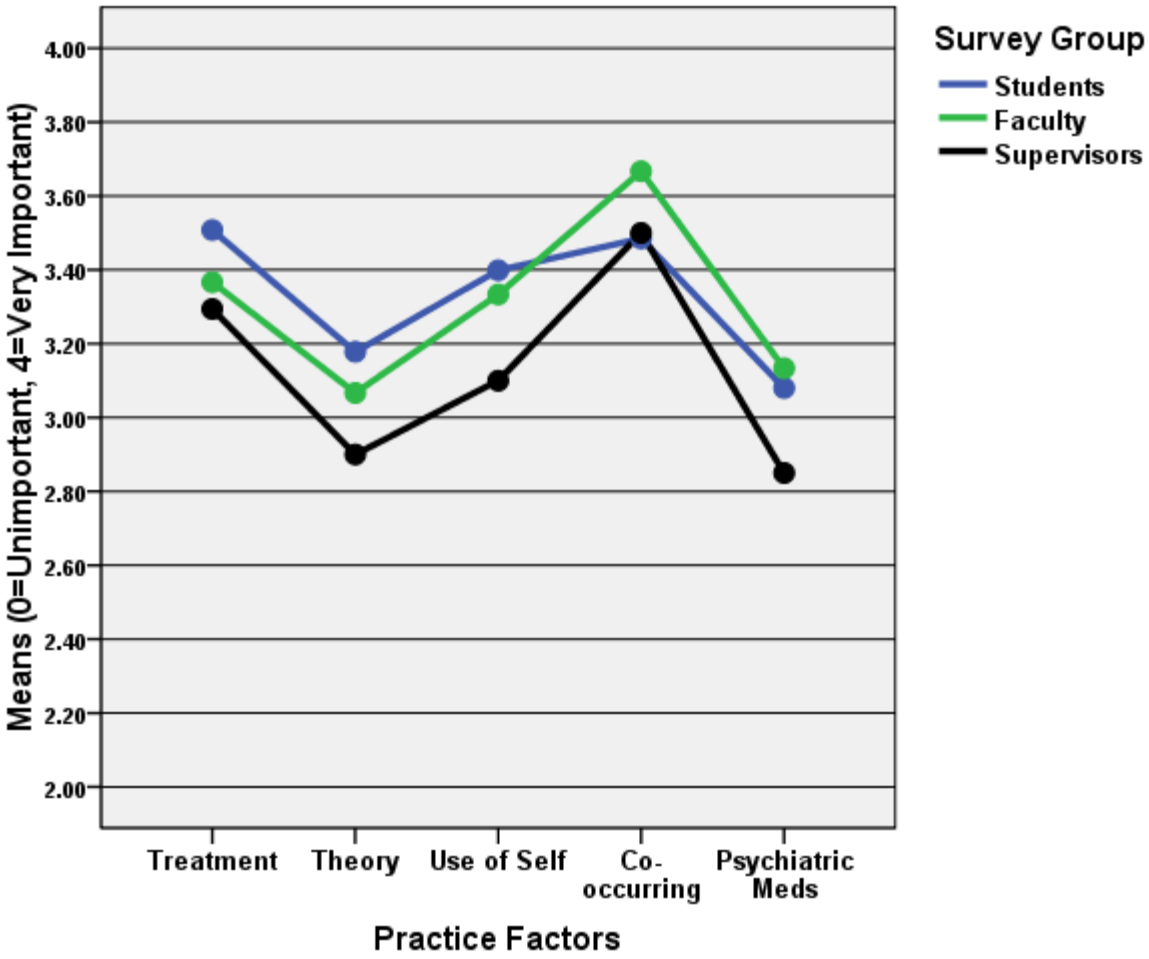
Stats for Importance of Knowledge Factors by Group: Mixed B/W Factorial ANOVA

- Within subjects Importance factor
  - $F(3,648) = 29.68$, $p < .001$, $eta^2 = .12$
    - Ethics > Practice, Evaluation, & Agency
    - Practice & Evaluation > Agency

- Importance by Group interaction
  - $F(6,648) = 2.12$, $p = .049$, $eta^2 = .02$

- Between subjects Group factor
  - $F(2,216) = 1.80$, $p = .167$, $eta^2 = .02$

Importance of Practice Factors by Group



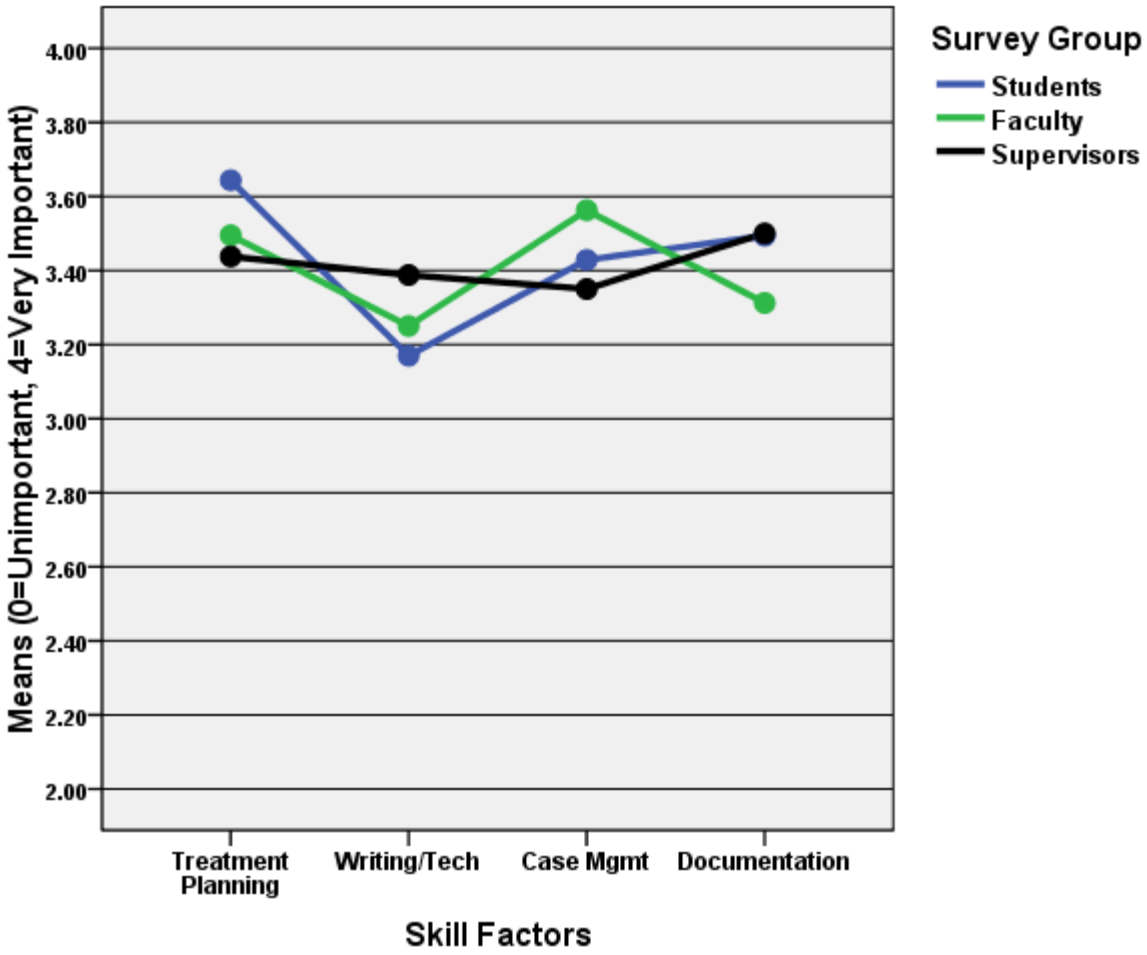
Stats for Importance of Practice Factors by Group Mixed B/W Factorial ANOVA

- Within subjects Importance factor
  - $F(4,860) = 16.09$, $p < .001$, $eta^2 = .07$
    - Treatment > Theory & Psychiatric Meds
    - Co-occurring Disorders > Theory, Use of Self, & Psychiatric Meds

- Importance by Group interaction
  - $F(8,860) = 1.19$, $p = .304$, $eta^2 = .01$

- Between subjects Group factor
  - $F(2,215) = 2.10$, $p = .126$, $eta^2 = .02$

Importance of Skill Factors by Group



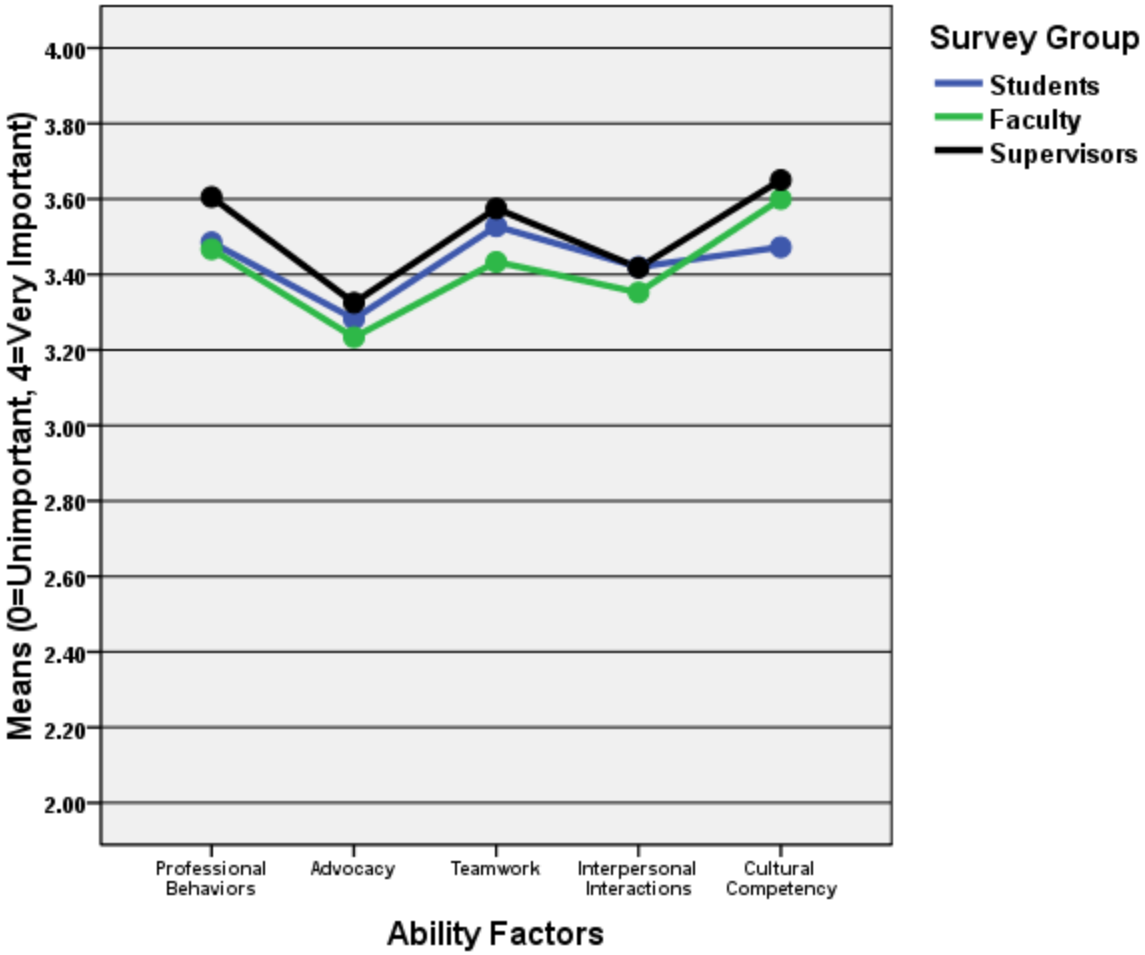
Stats for Importance of Skill Factors by Group: Mixed B/W Factorial ANOVA

- Within subjects Importance factor
  - $F(3,648) = 4.23$, $p = .006$, $eta^2 = .02$
    - Treatment Planning > Writing/Tech

- Importance by Group interaction
  - $F(6,648) = 2.55$, $p = .019$, $eta^2 = .02$

- Between subjects Group factor
  - $F(2,216) = .04$, $p = .959$, $eta^2 = .00$

Importance of Ability Factors by Group



Stats for Importance of Ability Factors by Group: Mixed B/W Factorial ANOVA

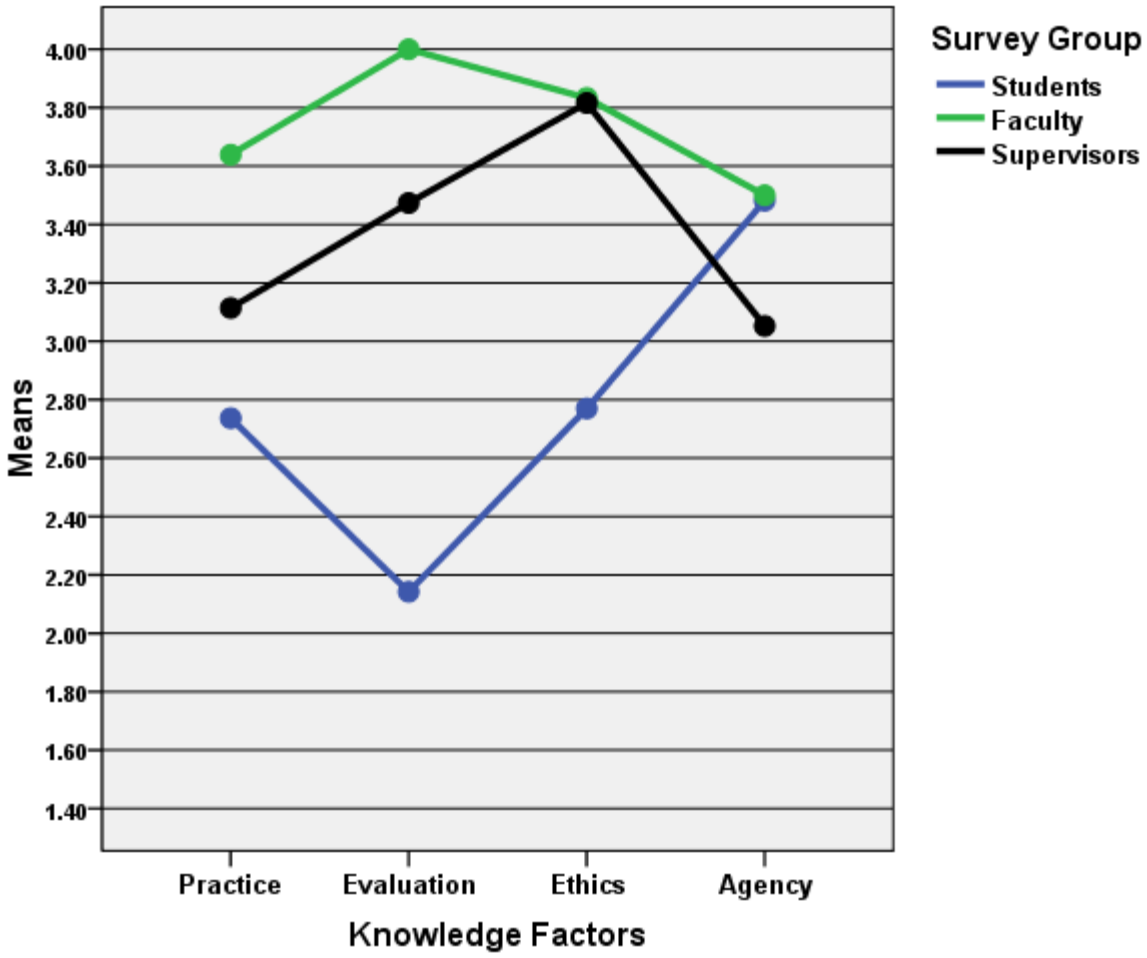
- Within subjects Importance factor
  - $F(4,860) = 7.32$, $p < .001$, $eta^2 = .03$
    - Professional Behaviors, Teamwork, & Cultural Competency > Advocacy

- Importance by Group interaction
  - $F(8,860) = .69$, $p = .698$, $eta^2 = .01$

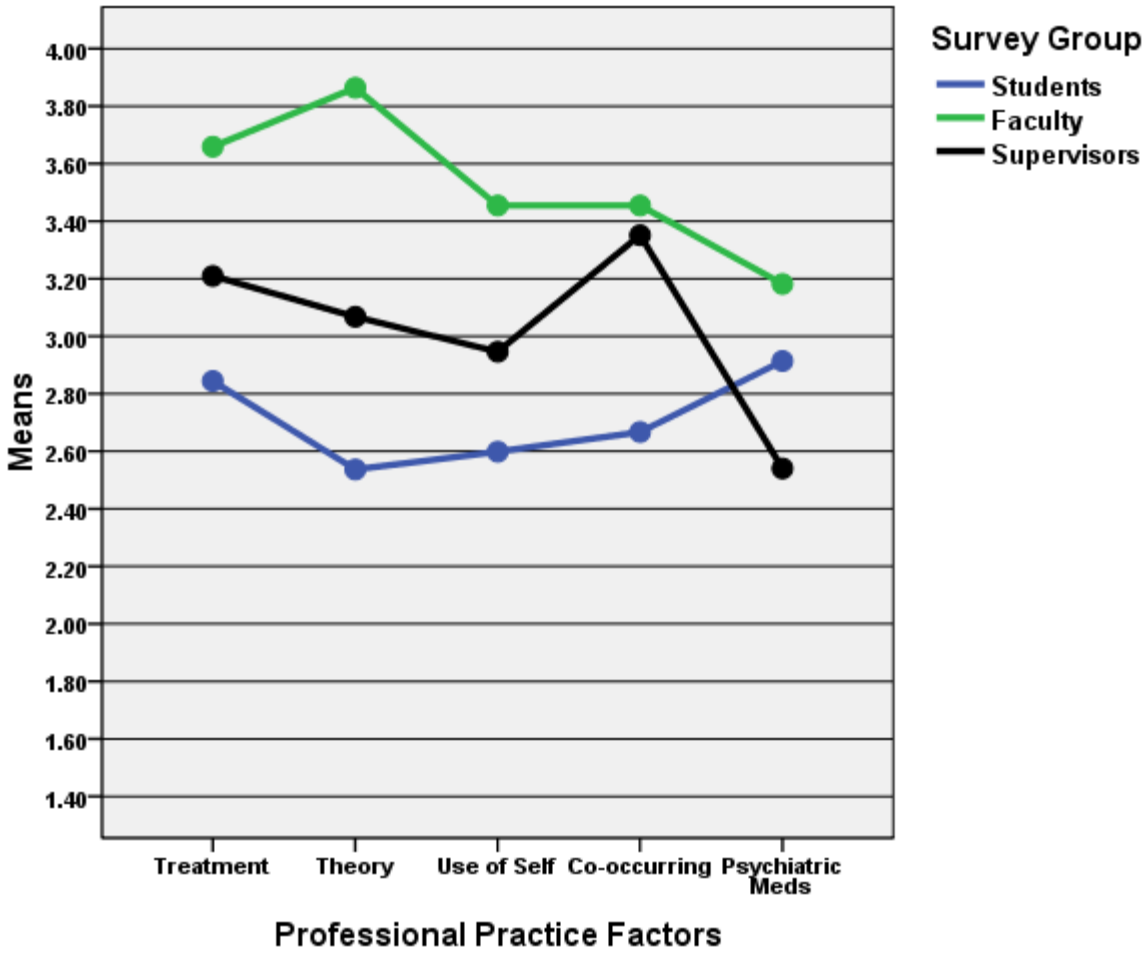
- Between subjects Group factor
  - $F(2,215) = .54$, $p = .583$, $eta^2 = .01$

Student, Supervisor, & Faculty Ratings of Provision or Presence of Knowledge, Skills, & Abilities

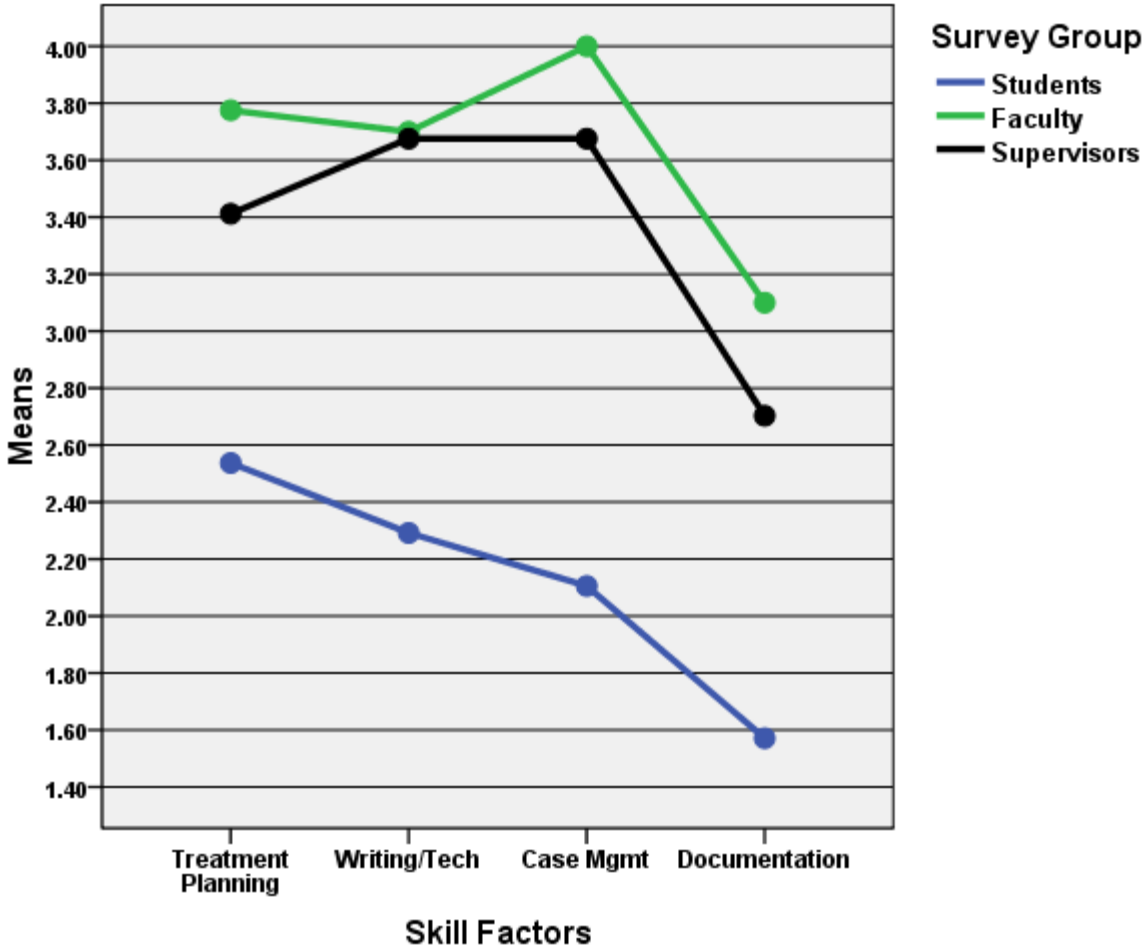
Provision of Knowledge by Group



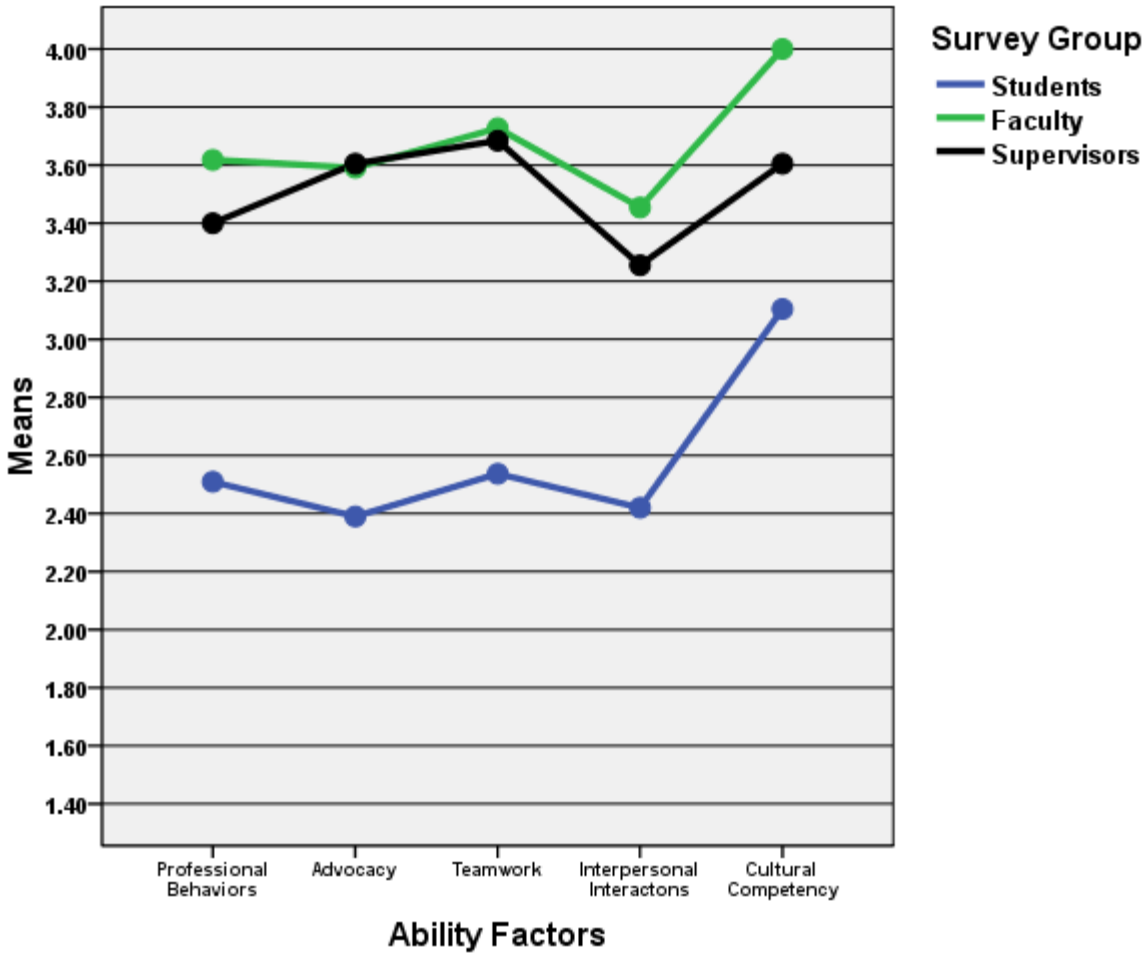
Provision of Professional Practice Knowledge by Group



Provision of Skills by Group



Provision of Abilities by Group



APPENDIX C

California Social Work Education Center (CalSWEC)
Mental Health Curriculum Content Analysis Project: Final Report

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CalSWEC Mental Health Coordinator/Lecturer
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Sarah Marie Pierce, Veronica Forbes, & Amanda Ng
Graduate Student Researchers

Funded by the Zellerbach Family Foundation via Loma Linda University

December 10, 2010

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List of Figures and Tables

Abstract

This exploratory content analysis study of 116 syllabi from 20 California schools of social work focused on incorporation of the California Social Work Education Center Curriculum Competencies for Public Mental Health in California (CalSWEC MH Competencies), key themes of the Mental Health Services Act (MHSA), and Knowledge, Skill, and Ability (KSA) areas previously identified through mental health employer and alumni focus groups. Findings suggest that California Social Work programs provide excellent coverage of topics such as cultural sensitivity in mental health settings and evidence-based practices, good coverage in areas such as trauma, consumer empowerment, and recovery, and emerging coverage in areas such as family member empowerment and co-occurring conditions.

Background and Purpose

The Mental Health Initiative of the California Social Work Education Center supports the mental health curriculum at schools of social work across the state through various activities, including statewide quarterly meetings for faculty and mental health administrators, development of competencies expected of Master's-level social work students, practice-based research, and various in-person and online training opportunities for social work faculty. The Mental Health Initiative also advances the values and goals of the Mental Health Services Act (MHSA), passed in California in 2004. MHSA seeks to transform the public mental health system in California by emphasizing new and innovative services, cultural competence, inclusion of consumer and family member perspectives at all levels of the system, and use of evidence-based practices. This study explored how schools of social work in California have incorporated California Social Work Education Center Curriculum Competencies for Public Mental Health in California (CalSWEC MH Competencies), key themes of the MHSA and Knowledge, Skill, and Ability (KSA) areas previously identified through mental health employer and alumni focus groups MHSA into their curriculum.

Methods

In September, 2010, mental health project coordinators at 20 schools of social work in California were invited to send syllabi that reflect the mental health competencies and/or values of MHSA (see Appendix A). All schools responded (100% response rate) and sent in a total of 116 syllabi. Three trained Master's-level Research Assistants and the Principal Investigator completed all analyses. The research team's training included one or more individual meetings with the Principal Investigator, completion and review of a "test" syllabus, and periodic random review of work completed.

A survey for evaluation of the CalSWEC MH Competencies and key themes of the MHSA was developed. Data was entered into a Surveymonkey (www.surveymonkey.com; see Appendix B) survey created for the study. To assess the KSA areas previously identified through mental health employer and alumni focus groups, the Principal Investigator used DiscoverText, an online qualitative analysis software package (http://discovertext.com) to complete keyword searches of the KSAs. To supplement the survey and keyword searches, word cloud software (though DiscoverText and Wordle – www.wordle.net) was used to identify and visualize the most frequently-appearing words in the syllabi and in the research team's open-ended responses.

Following an oral presentation of the preliminary findings (see Appendix C), the additional analyses based on participant feedback were completed. These included using searching for the terms "co-morbid" and "co-morbidity" in the syllabi and conducting a separate analysis of the mental health practice syllabi for integration of key themes of the MHSA. The findings presented below provide this additional data.

Findings

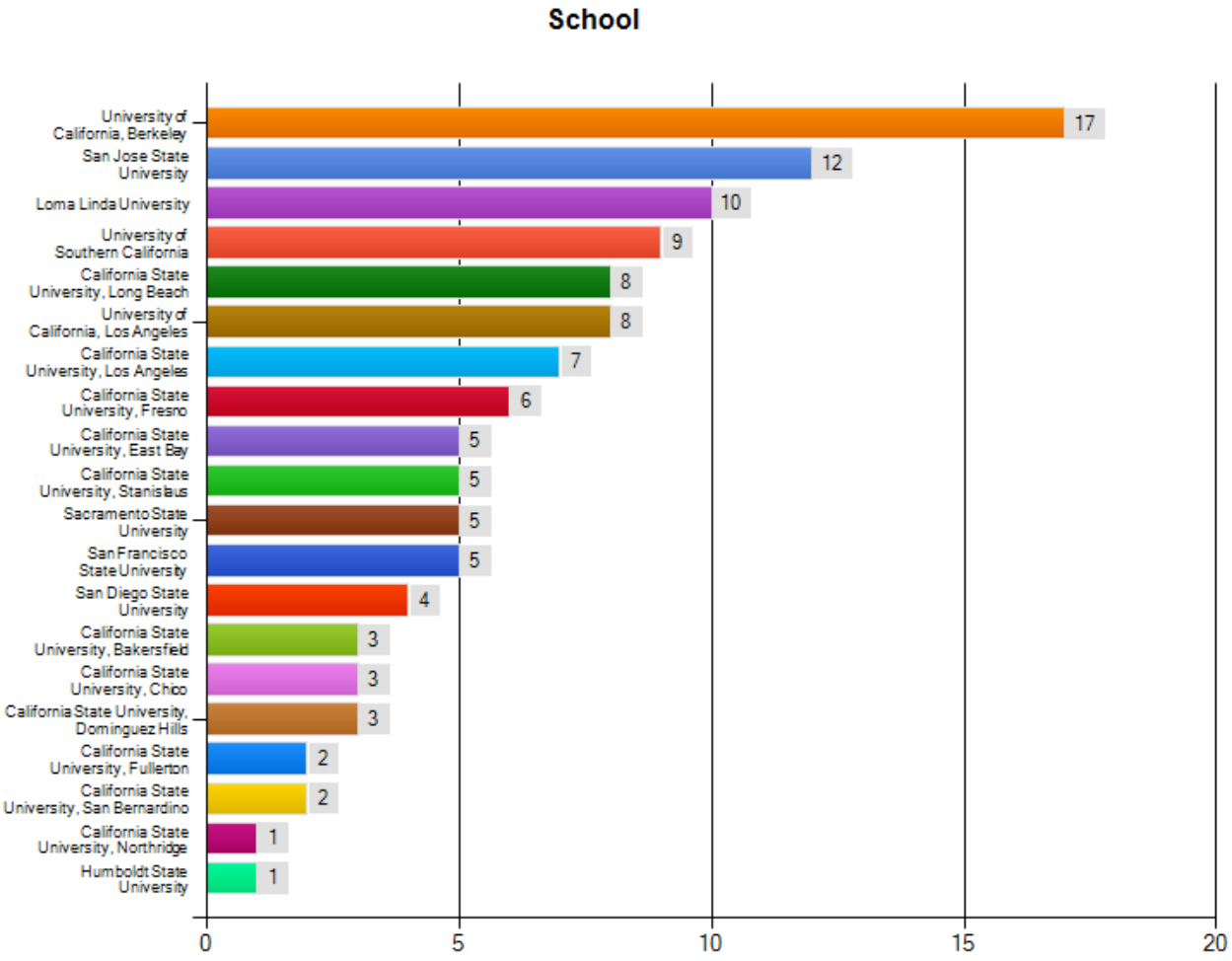
Findings are divided into six sections: 1) sample characteristics; 2) integration of KSA areas; 3) incorporation of key themes of the MHSA; 4) inclusion of CalSWEC MH Competencies; 5) assignments; and 6) innovation.

Sample Characteristics

All schools responded (100% response rate) to the request for syllabi and a total of 125 syllabi were received. Of the 125, some were for sections of the same course at the same school; in these instances, the research team randomly selected one section's syllabus to include in analysis. Another syllabus was not provided in a format that was compatible with any of our

software. Thus, 116 syllabi were included in the final analysis. Schools interpreted the call for syllabi differently (see appendix A), so the range of number of syllabi sent was significant, with some schools sending one syllabus, and others sending many more (see Figure 1). The length of syllabi ranged from 4-37 pages, thus there was also great variation in the level of detail provided for analysis.

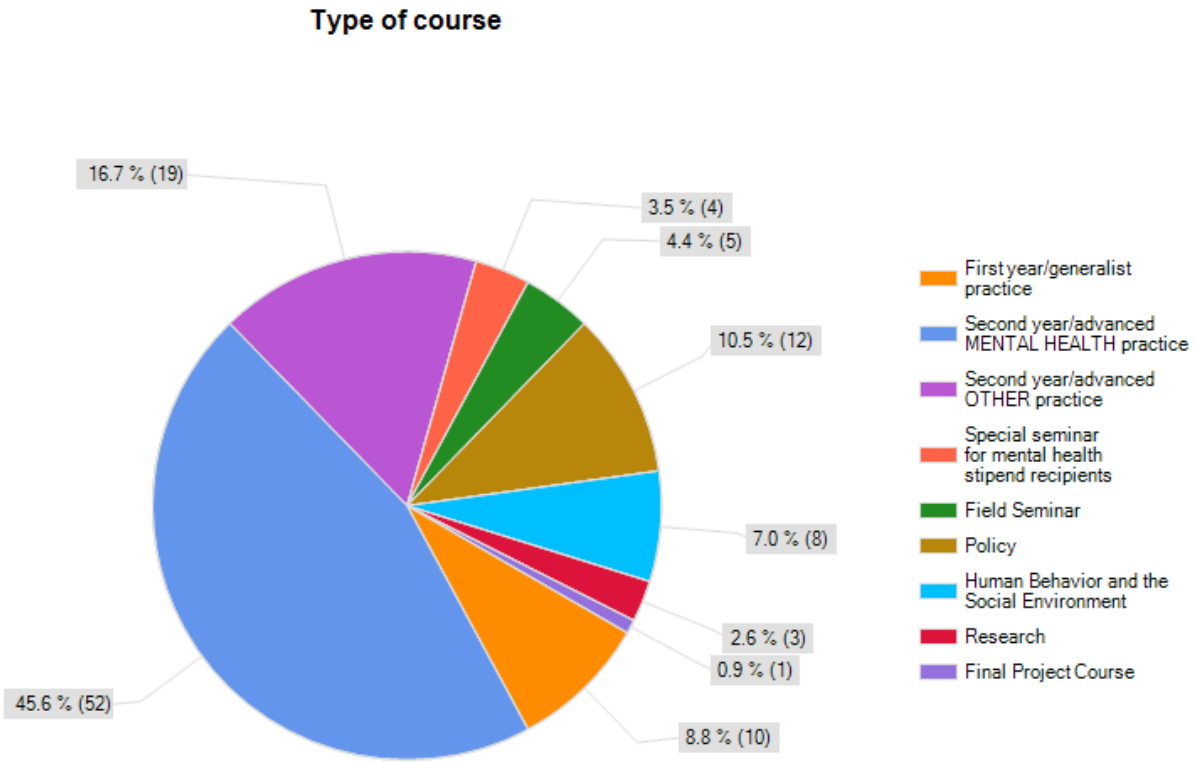
Figure 1: Number of Syllabi Received from Each School



Due to the differences in how schools interpreted the request, a wide variety of types of syllabi were also received, though many (45.6%) were for second year or advanced-level mental

health practice courses, followed by other second-year or advanced practice courses (16.7%). Figure 2 provides more detail about the types of syllabi received.

Figure 32*: Types of Syllabi Received*



Integration of Knowledge, Skill, and Ability Areas

Due to the limited time available for the analysis, keyword searches were selected as the primary research method for evaluation of KSA content. Keyword searches are useful for identifying the presence or absence of specific topics within syllabi. However, keyword searches must be interpreted cautiously. In some cases, a syllabus may appear to cover a topic, but if the keyword appears only in the title of a journal article in the bibliography at the end of the

syllabus, that is not necessarily an indication of adequate coverage. In other cases, the topic may be covered, but referred to using different terms that those searched, and therefore does not appear in the results.

For this keyword search, all syllabi were uploaded into DiscoverText (http://discovertext.com), a web-based qualitative software package. An "archive" of syllabi was created and each KSA area was searched separately. Each of the tables below lists the KSA topic area as provided to the research team, the keywords used to search the term, and the number of syllabi that used the term. Quotes around the keywords indicate that the words were searched as a phrase. If "no useful results" are reported, that was because almost all syllabi used the keyword, but not in a way that indicated that the topic is covered in the course. For example, almost all syllabi note that there are "writing requirements" for papers (typically 12 pt. font, one-inch margins, APA style, etc.), but this gives no indication as to whether the course supports improvement in student writing. Similarly, many syllabi use the term "confidentiality", but it is typically in the context of reminding students to maintain their clients' confidentiality in class and in papers by using pseudonyms. As some of the KSA areas overlap with the key themes of the MHSA that were searched more thoroughly through full review of each syllabus, the team obtained a more accurate understanding of how well these areas are covered. These areas of overlap include recovery, diversity, and co-occurring conditions.

Table 1: Integration of Knowledge Areas

Based on feedback during the oral presentation, additional searches were done for terms relating to co-occurring disorders/dual diagnosis. The results of these additional searches are as follows:

- Co-morbidity: 14
- Co-morbid: 9
- Co-morbidity OR co-morbid OR "dual diagnosis" OR co-occurring: 43

Table 2: Integration of Skill Areas

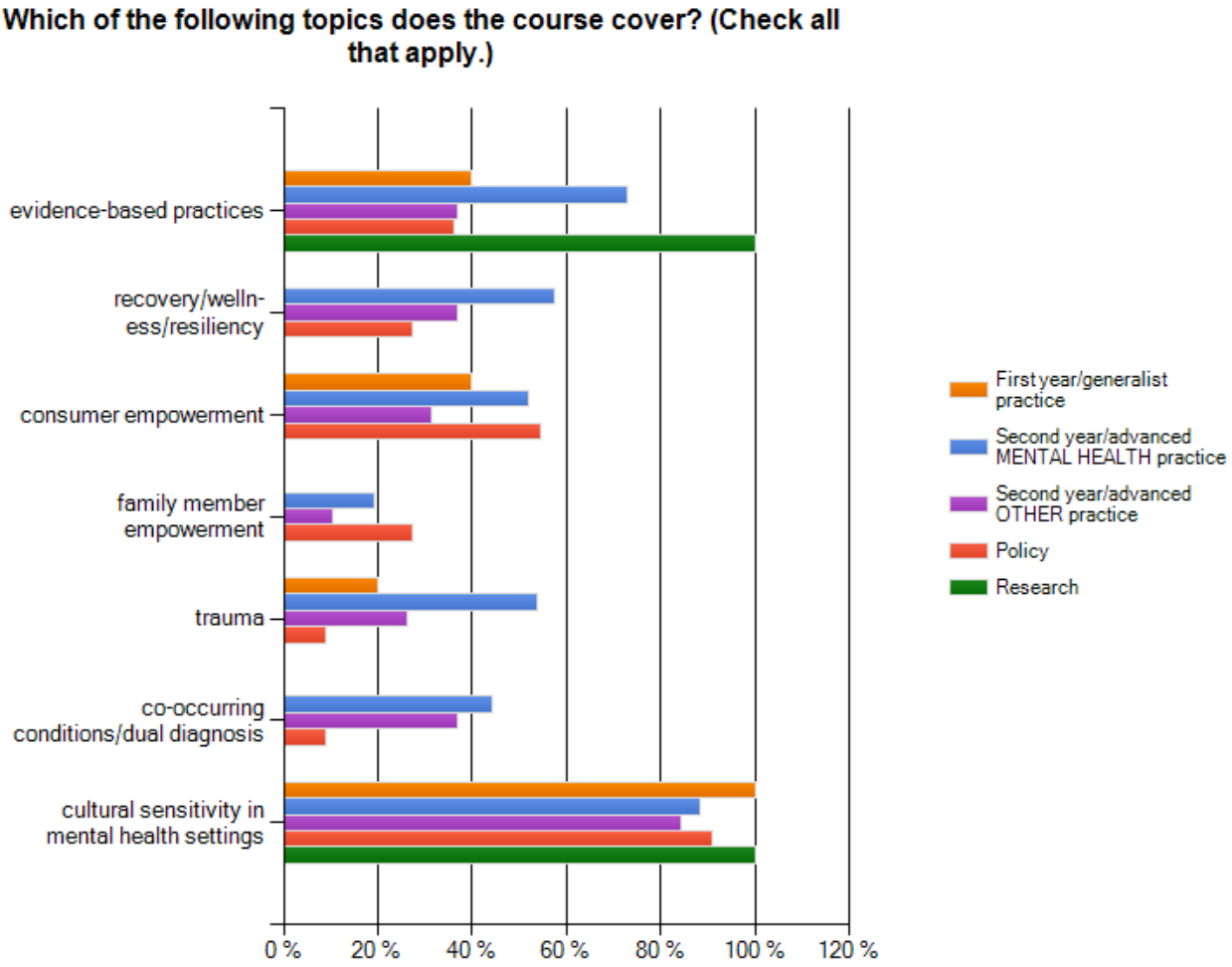
Table 3: Integration of Ability Areas

Incorporation of Key Themes of the Mental Health Services Act

To evaluate how well syllabi covered key themes of the MHSA, including evidence-based practices, recovery, consumer empowerment, family member empowerment, trauma, co-occurring conditions, and cultural sensitivity in mental health settings, the research team reviewed each syllabus individually for content related to these areas. The research team was instructed not to mark a syllabus as covering an area if the area was *only* noted in a reading in the

bibliography. If the area was clearly covered within the core text (e.g. a text focused specifically on psychosocial rehabilitation) or a reading for a class session, that was considered acceptable. Figure 3 shows how well five different types of courses incorporate key themes of the MHSA.

Figure 2: Incorporation of MHSA Key Themes in Five Types of Courses



Inclusion of CalSWEC Curriculum Competencies for Public Mental Health in California

Nineteen percent of syllabi explicitly listed the competencies the course covered on the syllabus itself, or, in the case of one school, on a separate matrix provided to the research team. Of those that listed the competencies explicitly on the syllabus itself, most (57%) included a

special section for the competencies. Figure 4 shows how syllabi that listed the competencies did so. The areas covered are shown in Figure 5.

Figure 3: Where Syllabi Explicitly List Competencies Covered in the Course

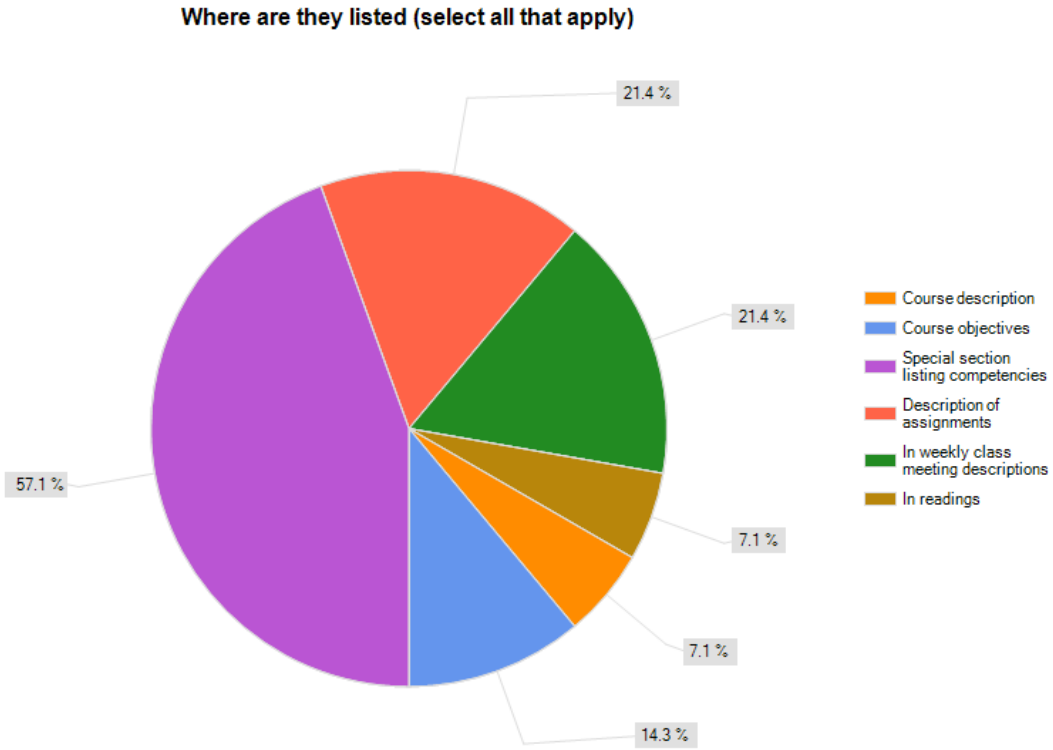
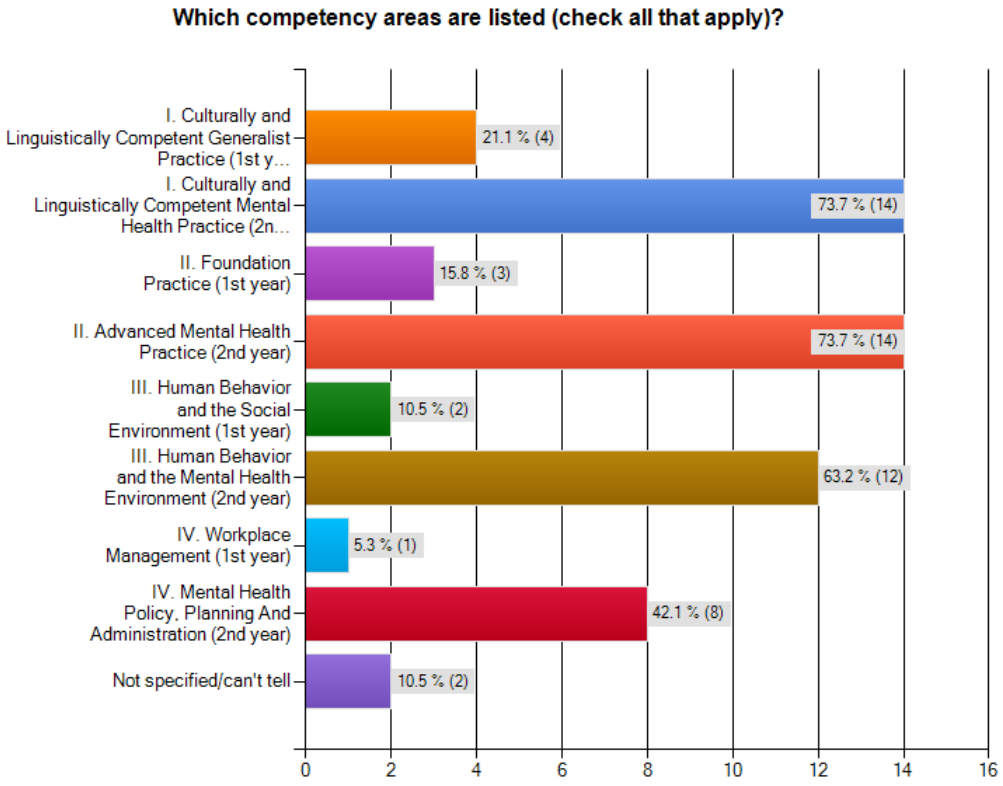


Figure 4: Areas Covered by Syllabi Explicitly Listing Competencies



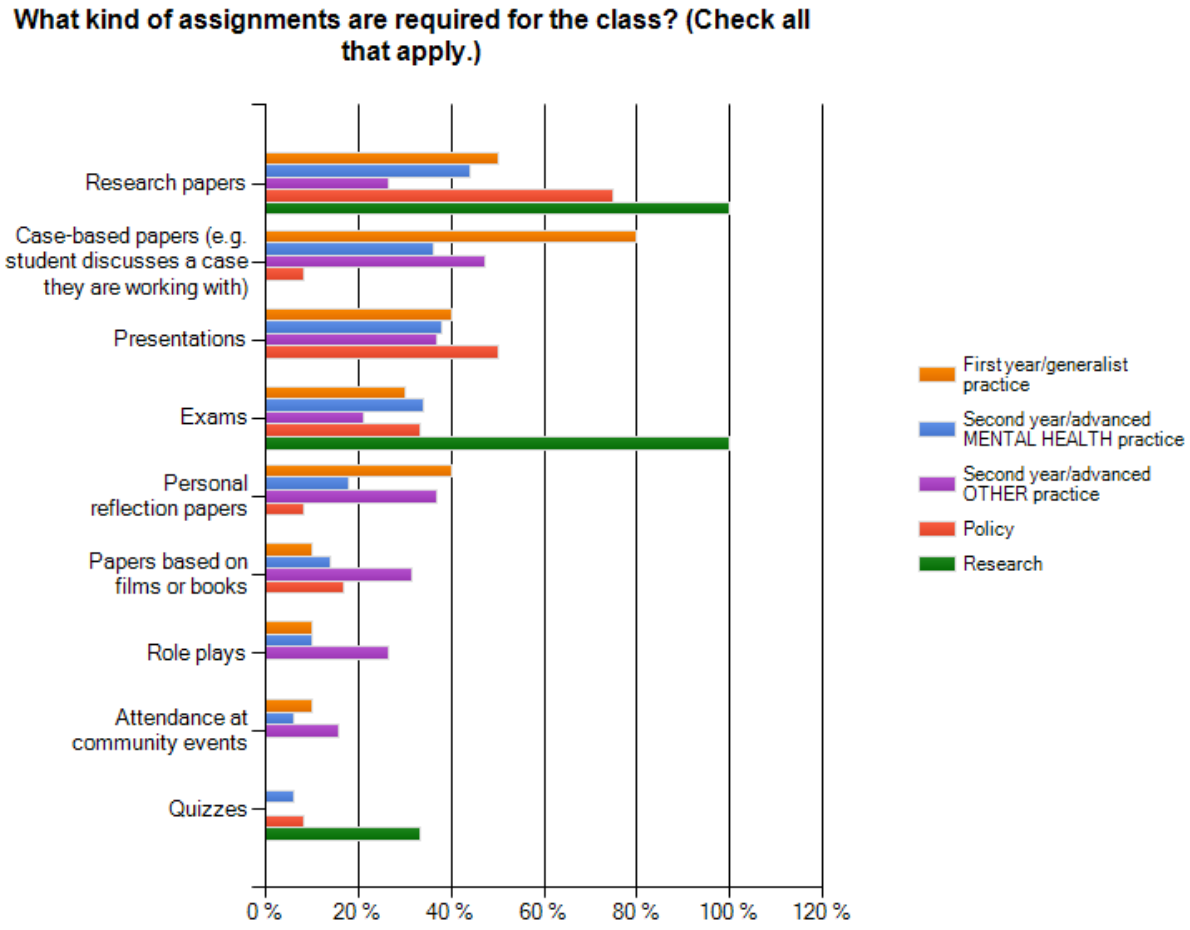
The research team was asked whether syllabi that did not explicitly list the competencies covered at least some competencies, and then asked to provide three examples of how the course covered one or more competencies. The research team indicated that 100% of syllabi covered at least some of the competencies. Due to limited time, the team was unable to complete in-depth analyses of these open-ended responses (the examples of how the competencies were covered). However, the word cloud below was created using Wordle (www.wordle.net) to show the topics noted by the research team as being covered. The size of the text indicates frequency of topic/word appearance, with the largest words being the most frequently appearing.

Figure 5: Open-Ended Responses Regarding Coverage of MH Competencies

Assignments

The team was asked to review the types of assignments required for each course, and to describe how the assignments helped students learn the MH Competencies and/or the key themes of the MHSA. The types of assignments required for five types of courses are presented in Figure 7.

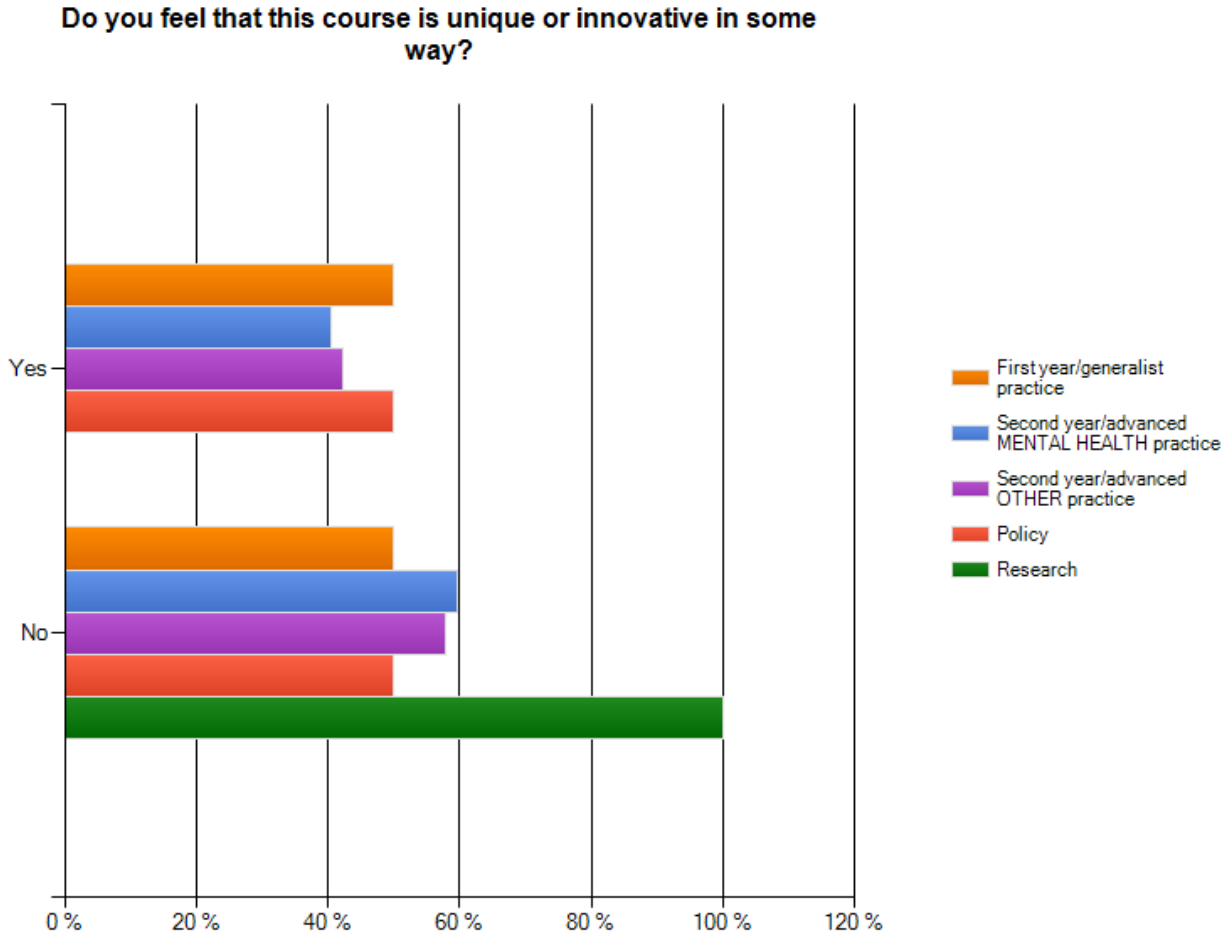
Figure 6: Assignments Required for Five Types of Courses



Innovation

The researchers were asked to use their judgment in determining whether a syllabus was "innovative". Overall, they rated 48% of syllabi as innovative. The team's ratings (innovative: yes or no) are shown in Figure 8 for five types of courses.

Figure 7: Researcher Ratings of Syllabi as Innovative



Following the rating of a syllabus as innovative, the researcher was asked to describe what was innovative about the course. The team most frequently identified assignments as innovative. Some of the assignments described were:

- Agency visits
- A “menu” of assignment choices
- Attendance at a client self-help meeting
- Advocacy-related assignments

- Attendance at a community meeting (e.g. an MHSA planning meeting)
- Experiential learning assignments
- WRAP plans
- Self-assessment assignments
- Mock licensing exam
- Creation and sharing of an artistic work (visual art, creative writing, etc.) to demonstrate growth and learning over the course of the semester

Other aspects of courses identified as innovative included:

- Guest speakers
- Comprehensiveness of material covered
- Group field trips
- Recovery focus
- Online learning opportunities
- Cultural diversity expressed through readings, topics, and guest speakers

One syllabus (see Appendix D) was noted for having multiple innovative components. The researcher, Amanda Ng, described it as innovative because it includes:

1) Attending mental health clinics for observation
2) Developing a Wellness Recovery Action Plan
3) Developing a strength-based and culturally sensitive model for consumers
4) Guest speakers on topics such as trauma and cultural humility
5) The parallel layout of course objectives, program objectives, and assignments under the Course Objectives section
6) Hybrid course with two online meetings
7) Discussion posts and News article discussions related to topics of mental health stigma, cultural sensitivity, etc.

When the Principal Investigator contacted the faculty member who created the syllabus, Donna Jensen, for permission to use it as an example, Ms. Jensen commented on the unique process through which the syllabus was developed. She wrote:

> It was a great process in that
> 1. The development/offering was paid for by the Superior Region Collaborative
> 2. In developing it I took it to the Collaborative meetings for feedback which included feedback from MH directors, WET coordinators, MHSA coordinators, consumers, family members, WWT and CIMH.
> 3. My MH Advisory Board at CSUC reviewed it.
> (D. Jensen, personal communication, December 8, 2010)

This suggests that a potential area for future investigation is the process of developing syllabi that meet CalSWEC MH Competencies, incorporate MHSA key themes, and teach to the KSA areas identified by alumni and employers.

Discussion

Before discussing the major findings of the study and possible implications, it is important to review the strengths and limitations of this project. Strengths of the project include the use of syllabi as the contract with the students about what a class will cover, the inclusion of MSW student research assistants who are consumers of social work education, and the multiple, overlapping foci of investigation (MHSA key themes, CalSWEC MH Competencies, and KSA areas).

As with any study of syllabi, the data available is limited to what appears in the syllabus, and syllabi may not be entirely representative of what happens in the classroom. Faculty may change or add topics based on student feedback, new developments in the field, or other emerging factors; these changes may not be incorporated into the syllabus during the course of a semester, or even after a year or more, if syllabus changes must be approved by curriculum committees. Though it is important for faculty to have the flexibility to adapt to changing

curricular needs, it is also necessary to document our work so that we can more readily assess ourselves. Therefore one implication of this study is to work towards creating syllabi that truly reflect course content.

The study was also limited in the time and resources available for completing it. Syllabi were received as late as the first week of October, leaving less than two months for recruitment and training of the research team, data entry, and analysis. Finally, some of the topics reviewed for this study, particularly the KSA areas, are likely to be covered in first-year courses, and relatively few first-year practice syllabi (n=10) were sent due to the variation in how schools interpreted the request for syllabi.

Despite these limitations, some interesting and important findings emerged. Using an arbitrary cut-off whereby approximately 80% of syllabi appear to include a particular area, CalSWEC Schools are covering the following areas well:

- Assessment
- Intervention
- Professional use of self
- Ethics
- Cultural sensitivity in mental health settings
- Evidence-based practices (when focusing specifically on research and second-year/advanced mental health courses)

Some key areas which fell below 80% coverage across all course types, including second-year/advanced mental health courses, based on thorough review of syllabi by course type, include:

- Recovery

- Trauma
- Co-occurring disorders/dual diagnosis
- Family member empowerment
- Consumer empowerment

Some areas that also fell below 80% coverage when using the (less accurate) keyword search strategy across all course types include:

- Agency/organizational issues
- DSM-IV
- Advocacy
- Managing resistance/motivational interviewing
- Psychopharmacology
- Collaboration
- Integrating theory into practice
- Empathy & listening skills
- Conflict resolution
- Peer support/self-help
- Use of software and other technology
- Documentation
- Relationship-building
- Self-care
- Supervision
- Treatment planning
- Continuing professional education and development

These findings suggest that…

Areas for future research include…

Appendix A: Request for Syllabi

September 6, 2010

Dear Colleagues,

A primary goal of the CalSWEC Mental Health Initiative is to provide curriculum resources to assist schools in infusing social work courses with content related to the CalSWEC Mental Health Competencies and the core values of the Mental Health Services Act. Supplemental support from the Zellerbach Family Foundation Curriculum Implementation Grant will allow us to evaluate how well we have accomplished this, what additional resources are needed and will help to inform the MH Competency renewal process. We are requesting your participation in a study of social work course syllabi from the schools in California.

We are looking for syllabi that reflect the CalSWEC Mental Health Competencies and/or the core values of the Mental Health Services Act. Both of these documents are attached to this email for your review. Topics of particular interest to us include:

evidence-based practices;
recovery/wellness/resiliency;
consumer empowerment;
trauma;
co-occurring conditions; and
cultural sensitivity in mental health settings

We recognize that each program is different, and that these topics may be covered in a variety of courses, including mental health specialization courses, mental health seminars, field practicum, generalist practice, HBSE, policy, or elective courses. We are particularly interested in seeing "before and after" syllabi, so if you have a course that has been significantly revised during the past three years, specifically to include the CalSWEC competencies or the core values of the Mental Health Services Act, we would appreciate seeing the old and new versions. We are also aware of CSWE's recent call for mental health course syllabi and appreciate your response to this additional request.

Please send your course syllabi by email, hard copy or cd to

Sarah Taylor, PhD
sarah.taylor@csueastbay.edu

Department of Social Work
25800 Carlos Bee Blvd.

Hayward, CA 94542

To facilitate timely review of syllabi, please send your materials by September 24

We understand how busy you are at the start of the school year and appreciate your attention to this request. The syllabi review results will be shared with Mental Health Stipend Program Coordinators to assist them in further developing curriculum at their respective schools.

We anticipate that the findings of this project will inform continuing social work mental health curriculum development, contribute to the Continuous Quality Improvement project already underway, and provide critical information for future revisions of the MH Competencies. In addition, we will post the course syllabi on the CalSWEC Mental Health website, replacing the existing postings which are out of date.

If you have questions about the project, please contact Sarah Taylor using the above email address, or by phone at 510-885-2155;

Sincerely,

Sarah Taylor, Ph.D.
CalSWEC-II Mental Health Coordinator/Lecturer
California State University, East Bay

Jan Black, LCSW
Consultant
CalSWEC Mental Health Initiative

Attachments:
CalSWEC Mental Health Competencies – Foundation Year
CalSWEC Mental Health Competencies – Advanced/Specialization Year
Mental Health Services Act/Regional Partnerships Overview

Appendix B: Survey Used for Data Entry

Curriculum Content Analysis

1. Syllabus Overview

1. Researcher/Reviewer name

2. School

- ◯ California State University, Bakersfield
- ◯ California State University, Chico
- ◯ California State University, Dominguez Hills
- ◯ California State University, East Bay
- ◯ California State University, Fresno
- ◯ California State University, Fullerton
- ◯ California State University, Long Beach
- ◯ California State University, Los Angeles
- ◯ California State University, Northridge
- ◯ California State University, San Bernardino
- ◯ California State University, Stanislaus
- ◯ Humboldt State University
- ◯ Loma Linda University
- ◯ Sacramento State University
- ◯ San Diego State University
- ◯ San Francisco State University
- ◯ San Jose State University
- ◯ University of California, Berkeley
- ◯ University of California, Los Angeles
- ◯ University of Southern California

Other (please specify)

3. Course number and title

Curriculum Content Analysis

4. Type of course

- ◯ First year/generalist practice
- ◯ Second year/advanced MENTAL HEALTH practice
- ◯ Second year/advanced OTHER practice
- ◯ Special seminar for mental health stipend recipients
- ◯ Field Seminar
- ◯ Policy
- ◯ Human Behavior and the Social Environment
- ◯ Research
- ◯ Final Project Course

Other (please specify)

Curriculum Content Analysis

2. Syllabus overview continued

1. Length of syllabus in pages

2. Name of professor listed on syllabus. (Put none if there is no name.)

3. Units of course

4. Grading scale

- ◯ Credit/no credit
- ◯ Graded

Other (please specify)

Curriculum Content Analysis

3. CalSWEC Competencies

1. Are the CalSWEC Competencies covered by the course explicitly listed on the syllabus?

- ◯ Yes
- ◯ No

Curriculum Content Analysis

4.

1. Where are they listed (select all that apply)

- [ ] Course description
- [ ] Course objectives
- [ ] Special section listing competencies
- [ ] Description of assignments
- [ ] In weekly class meeting descriptions
- [ ] In readings

Other (please specify)

2. Which competency areas are listed (check all that apply)?

- [ ] I. Culturally and Linguistically Competent Generalist Practice (1st year)
- [ ] I. Culturally and Linguistically Competent Mental Health Practice (2nd year)
- [ ] II. Foundation Practice (1st year)
- [ ] II. Advanced Mental Health Practice (2nd year)
- [ ] III. Human Behavior and the Social Environment (1st year)
- [ ] III. Human Behavior and the Mental Health Environment (2nd year)
- [ ] IV. Workplace Management (1st year)
- [ ] IV. Mental Health Policy, Planning And Administration (2nd year)
- [ ] Not specified/can't tell

3. Does the syllabus reflect the competencies, even if it does NOT explicitly list them? (Review competencies before answering this question.)

- ◯ Yes
- ◯ No

Curriculum Content Analysis

5.

1. If yes, please provide up to three examples of how the syllabus covers the competencies.

Curriculum Content Analysis

6. Topics and Values

1. Which of the following topics does the course cover? (Check all that apply.)

- [ ] evidence-based practices
- [ ] recovery/wellness/resiliency
- [ ] consumer empowerment
- [ ] family member empowerment
- [ ] trauma
- [ ] co-occurring conditions/dual diagnosis
- [ ] cultural sensitivity in mental health settings

2. Where are these topics noted? (Check all that apply.)

- [ ] Course description
- [ ] Course objectives
- [ ] Description of assignments
- [ ] In weekly class meeting descriptions
- [ ] In readings

Other (please specify)

Curriculum Content Analysis

7. Assignments

1. What kind of assignments are required for the class? (Check all that apply.)

- [ ] Presentations
- [ ] Research papers
- [ ] Personal reflection papers
- [ ] Interview papers (e.g. student interviews someone else and reports on it)
- [ ] Case-based papers (e.g. student discusses a case they are working with)
- [ ] Exams
- [ ] Quizzes
- [ ] Portfolio
- [ ] Advocacy Project
- [ ] Process Recording
- [ ] Role plays
- [ ] Attendance at community events
- [ ] Papers based on films or books

Other (please specify)

Curriculum Content Analysis

2. NO detail is provided about the assignments - can't answer specific questions about them (eg. syllabus vaguely refers to a paper or presentation, but does not describe content of assignment). If you pick "yes", you will skip the next two questions. Please only do so if there is really NO detail.

- ◯ Yes (skip next two questions)
- ◯ No (answer next two questions)

Curriculum Content Analysis

8.

1. How do the assignments reflect the CalSWEC Mental Health Competencies? (Review competencies before answering this question!)

2. How do the assignments reflect the following topics:

- evidence-based practices

- recovery/wellness/resiliency

- consumer empowerment

- trauma

- co-occurring conditions/dual diagnosis

- cultural sensitivity in mental health settings

Curriculum Content Analysis

9. Innovation

1. Do you feel that this course is unique or innovative in some way?

- ◯ Yes
- ◯ No

Curriculum Content Analysis

10.

1. How is it unique or innovative? You can comment on the organization, readings, assignments, guest speakers, etc.

2. How difficult was it to review this syllabus?

- ◯ 1 Easy and straightforward
- ◯ 2 Not easy, but I was able to figure it out
- ◯ 3 Challenging - request second reviewer

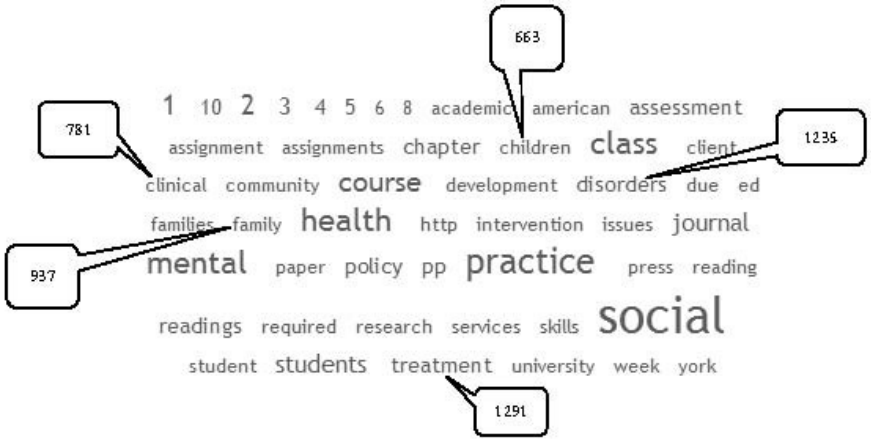
Other (please specify)

Appendix C: Presentation Delivered at Loma Linda University on 12/1/2010

CalSWEC Mental Health Curriculum Analysis Project: Preliminary Findings

December 1, 2010, Loma Linda University

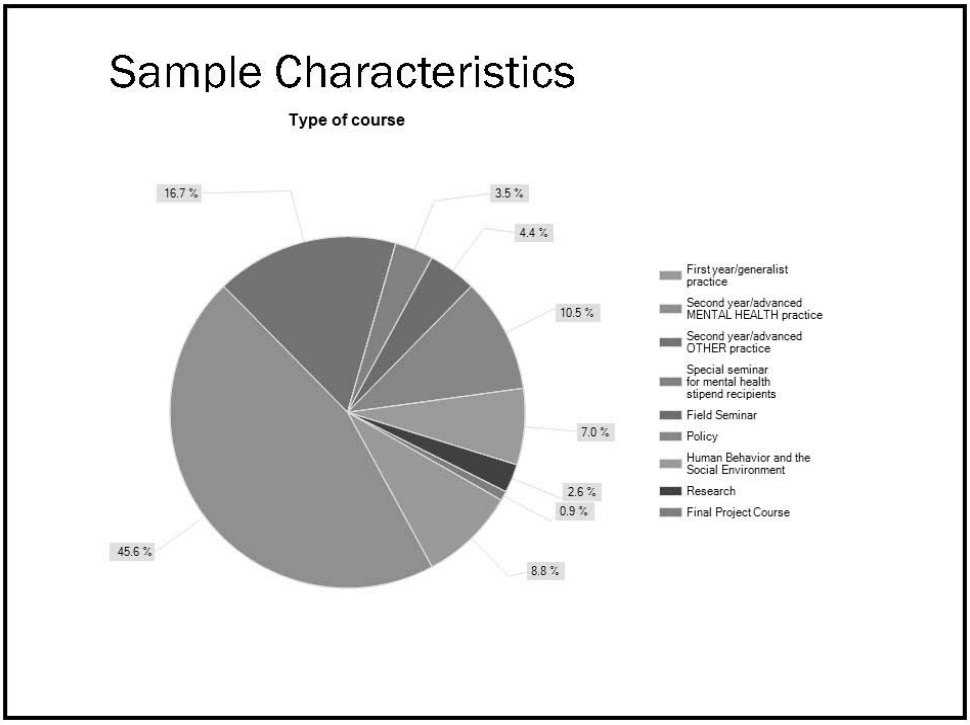
Sarah Taylor, PhD, Sarah Marie Pierce, Veronica Forbes, & Amanda Ng, Cal State East Bay



Project funded by the Zellerbach Foundation via Loma Linda University.
Thanks to Jan Black and Bev Buckles for supporting this project.

Project Overview

- Purpose
  - Review of how CalSWEC schools are integrating KSAs, key themes of the MHSA, and the CalSWEC MH Competencies
- Methods
  - Letter requesting syllabi sent late September 2010
  - 100% response rate (20 schools; ~115 syllabi)
  - Research team: 3 MSW students + Sarah
  - Surveymonkey for data collection (www.surveymonkey.com)
  - Discovertext for title page word cloud and counts (www.discovertext.com)
  - Competency word cloud in Wordle (www.wordle.net)
- Study strengths and limitations
  - Syllabi are a contract between students and faculty
  - Study team included MSW students, the consumers of MSW education
  - Syllabi are an incomplete portrait of what happens in the classroom
  - Schools interpreted call for syllabi differently

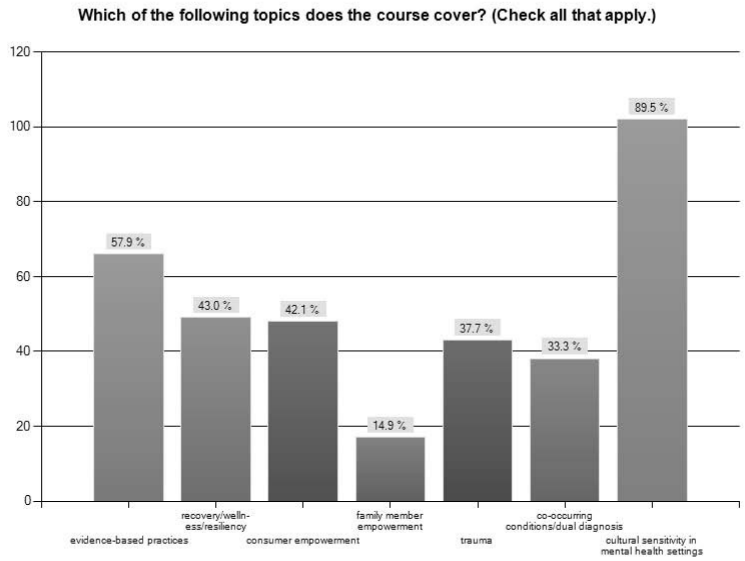


Integration of Knowledge, Skill, and Ability (KSA) Areas: Knowledge

Integration of Knowledge, Skill, and Ability (KSA) Areas: Skills

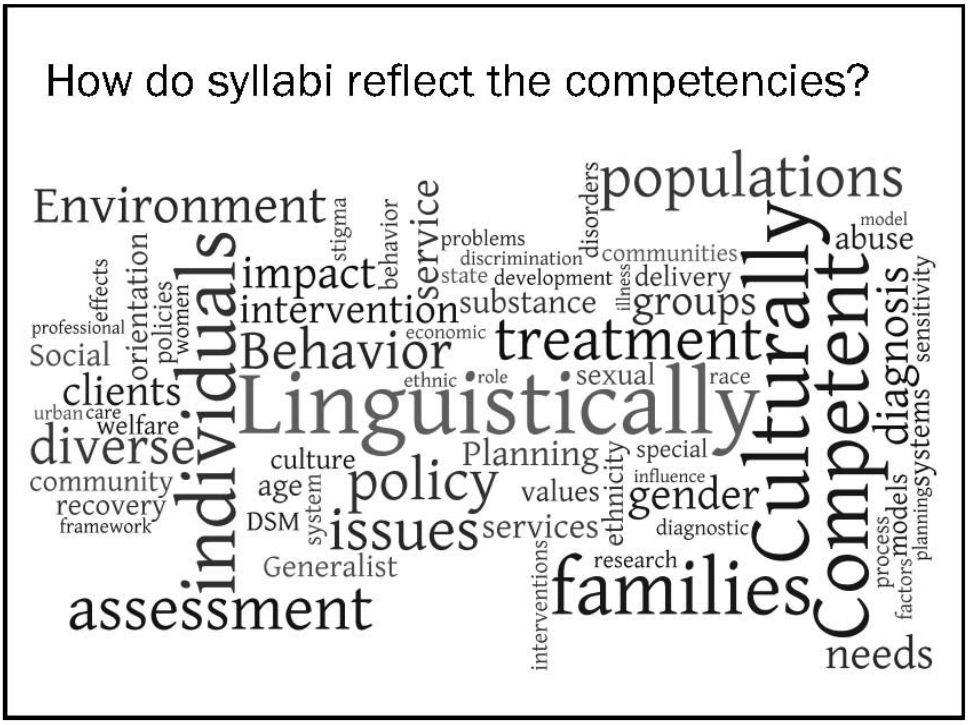
Integration of Knowledge, Skill, and Ability (KSA) Areas: Abilities

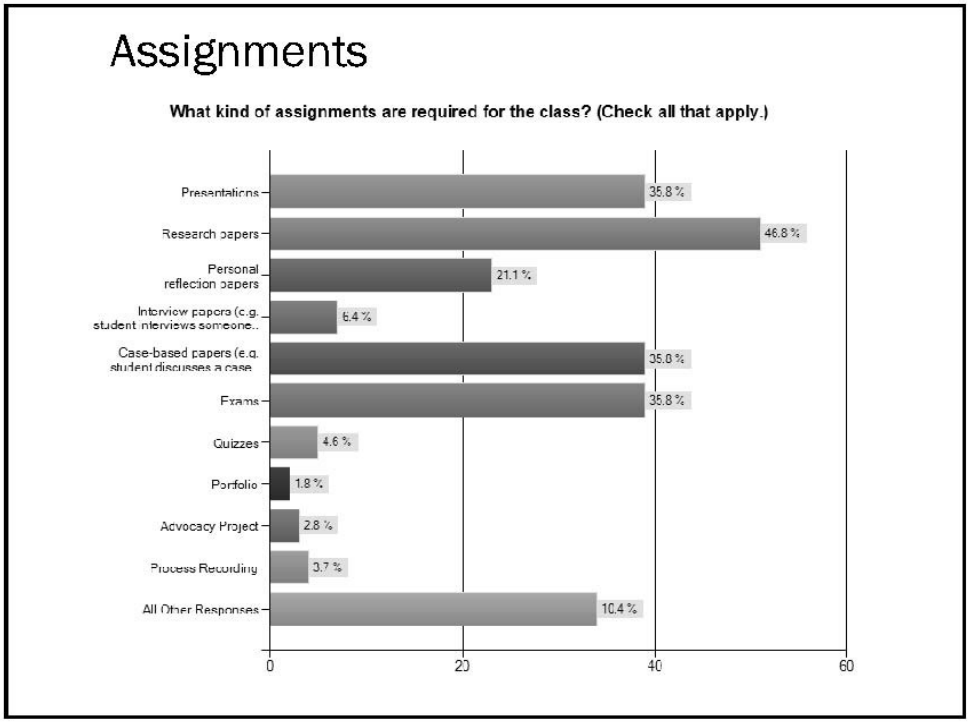
Integration of MHSA Key Themes



Integration of CalSWEC MH Curriculum Competencies

- About 19% of syllabi explicitly listed the CalSWEC Mental Health Competencies that the course met.
- Of those that listed the competencies specifically, the majority were in the areas of culturally and linguistically competent mental health practice and foundation or advanced practice.
- Though most syllabi did not explicitly list competencies, the research team indicated that <u>all</u> syllabi covered at least some of the competencies.


How do syllabi reflect the competencies?
Environment
populations
individuals
impact
intervention
Behavior
treatment
Linguistically
Culturally
Competent
clients
diverse
assessment
families
needs
policy
issues
Planning
gender
Generalist
Social
professional
orientation
policies
women
effects
stigma
behavior
service
problems
discrimination
state
development
disorders
communities
delivery
illness
groups
substance
economic
ethnic
role
sexual
race
abuse
model
diagnosis
sensitivity
systems
urban
care
welfare
culture
age
community
recovery
framework
DSM
system
special
influence
values
ethnicity
services
diagnostic
research
interventions
process
factors
models
planning


Assignments
What kind of assignments are required for the class? (Check all that apply.)
Presentations
35.8 %
Research papers
46.8 %
Personal reflection papers
21.1 %
Interview papers (e.g. student interviews someone...
6.4 %
Case-based papers (e.g. student discusses a case
35.0 %
Exams
35.8 %
Quizzes
4.6 %
Portfolio
1.8 %
Advocacy Project
2.8 %
Process Recording
3.7 %
All Other Responses
10.4 %
0
20
40
60

Innovation

- Research team selected 48% of syllabi as innovative.
- Most of what the team identified as innovative were the assignments. Some of the assignments described were:
  - Agency visits
  - A "menu" of assignment choices
  - Attending a self-help meeting
  - Advocacy-related assignments
  - Community meetings
  - Experiential learning assignments
  - WRAP plans
  - Self-assessment assignments
- Other aspects of courses identified as innovative included:
  - Guest speakers
  - Comprehensiveness of material covered
  - Group field trips
  - Recovery focus

Conclusion: Strengths

- Based on the preliminary findings of this survey, CalSWEC schools are doing an excellent job in the areas of:
  - Assessment
  - Intervention
  - Professional use of self
  - Ethics
  - Cultural sensitivity in mental health settings

Conclusion: Areas in Progress

- Some areas where about half of courses seem to have good coverage and about half may need additional focus include:
  - Recovery
  - Trauma
  - Evidence-based practice
  - Consumer empowerment
  - Agency/organizational issues
  - DSM-IV
  - Advocacy
  - Managing resistance/motivational interviewing
  - Psychopharmacology
  - Collaboration
  - Integrating theory into practice

Conclusion: Areas for Consideration

- Some areas that may require additional focus include:
  - Co-occurring disorders/dual diagnosis
  - Family member empowerment
  - Empathy & listening skills
  - Conflict resolution
  - Peer support/self-help
  - Use of software and other technology
  - Documentation
  - Relationship-building
  - Self-care
  - Supervision
  - Treatment planning
  - Continuing professional education and development

Contact Info

Sarah Taylor, PhD
CalSWEC-II Mental Health Project Coordinator/Lecturer
California State University, East Bay
25800 Carlos Bee Blvd.
Hayward, CA 94542
(510) 885-2155
Sarah.taylor@csueastbay.edu

Appendix D: Example Syllabus

California State University, Chico
School of Social Work
Master of Social Work Program

SWRK 698-01: WELLNESS AND RECOVERY
SPRING 2010

Instructors: Donna Jensen MSW, LCSW
Time: Online with two meetings 2/25 and during course final time TBA.
Classroom: Online
Office Location: Butte 543C
Telephone: (530) 898-6668
E-Mail: djensen@csuchico.edu
Office Hours: Monday 3:00-4:00 online

I. COURSE DESCRIPTION

SWRK 698: Recovery and Wellness 3.0 Units
***Prerequisites**: Completion of the Foundation year or instructor permission.*
This course examines the concepts and practices of wellness and recovery for individuals, families, and society. The course addresses mental health, wellness and recovery movements and system transformation concepts. Underlying values and components of recovery and recovery based programs will be addressed.

II. Purpose of the Course

This course is intended to provide students with relevant information regarding wellness and recovery in the field of mental health. Concepts, roles and applications useful for practice related to the field of mental health will be covered. California's mental health service system is undergoing a system transformation; these changes will be explored and evaluated. Many service delivery agencies are struggling with the paradox of traditional mental health services and funding mechanisms and California's Mental Health Services Act philosophy and funding mechanisms. The purpose of this course is to meet the need in our region for social work practitioners who are knowledgeable and have essential skills in the area of recovery and wellness.

III. MAJOR COURSE CONTENT OUTLINE

A. Exploration of recovery and wellness concepts.
B. Wellness Recovery Action Plans
C. Consumer movements in mental health
D. Evidenced based practices in mental health recovery approaches
E. Creating welcoming spaces
F. Strengths, talent and gifts
G. Partnering in recovery, working as part of a recovery team, multi-disciplinary approaches.

H. Laws guiding practice, exploration of voluntary and involuntary treatment, wellness and civil rights.
I. Cultural Humility in providing wellness services. Addressing the needs of un-served and under-served individuals
J. Recovery Oriented Leadership and creating recovery oriented systems
K. Involving families in recovery
L. Stigma and discrimination

IV. MSW PROGRAM OBJECTIVES

The School of Social Work program objectives are measured in the section V table.
(Note: not all courses will address all the program objectives)

1. Prepare advanced social work practitioners who have the knowledge, skills and values to intervene with individuals, families, groups, organizations and communities, and who are committed to maintaining their professional growth through lifelong learning and continuing education;

2. Prepare advanced social work practitioners who have the knowledge, understanding and respect for people from diverse backgrounds and who can provide culturally competent social work practice at multiple system levels, and promote culturally sensitive services for diverse client systems;

3. Prepare advanced social work practitioners who can identify vulnerable populations and those factors that place them at risk, and implement strategies at multiple system levels that work to promote social and economic justice through alleviation of discrimination, oppression, and economic deprivation;

4. Prepare advanced social work practitioners who are knowledgeable about selected theories of all systems levels, and apply those theories specifically relevant for practice at multiple system levels;

5. Educate advanced social work practitioners who are knowledgeable about and can analyze social policies and services relevant to practice, and provide leadership in policy practice to influence, formulate and advocate for policies consistent with social work values;

6. Provide knowledge to graduates that enable them to provide advanced practice with multiple systems at the advanced level in the fields of mental health, and families, youth and children;

7. Prepare graduates who will engage in quantitative and qualitative research for effective practice and program evaluation to improve one' own practice, as well as services and policies;

8. Prepare advanced social workers who will provide leadership for and act as catalysts in promoting collaborative endeavors in social service agencies in the community;

9. Prepare advanced social work practitioners who can work effectively in a broad range of social services and functions in rural and urban environments.

V. COURSE OBJECTIVES

Upon successful completion of this course, the student will be able to:

Course Objectives	Program Objectives	Assignments
1. Demonstrate an understanding of recovery and wellness in the provision of mental health services.	3	1,2,3,4,5
2. Compare and critically evaluate major models and theories of mental health treatment.	4	1,2,4
3. Discuss psychiatric medications and the role of psychopharmology in person-centered recovery.	1	3,4
4. Demonstrate an understanding of assessment, treatment planning and person-centered care.	1	3, 4
5. Identify and describe the effects of mental illness on families and communities, with special attention to characteristics such as what creates healing and wellness.	3	1, 2, 3, 4, 5
6. Differentiate between treatment procedures of children, youth, adults and older adults.	6	1, 2, 4
7. Demonstrate the family's role in healing and mental health recovery, including the function of consumer and family advocacy groups.	4	1, 2, 3, 4, 5
8. To demonstrate awareness and practice implications of culturally sensitive practice in the field of mental health.	2, 5	1, 2, 3, 4, 5
9. Explore practice approaches with individuals dually diagnosed with mental health and substance abuse issues.	3, 9	3, 4
10. Understand the knowledge, skills, and values necessary for recovery oriented treatment.	2	1, 2, 3, 4, 5
11. Research and evaluate the California Mental Health Services Act.	5	2,

12. Understand the principles and role of community collaborations in mental health recovery.	8	2, 3, 4
13. Demonstrate an understanding of the implications of evidenced-based interventions and outcomes research in mental health practice.	7	3, 4, 6
14. Evaluate their own practice within the mental health treatment network and the relevant systems associated with it.	9	1, 2, 3, 4

VI. Integration with other Courses

As in other social work second year courses, the Wellness and Recovery elective is linked with the knowledge and skills gained throughout the educational career of the student. This course builds on human development knowledge gained in SWRK 601 Human Behavior in the Social Environment. It links with SWRK 602 Social Work in Multicultural Contexts, as cultural sensitivity is critical to accurate and empathic assessment and treatment of persons with substance abuse or addiction problems. It relates to SWRK 608 Generalist Social Work Theory and Practice I and SWRK 609 Practice II (Groups) as they provide a basis for social work practice with individuals and families with substance abuse problems. It builds on SWRK 610 Macro Practice as it provides the basis for community assessment and practice relevant for addressing mental health treatment and recovery. From knowledge gained in the foundation policy course students examine selected policies relevant to mental health. Students will apply the knowledge, skills and values gained in this class to their practicum experiences.

VII. COURSE LEARNING ENVIRONMENT

A. Students with Disabilities or Physical Limitations

It is the responsibility of students with a disability or physical limitation to initiate requests for services and accommodations at Disability Support Services, University Center, (530) 898-5959 v/t, (530) 898-4411 fax, e-mail dss@csuchico.edu. Students with a disability are encouraged, but not obligated, to register with DSS. After reviewing the student's records, the DSS adviser will determine eligibility and consult with the instructor to facilitate access.

If you need assistance in evacuating the building during a fire or other emergency please inform the instructor immediately so that arrangements can be made for your safety.

B. Attendance

Students are expected to **attend all class meetings and to arrive on time**. This is a professional program and student involvement in all classes is essential to gain knowledge and skills for competent practice. Absences from more than two classes or chronic lateness, whether "excused" or "unexcused," may result in a lowered course grade or, in extreme instances, in failing the course. Instructors may provide additional written guidelines for attendance. Students who must miss class should call or email the instructor before class begins.

Any student majoring in social work who is absent from scheduled class sessions 10% or more of the time for any reason will meet with the instructor and be referred to the MSW or BSW Director for consultation and discussion.

15 weeks of class:

MWF	= 45 classes	10%	=	4.5 classes
TTh	= 30 classes	10%	=	3.0 classes
3 hr class	= 15 classes	10%	=	1.5 classes
3yr wkend	= 8 hr days/6days	10%	=	4.8 hours

Absences Policy for Online Courses

If a student does not log on to WebCT Vista during the first two weeks of the semester, s/he will be automatically dropped from the course. Students are expected to log on to the WebCT Vista Course Modules in session and participate in weekly assignments, including discussion postings, quizzes, papers, and activities.

Absence from course participation in WebCT Vista, whether "excused" or "unexcused," may result in a lowered course grade. If a student misses one week, there will be no grade reduction. For each week over one week, s/he will receive a half grade reduction from the overall course grade.

Any student majoring in social work who is absent from scheduled class modules 10% or more of the time for any reason will meet with the instructor and be referred to the MSW or BSW Director for consultation and discussion.

C. Academic Honor and Honesty

It is expected that all students will conduct themselves with honor and honesty regarding their academic work during the course. All academic dishonesty, including cheating, plagiarism, and misrepresentation is prohibited. Please read the university policy regarding academic misconduct located in the University catalog and MSW Student Handbook. It includes taking information, providing information, plagiarism, misrepresentation, and other forms of academic dishonesty. Deliberate failure to properly cite another's work is cheating.

D. Writing Standards

All papers are to be double spaced with one-inch margins and 12-point font. After you spell check your papers, be sure to proofread again to ensure that the words you used were the ones that you desired. Watch for homonyms such as *there*, *their*, and *they're*. American Psychological Association (Fifth Edition) documentation is required. You are required to use the writing guidelines as described by CSUC and professional writing standards. The use of nonsexist language is expected in class discussions and written assignments.

E. Evaluation

Students' work will be graded on criteria for each assignment, exam, level of participation, etc. as described for the course as a whole. They are encouraged to meet with the instructor regarding any request to change a particular assignment or requirement to better meet her or his particular goals or learning needs.

Students are encouraged to meet with their instructors to provide feedback regarding relevance of course content, reading assignments, texts, evaluation methods and other learning experiences. This is the best way for students to provide feedback to the instructor for ongoing evaluation and course/curriculum improvement. Students also have the opportunity to provide feedback through the university's formal Student Evaluation of Teaching (SET) process.

F. Grades

Grades are determined by each student's point totals applied to the following percentages:

A = 94 - 100	B+ = 87 – 89	C+ = 77 - 79	F = ≤ 69
A- = 90 - 93	B = 84 – 86	C = 74 – 76	
	B- = 80 – 83	C- = 70 - 73	

G. Incomplete Grades

An "incomplete" in a graduate-level course is designated as RP (report in progress), and is given only in rare circumstances when a student has serious and compelling reasons for not being able to complete all assignments for a given course. **Prior** to the end of the semester, the student must initiate a request to the instructor, indicating reasons why the work could not be completed, and present a plan for completing the missing work prior to the beginning of the following semester. The instructor will grant or deny the request. If approved, the instructor must draft a final written plan for completing the work, acquire the student's signature on the incomplete form, and along with the instructor's signature, submit the plan to the School office for the student's file.

H. Cell Phones/Pagers

The classroom is a professional environment; please respect this environment by turning cell phones and pagers off or alternatively, setting them to the 'vibrate' mode. If you are expecting to be contacted during class, notify the instructor before the class begins and take a seat near the door where you will be able to leave the room quickly and quietly so as to not to disrupt the learning experience of your colleagues.

I. Confidentiality

Learning products or discussions associated with the class will be treated as privileged; as such, they will not be shared beyond the classroom with three exceptions: 1) those discussions that indicate the likely endangerment or the compromising of the well-being of enrollees or specific persons identified as being targeted for such activity; 2) those discussions related to consultation with faculty regarding classroom conduct and student learning; and 3) those learning products that are referenced by the School of Social Work as one aspect of the instructor's retention, tenure and promotion (RTP) process and the general education review process. Student learning products included in review processes will be modified in such a way as to safeguard the identity of the student(s) and the identity of his/her/their object of study.

J. NASW Legislative Advocacy Days

Students are encouraged to attend NASW-CA Legislative Advocacy Days, which will be held Saturday, Sunday and Monday, April 11 and 12, in Sacramento. A large contingent of CSUC School of Social Work students is anticipated. This is an excellent opportunity to observe your

profession in action, and to learn about the legislative process. The CSUC School of Social Work highly encourages all BSW and MSW students to attend this conference. Since the conference will continue through Monday *April 12,* students will need to confer with his/her instructor of each class if s/he plans to attend. If a student is in field during this time, s/he will need to confer with the field instructor regarding field hours and attending the conference. Students who desire to attend the conference should not assume that either field agencies or instructors will permit the student to attend without prior discussion and consent from the agency or classroom instructor. Some School classes may be cancelled to allow faculty to attend. If a class is cancelled *students who do not attend Lobby Days* will be required to complete an assignment relevant to the class time that would be spent at NASW Legislative Lobby Days.

VIII. COURSE REQUIREMENTS AND ASSIGNMENTS

A. Required Texts

California Association of Social Rehabilitation Agencies, (2007). *Developing Systems and Services that Support People in Wellness and Recovery: A Primer for Holding Informed Discussion.* Sacramento: California Institute for Mental Health. (can be ordered through: http://www.casra.org/education/bookstore.html).

Lopez, Steve (2008). *The Soloist* New York: Putnam Adult.

Rath, T. (2007). *StrengthsFinder* New York: Gallup Press.
DO NOT PURCHASE USED COPY OF STRENGTHSFINDER, YOU WILL NEED THE ASSESSMENT ACCESS CODE WHICH IS ONLY AVAILABLE IN A NEW BOOK.

Required readings will be available through WebCT Vista and posted in corresponding modules.

B. Assessment of Student Learning and Grades

Grades are determined by each student's point totals applied to the following percentages:

A = 94 - 100	B+ = 87 – 89	C+ = 77 - 79	F = ≤ 69
A- = 90 - 93	B = 84 - 86	C = 74 – 76	
	B- = 80 - 83	C- = 70 - 73	

C. Course Assignments and Exams

One cumulative paper will comprise 60% of the grade in this course. This paper will consist of three smaller, but essential papers. The goal is to critically analyze the mental health system and its transformation from a medical model service delivery to a recovery oriented, consumer empowerment model. This is not to imply the medical model approach is wrong, or ineffective. It is, however, an opportunity to analyze service delivery and evaluate all the components that come with system transformation. You will be asked not only to assess these two models of service delivery, but present your ideas for a program or service that incorporates the mission and philosophy of the Mental Health Services Act (MHSA). Each paper is to be 3-5 pages in length, utilizing APA formatting.

1. Visit two mental health clinics providing community mental health services (i.e. county mental health clinic and a community based organization contracted with the county mental health department (can be providing youth or adult services – or one of each). Sit in the waiting room for 15-20 minutes and observe how it feels to you. What feeling does the atmosphere give you? Is it a warm and welcoming environment? What feels welcoming or unwelcoming to you? Is it accessible, clean and safe? Is it culturally sensitive, does it feel inclusive to individuals of varying cultures, ethnicities and abilities? (i.e. Does the clinic offer help in multiple languages? Is the art work all Eurocentric? Do the hours accommodate individuals working a Monday-Friday 9:00am-5:00pm job? Do you see staff representing varying cultures?) Write a 3-5 page paper with your observations of the two agencies you visited. Compare and contrast what you saw, if there were differences, and your hypothesis for why you believe they are different. Please don't mention the name of the clinic, you can simply describe it (i.e. "a contracted agency providing services to adults", or "a county mental health agency serving youth", etc). Incorporate relevant readings and discussions from the course in your paper.
DUE: February 28, 2010
20 Points

2. Models of Mental Health Treatment Paper: The last five decades of mental health services has been built upon a medical model of service delivery. The California MHSA has changed the philosophy of how services to individuals with mental illness are delivered. Compare and contrast the traditional medical model of service delivery with more consumer-driven recovery oriented service delivery. What approach/steps would you take to transform mental health clinics to a recovery oriented system? Utilize course material, research and any professional or personal experiences you may wish to share.
DUE: March 31, 2010
20 Points

3. Exemplary Program: Utilizing knowledge learned from this course, and your professional or personal experience, develop a "model" mental health program. If you were charged with developing a model program, what would it look like (structure & function)? What theory or theories might the service delivery utilize? Include a mission statement that conveys your beliefs, attitudes and values. Incorporate information from your Strengthsfinder assessment and include your talents and strengths as well as the types of personnel you will recruit to balance your talents. An outline will be made available to assist you with this paper.

DUE: April 30, 2010
20 Points

4. Discussion Questions – To be completed in each module. Each student must post an original response, and reply to at least one other classmates post.
Due: by 12:00 midnight, Sunday of the corresponding week, but you are encouraged to reply early in the week to allow a thoughtful discussion of the subject.
20 Points

5. News articles to be brought in for discussion purposes that relate to mental health stigma, policies, laws, new research, etc. You must send at least one of these to the professor during the semester.
DUE: Due dates for individual students will be posted in Module 1.
5 Points

6. Wellness Recovery Action Plan (WRAP) – Compete the web cast (linked in Module 2) and develop your own WRAP plan and utilize the journal feature in Vista to process your experience. See specific information in Module 2.
DUE: February 7, 2010
15 Points
The instructor may require additional graded or ungraded assignments.

IX. WEEKLY COURSE SCHEDULE (subject to change)

Week

1. Introduction – January 25-31
- a. Self Introduction
- b. Introduction to Course/Technology
- c. What is Wellness, Recovery & Healing
- d. What is Mental Health Treatment

2. Historical Context of Mental Health and Wellness – February 1-7
- a. MHSA
  - i. Philosophy – policy into practice
  - ii. Consumer Movement – community organizing, social justice
- b. Un-served/Underserved individuals (rural, cultural, ethnic, GLBTQ)
- c. WRAP – Mary Ellen Copeland

WRAP PLAN DUE 2/7 BY MIDNIGHT

3. Creating Welcoming Spaces - February 8-14
- a. Assessing and building upon gifts
- b. Evidence Based Practices in Mental Health Recovery Approaches
- c. Consumers as Colleagues

4. **Through the Life Span – February 15-21**
- a. Early Childhood
- b. Family
- c. Youth
- d. Adult
- e. Older Adults

5. **Stigma and Discrimination – February 22-26 FACE TO FACE MEETING 2/25**
- a. Stigma and discrimination
- b. Multi Disciplinary approaches – working as part of recovery team
- c. Voices Experience/processing
- d. Partnering in Recovery

PAPER #1 DUE 2/28 BY MIDNIGHT

6. **Medical Necessity & Person Centered Planning – March 1-5**
    a. Medical Necessity/Medi-Cal Billing in context of Recovery and Wellness
    b. Person-centered Planning
    c. Laura's Law/Involuntary Treatment & Wellness/Civil Rights

7. **Trauma Informed Care – March 8-12 (March 9th Mark Ragins)**
    a. Intergenerational Trauma
    b. Trauma Informed Care
    http://mentalhealth.samhsa.gov/nctic/trauma.asp
    c. ACE study

SPRING BREAK – March 15-19 – NO SCHOOL

8. **Cultural Humility & Recovery Oriented Care – March 22-26 (March 23 – Steve Lopez)**
    a. Creating recovery oriented systems (agencies, consumers, families, communities)
    b. Cultural Humility
9. **Dual Diagnosis & Harm Reduction – March 29 – April 2**
    a. Dual Diagnosis
    b. Harm Reduction

PAPER #2 DUE 3/31 BY MIDNIGHT

10. **Psychopharmacology – April 5-9**
    a. Medications in Recovery
11. **Consumer and Family Empowerment – April 12-16**
    a. NAMI/WWT/CalNet/CASRA/National Empowerment Institute
    b. Family Strengths/Involvement
    c. Families in Recovery
12. **Ethical and Responsible Practice – April 19-23**
    a. NASW/CAMFT code of ethics and how they support or challenge concepts of recovery and wellness.
    b. Spirituality in Recovery

13. **Recovery Oriented Leadership – April 26-30**
    a. Recovery Oriented Leadership
    b. Partnerships in Recovery – working with consumers as colleagues

PAPER #3 DUE 3/31 BY MIDNIGHT

15. **Collaboration and Evaluation – May 3-7**
    a. Integrated Services/Full Service Partnerships
    b. Milestones of Recovery (MORS)
16. **Current and Future Issues – May 10 – 16**

Finals Week – School of Social Work Culminating Event – Meet in person - Time/Date: TBA

Bibliography

Adams, N. & Grieder, D. M. (2005). T*reatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery.* Burlington, MA: Elsevier

American Psychiatric Association, (2000). *DSM-IV-TR: Diagnostic and statistical manual of mental disorders, text revision*, Washington, DC: American Psychiatric Press.
Anderson, B. (n.d.). *We Come Bearing Gifts*. Retrieved from http://www.communityactivators.com/downloads/WeComeBearingGifts.pdf

California Association of Social Rehabilitation Agencies, (2007). *Developing Systems and Services that Support People in Wellness and Recovery: A Primer for Holding Informed Discussion.* Sacramento: California Institute for Mental Health.

Community Activators. (2004). Recovery Oriented Leadership. Retrieved at http://www.communityactivators.com/downloads/ROLBooklet.pdf

Copeland, M. E. (1997). *Wellness Recovery Action Plan.* West Dummerston, VT: Peach Press

Davidson, L, Harding, C. & Spaniol, L. (2005). *Recovery from Severe Mental Illnesses: Research Evidence and Implications for Practice.* Boston, MA: Center for Psychiatric Rehabilitation

Lopez, S. (2009). *The Soloist: A Lost Dream, an Unlikely Friendship, and the Redemptive Power of Music.* New York, NY: G. P. Putnam's Sons

Mental Health Services Act, C*alifornia Code* of Regulations, Title 9, Division 1, Chapter 14 (2004).

New Freedom Commission on Mental Health (2003). *Achieving the Promise Transforming Mental Health Care in America. Final Report*. Rockville, MD: DHHSPub. No. SMA-03-3831. Retrieved from http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf

Oades, L, Deane, F, Crowe, T., Lambert, W. G., Davanagh D. (2005). Collaborative recovery: an integrative model for working with individuals who experience chronic and recurring mental illness. *Australasian Psychiatry*, 13(3), 279-284, doi:10.1111/j.1440-1665.2005.02202.x

Preston, J. D., O'Neal, J. H. & Talaga, M. C. (2008). *Handbook of Clinical Psychopharmacology for Therapists.* Oakland, CA: New Harbinger Publications

Ragins, M. (n.d.). Proposition 63 Begins: The Mental Health Services Act **-** Implementation

Toolbox. Retrieved from http://www.village-isa.org/Village%20Writings/Proposition%2063%20Begins%20as%20of%20Sept%2005%20with%20Part%202.pdf

Ragins, M. (n.d.). Road to Recovery. Retrieved from http://www.village-isa.org/Ragin's%20Papers/Road%20to%20Recovery.htm

Rath, T. (2007). *StrengthsFinder* New York: Gallup Press.

Selected Online Resources

Active Minds on Campus http://www.activeminds.org/
California Association of Social Rehabilitation Agencies www.casra.org
California Council of Mental Health Agencies http://www.cccmha.org/
California Department of Mental Health http://www.dmh.ca.gov/
California Institute for Mental Health www.cimh.org
California Mental Health Directors Association www.cmhda.org
Center for Mental Health Services http://www.mentalhealth.samhsa.gov/cmhs/
Club Stairways http://www.clubstairways.org/
Human Services Research Institute http://tecathsri.org/
Indian Health Services http://www.ihs.gov/
International Center for Clubhouse Development http://www.iccd.org/
Mental Health America http://www.nmha.org/
National Association for Rural Mental Health http://www.narmh.org/
National Alliance for Mental Illness http://www.nami.org/
National Empowerment Center http://www.power2u.org/
National Institute of Mental Healthhttp://www.nimh.nih.gov/
Rehabilitation Research and Training Center on Employment Policy for Persons with Disabilities http://www.ilr.cornell.edu/edi/p-eprrtc.cfm
Social Security Administration http://www.ssa.gov/
Social Security Administration Return to Work Website http://www.ssa.gov/work/
Steve Lopez, The Soloist http://www.stevelopezonline.com/
Substance Abuse & Mental Health Administrationhttp://www.samhsa.gov/
SAMHSA Mental Health http://mentalhealth.samhsa.gov/
U.S. Department of Health and Human Services: http://www.os.dhhs.gov/
Working Well Together http://www.workingwelltogether.org/dnn/

California Social Work Education Center Mental Health Program

Demonstrating Educational Effectiveness through Continuous Quality Improvement (CQI)

Continuous Quality Improvement (CQI):
Background

- ***MHSA (2005) – Early Implementation***
  - Approval received from MH Planning Council to initiate stipend program one year prior to all other professions
    - Built on CalSWEC expertise and prior development of MH curriculum competencies
  - Implementation of competencies began through joint meetings with schools and counties to review competencies and MHSA requirements, disseminate curriculum resources that supported competencies, MHSA values and practice principles
    - Process began prior to the emergence of regional partnerships
    - Supplemental support received to engage expertise in schools to develop and disseminate curriculum modules in select practice areas as requested by program faculty

CQI: A Multi-phase Process

- ***Phase I**: Curriculum Implementation Activities*
- ***Phase II:** Assessment of Graduates' Perceptions*
- ***Phase III:** Assessment of Educational Effectiveness*

The CQI Process: Phase I

Implementation of the MH Curriculum Competencies

- ***Phase I**: Curriculum Implementation Activities*
  - *Objectives:*
    - *To track activities supporting the implementation of the MH curriculum competencies by the 17 social work schools and programs*
    - *Synthesize and identify strengths and needs*
    - *Make recommendations for ways to support implementation activities*

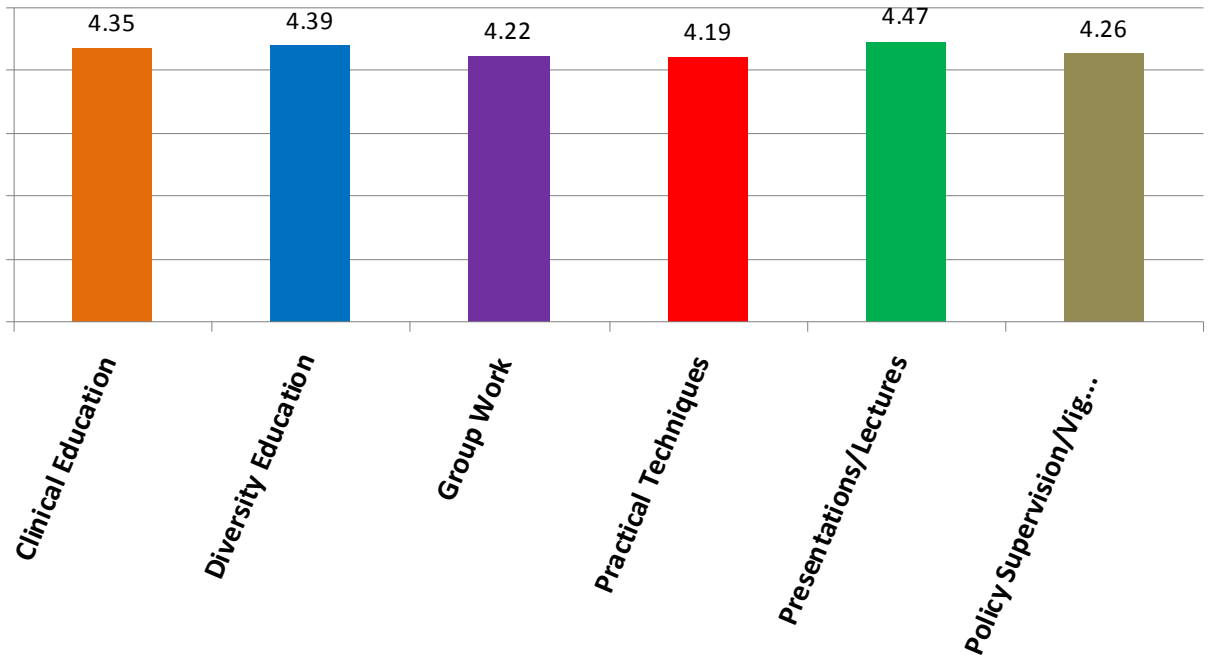
The CQI Process: Phase II
Assessment of Graduates' Perceptions

- ***Phase II:*** *Assessment of Graduates' Perceptions*
  - ***Objective:***
    - *To assess graduates perceptions of MH curriculum as preparing them for employment*
    - **Study Methods**
      - CQI Instrument--Survey on Knowledge Skills and Abilities (KSAs, i.e., key concepts from competencies and MHSA validated through focus groups (N=6) across the state (included county and contract agencies)
      - Samples—2006-2009 Graduates (N=163)
      - SurveyMonkey—used for data collection
      - Data Analysis—Factor Analysis, ANOVA
    - **Data Strengths and Limitations:**
      - Graduate data-strong sample size
      - Stable results within group
    - **Statistical Tests:**
      - Conducted with scales/measures that were directly comparable
      - Scale anchors same among groups on importance factors; clarification needed on some provision factors;

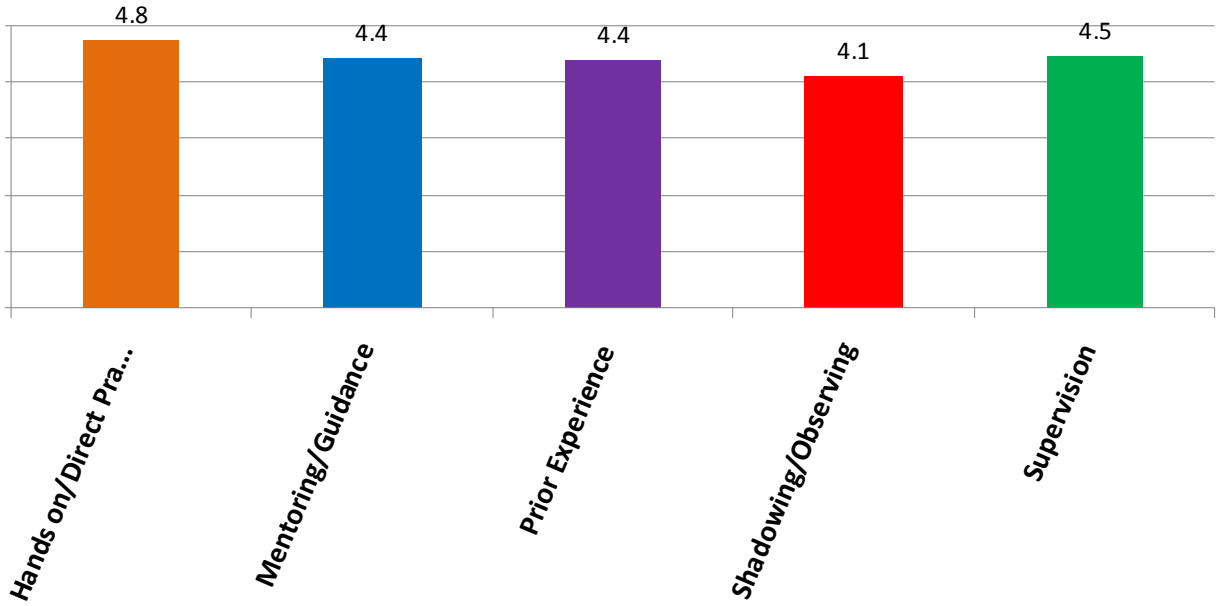
Phase II: Demographics

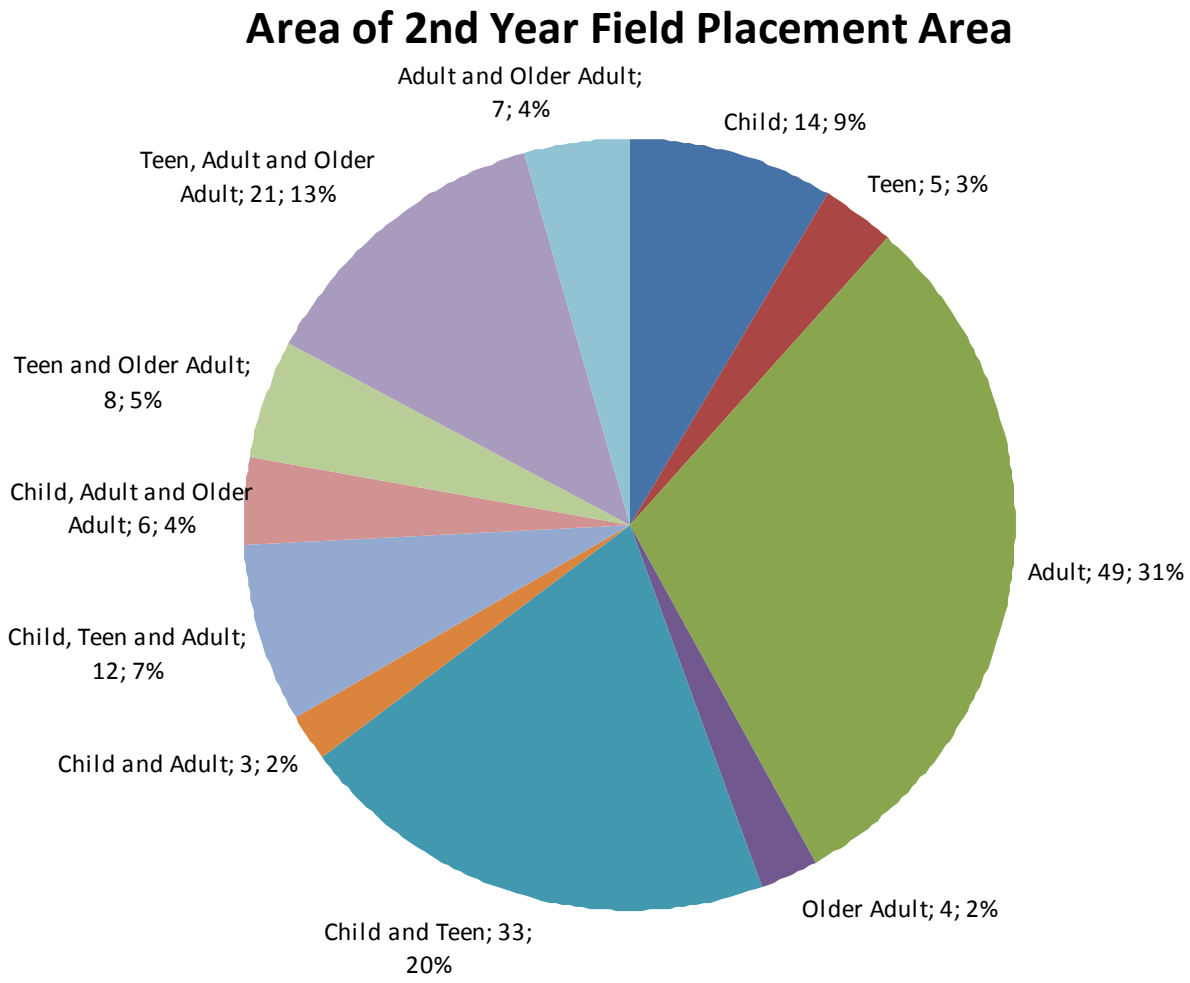
Study Demographics: Graduates (N = 163)			
Number (%) of Grads		**Number (%) of Grads**	
Graduation Cohorts		**Race**	
2006	33 (20)	African American	8 (4.9)
2007	48 (29.4)	Asian - Pacific Islander	25 (15.3)
2008	42 (26)	Hispanic/Latino	36 (22.1)
2009	40 (24.5)	Native American	1 (.6)
		White	83 (50.9)
		Other	10 (6.1)
Gender		**Age Groups**	
Male	31 (19)	18-24	1 (.6)
Female	132 (81)	25-34	110 (67.5)
		35-44	32 (19.6)
		45-64	20 (12.3)
		≥65	0 (0)
		Mean Age [years]	*34 (SD = 8.17)*

Classroom Experiences



Field Experiences




Area of 2nd Year Field Placement Area
Adult and Older Adult; 7; 4%
Child; 14; 9%
Teen; 5; 3%
Teen, Adult and Older Adult; 21; 13%
Teen and Older Adult; 8; 5%
Child, Adult and Older Adult; 6; 4%
Adult; 49; 31%
Child, Teen and Adult; 12; 7%
Child and Adult; 3; 2%
Older Adult; 4; 2%
Child and Teen; 33; 20%

Graduates: KSA--Knowledge Content Factors

Pattern Matrix[a]

	Factor		
	1	2	3
Imp_Recovery_Process	**.826**	-.175	-.076
Imp_Cooccuring_ Disorders	**.612**	.126	-.151
Imp_Affect_Lifestyle_ Mood	**.598**	-.029	.231
Imp_Psychiatric_Meds	**.490**	.321	-.208
Imp_Tx_Interventions	**.485**	.213	-.148
Imp_Trauma_Impact	**.481**	.018	.039
Imp_Major_Theories	**.404**	.327	.121
Imp_Therapeutic_Use_ Self	**.364**	.086	.274
Imp_EBPs	**.361**	.349	.069
Imp_Agency_Systems_ Resources	.273	.011	.043
Imp_DSM_IV	-.163	**.937**	-.009
Imp_Evaluation_Process	.079	**.785**	.056
Imp_Client_ Assessment_Processes	.178	**.335**	.152
Imp_Client_ Confidentiality	-.159	.039	**.887**
Imp_Ethical_Legal_ Issues_Tx	-.105	.105	**.825**
Imp_Impact_Racial_ Ethnic	.431	-.219	**.529**

Extraction Method: Principal Axis Factoring.
Rotation Method: Promax with Kaiser Normalization.

a. Rotation converged in 6 iterations.

Professional Practice

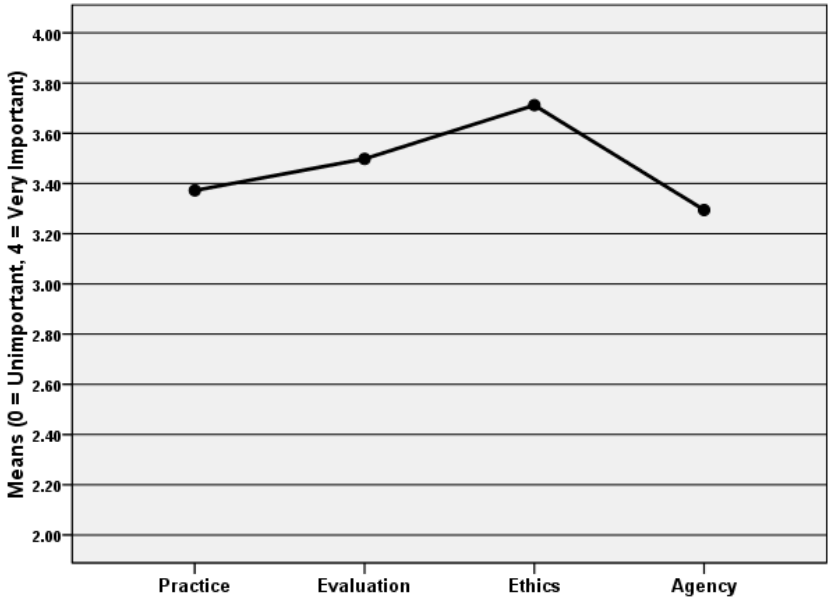
Evaluation & Assessment

Ethics & Ethnic/ Gender Issues

Agency Resources

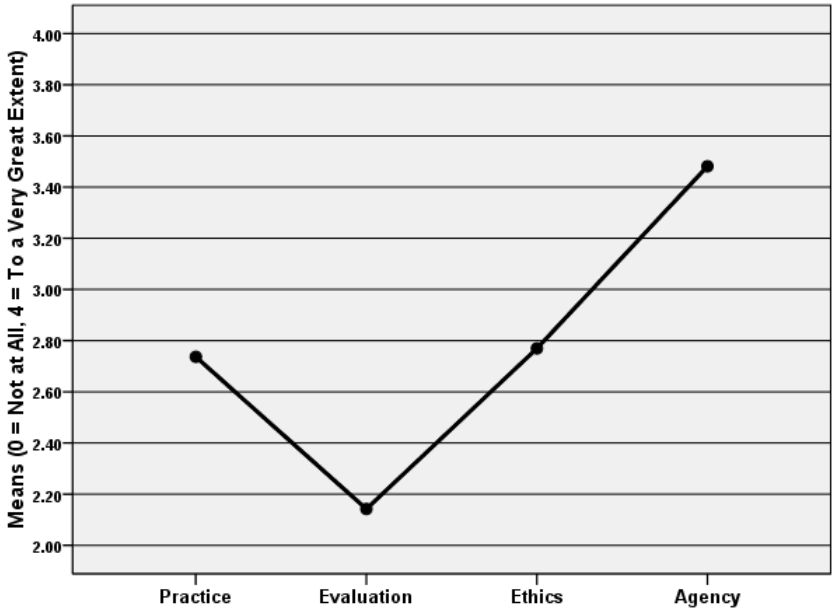
Graduates: Perception of Importance vs. Provision of KSA Knowledge Content

Importance of Knowledge



- Within subjects Importance factor
  - F (3,486) = 21.21, $p < .001$, $eta^2 = .12$
    - Ethics > Evaluation, Practice, & Agency
    - Evaluation > Practice & Agency
    - Practice > Agency

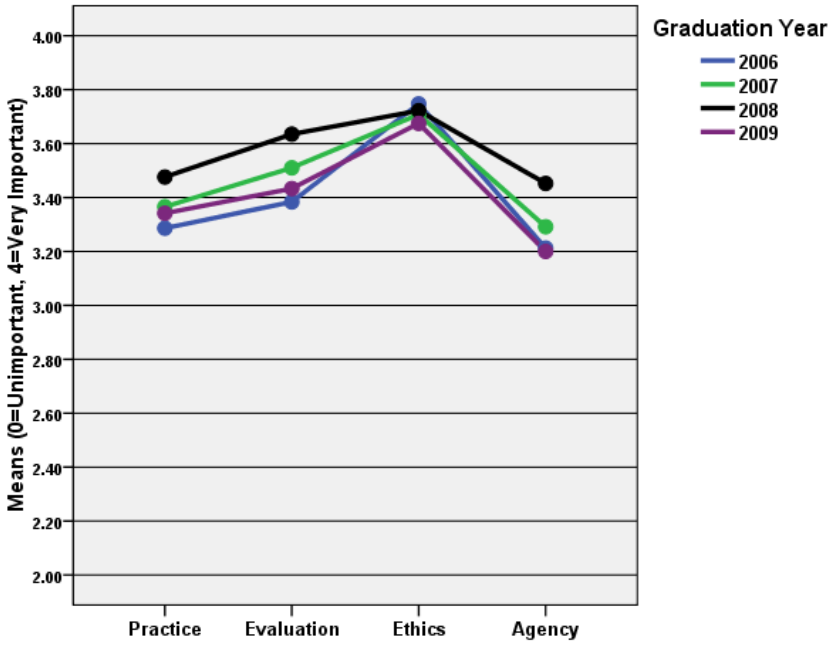
Provision of Knowledge



- Within subjects Provision factor
  - F (3,486) = 147.12, $p < .001$, $eta^2 = .48$
    - Only non-significant difference between Practice & Ethics

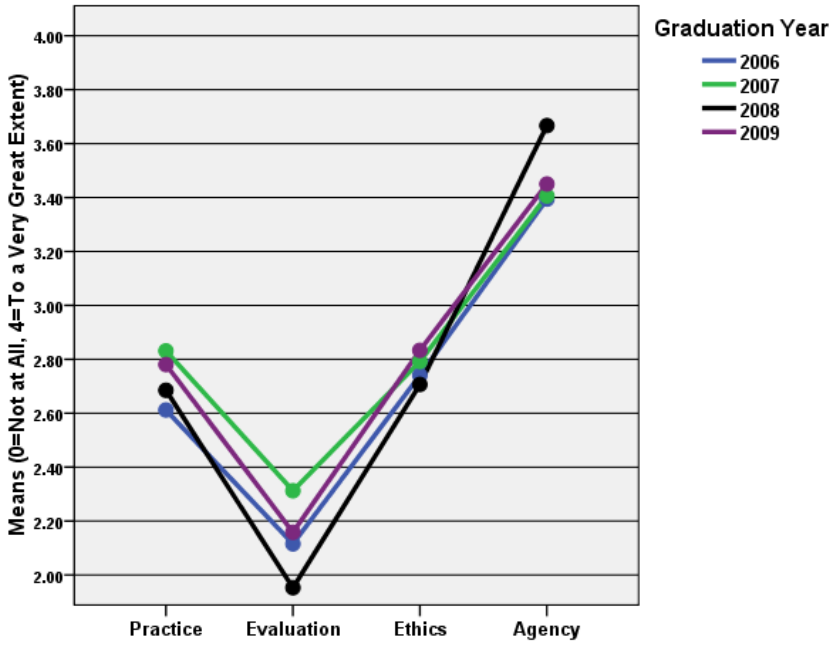
Graduates: Perception of KSA Knowledge Content by Cohorts

Importance of Knowledge



- Within subjects Importance factor
  - F (3,477) = 21.29, $p < .001$, $eta^2 = .12$

Provision of Knowledge



- Within subjects Provision factor
  - F (3,477) = 147.62, $p < .001$, $eta^2 = .48$

Graduates: Factoring of Select KSA Practice-Knowledge Construct

Pattern Matrix[a]

	Factor			
	1	2	3	4
Imp_Trauma_Impact	**.772**	.016	-.033	-.074
Imp_Affect_Lifestyle_ Mood	**.564**	-.079	.070	.242
Imp_Tx_Interventions	**.457**	.332	-.004	-.063
Imp_Recovery_Process	**.433**	-.035	.202	.137
Imp_EBPs	.168	**.779**	-.074	-.049
Imp_Major_Theories	-.180	**.686**	.145	.173
Imp_Cooccuring_ Disorders	-.009	-.017	.884	-.038
Imp_Psychiatric_Meds	.149	.148	.475	-.057
Imp_Therapeutic_Use_ Self	.020	.061	-.062	**.839**

Treatment

Theory

Use of Self

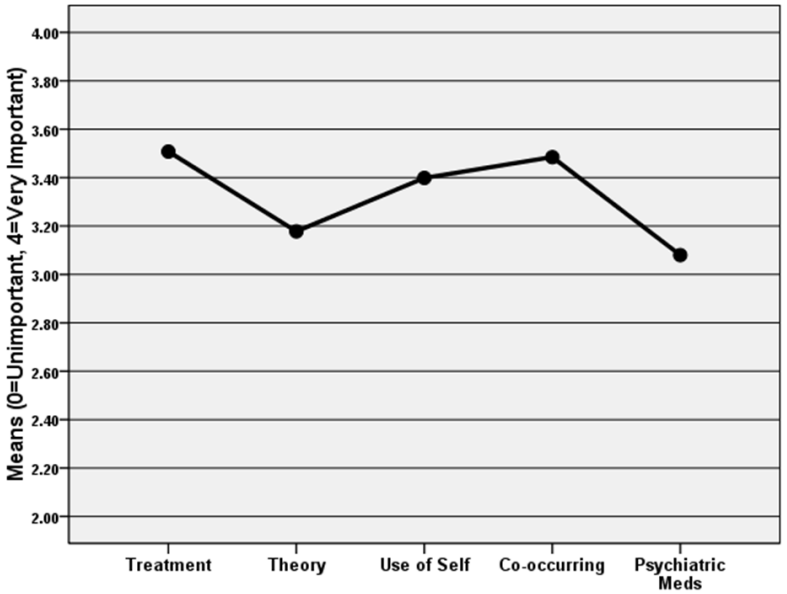
Extraction Method: Principal Axis Factoring.
Rotation Method: Promax with Kaiser Normalization.

a. Rotation converged in 7 iterations.

**Decision made to analyze Co-occurring Disorders and Psychiatric Meds as separate variables.*

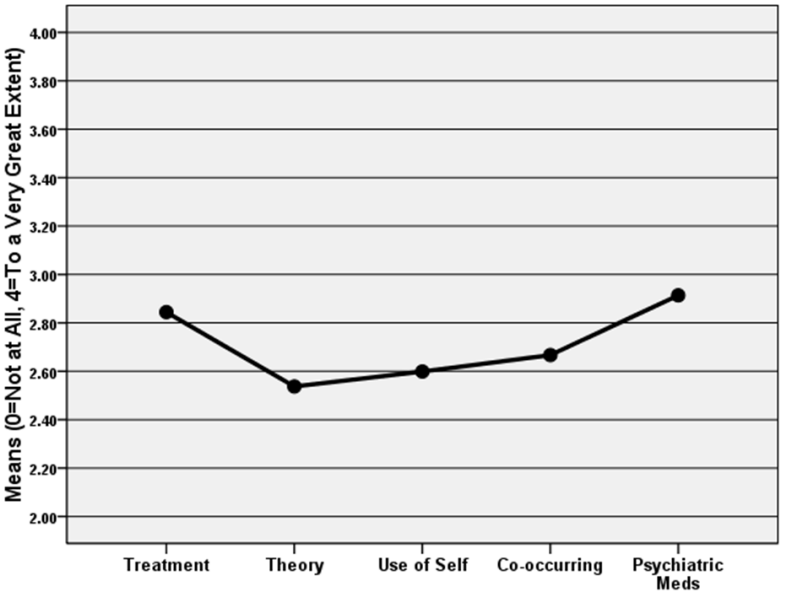
Graduates: Perception of Importance vs. Provision of Select KSA Practice-Knowledge Content

Importance of Select Practice-Knowledge



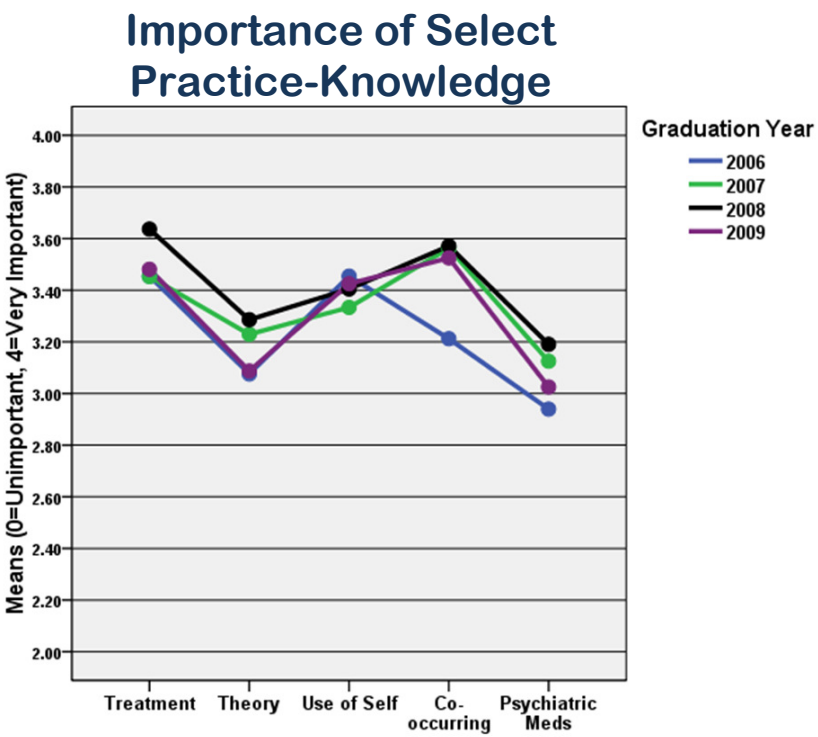
- Within subjects Importance factor
  - F (4,648) = 20.30, $p < .001$, $eta^2 = .11$
    - Treatment, Use of Self, & Co-occurring Disorders > Theory & Psychiatric Meds

Provision of Select Practice-Knowledge

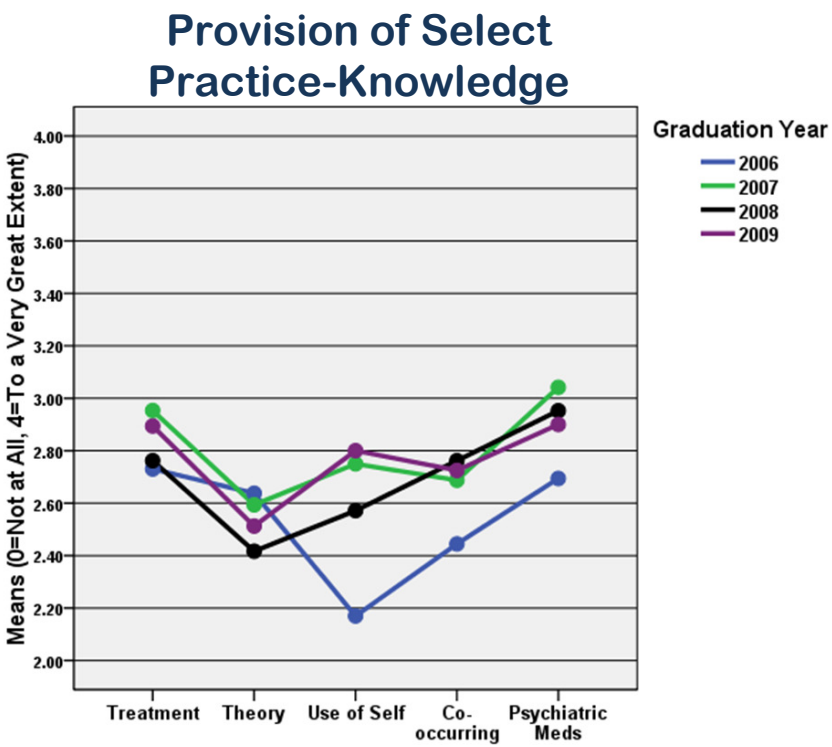


- Within subjects Importance factor
  - F (4,648) = 9.80, $p < .001$, $eta^2 = .06$
    - Treatment > Theory & Use of Self
    - Psychiatric Meds > Theory, Use of Self, & Co-Occurring Disorders

Graduates: Perception of Select KSA Knowledge-Practice Content by Cohorts



- Within subjects Importance factor
  - F (4,636) = 20.33, $p < .001$, $eta^2 = .11$
    - Treatment > Theory & Psychiatric Meds
    - Use of Self & Co-occurring Disorders > Theory & Psychiatric Meds



- Within subjects Importance factor
  - F (4,636) = 9.48, $p < .001$, $eta^2 = .06$
    - Treatment > Theory & Use of Self
    - Psychiatric Meds > Theory, Use of Self, & Co-occurring

Graduates: KSA Skills Content Factors

Pattern Matrix[a]

	Factor		
	1	2	3
Imp_Assessment_Indv_Fam	**.902**	-.010	.045
Imp_Communication	**.604**	-.010	-.023
Imp_Devt_Tx_Int_Dis_Plans	**.527**	.070	-.228
Imp_Technical	-.134	**.732**	-.107
Imp_Writing	.101	**.596**	.070
Imp_Case_Management	-.022	-.067	**-.869**
Imp_Documentation_MediCal	.009	.059	**-.568**
Imp_Revising_Tx_Plans	.249	.086	**-.541**

Treatment Planning

Writing & Tech

Treatment Planning

Extraction Method: Principal Axis Factoring.

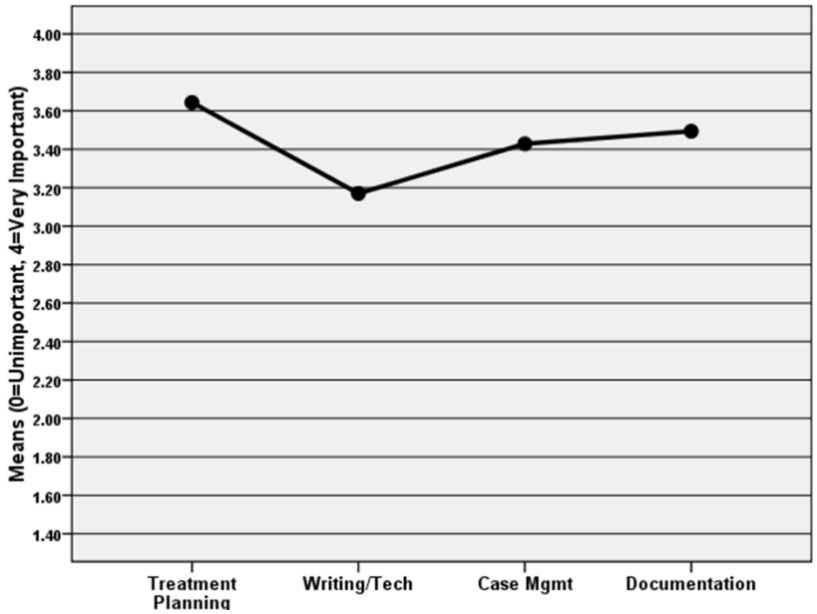
Rotation Method: Oblimin with Kaiser Normalization

a. Rotation converged in 7 iterations.

*Decision made to add Revision of Treatment Plans to Treatment Planning factor, and to analyze Case Management & Documentation as separate variables.

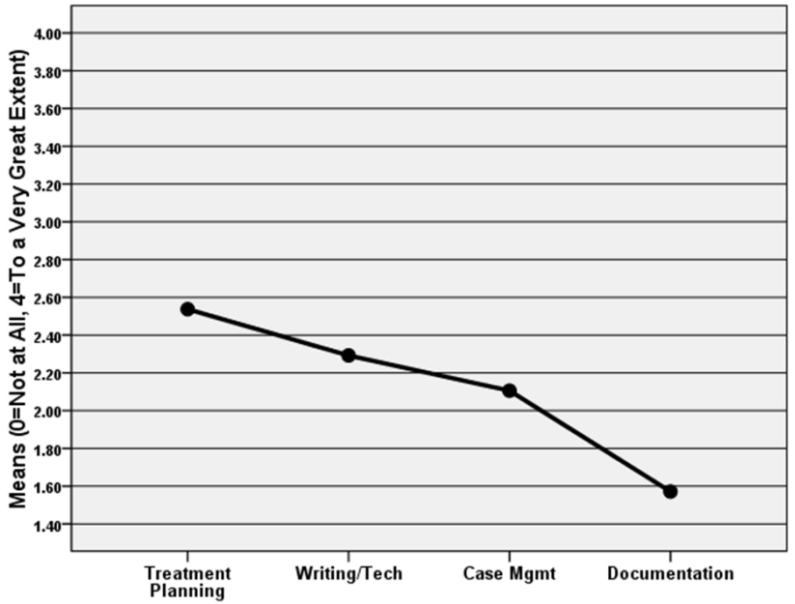
Graduates: Perception of Importance vs. Provision of KSA Skills Content

Importance of Skills Content



- Within subjects Importance factor
  - F (3,486) = 25.69, p < .001, eta² = .14
    - Treatment Planning > Writing/Tech, Case Mgmt, & Documentation
    - Case Mgmt, & Documentation > Writing/Tech

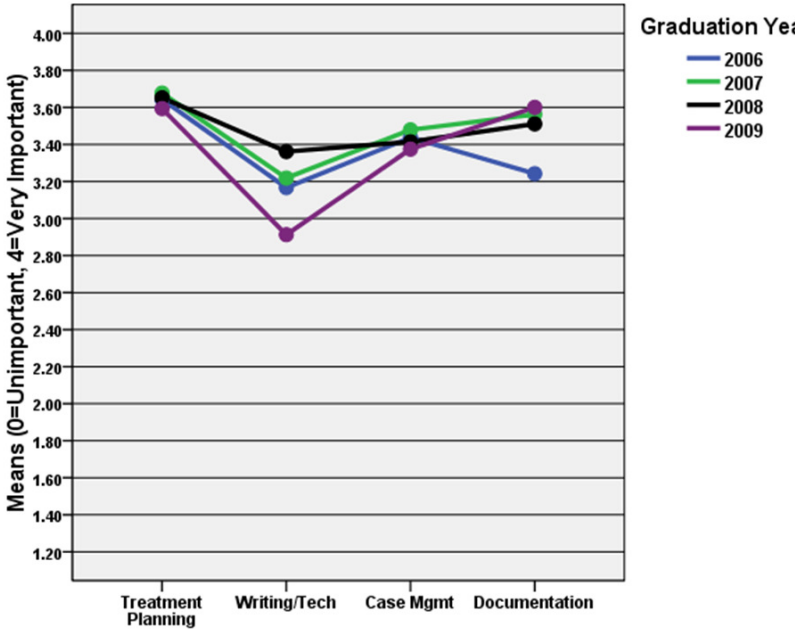
Provision of Skills Content



- Within subjects Importance factor
  - F (3,486) = 39.67, p < .001, eta² = .20
    - Treatment Planning > Writing/Tech, Case Mgmt, & Documentation
    - Writing/Tech & Case Mgmt > Documentation

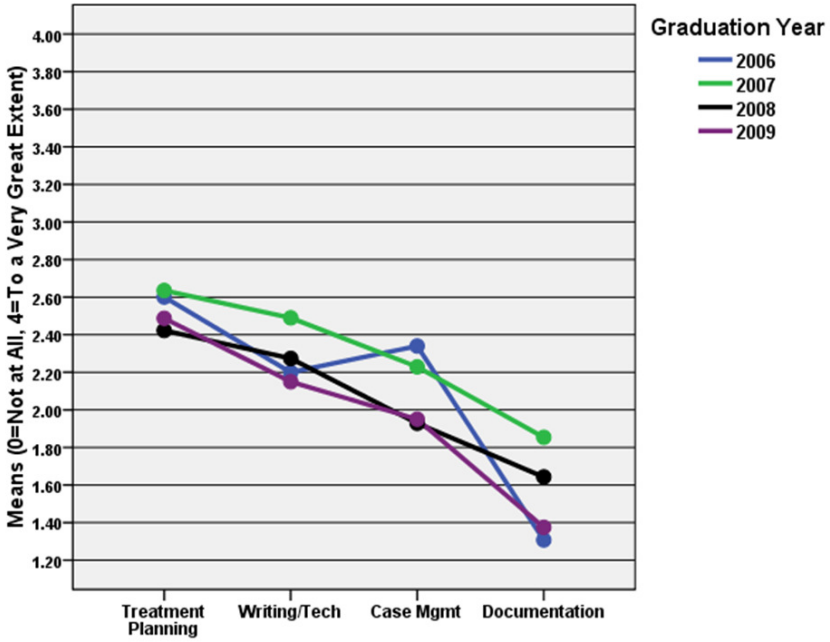
Graduates: Perception of KSA Skills Content by Cohorts

Importance of Skills Content



- Within subjects Importance factor
  - $F(3,477) = 25.98$, $p < .001$, $eta^2 = .14$
    - Treatment Planning > Writing/Tech, Case Mgmt, & Documentation
    - Increase in Documentation from 2006 to later years
    - Drop in Writing/Tech in 2009 compared to previous years

Provision of Skills Content



- Within subjects Importance factor
  - $F(3,477) = 41.03$, $p < .001$, $eta^2 = .21$
    - Treatment Planning > Writing/Tech, Case Mgmt, & Documentation
    - Writing/Tech & Case Mgmt > Documentation

KSA Abilities Content Factors

Pattern Matrix[a]

	Factor 1	2	3	4
Imp_Utilization_Supervision	**.784**	-.012	-.084	-.022
Imp_Strategies_Learning	**.672**	.208	.022	.014
Imp_Time_Mgmt	**.604**	.142	-.016	.045
Imp_Stress_Mgmt	**.588**	-.194	-.256	.122
Imp_Maintaining_App_Bound	**.447**	.261	.115	.072
Imp_Advocacy	-.049	**.761**	-.054	-.040
Imp_Cultural_Competency	.089	**.552**	.006	.225
Imp_Assertiveness	.145	**.535**	-.015	.055
Imp_Mult_Int_Teamwork	.305	.142	**-.672**	.062
Imp_Collaboration	.182	.352	**-.385**	.135
Imp_Conflict_Resolution	-.136	.128	-.219	**.728**
Imp_Devt_Therapeutic_Rel	.004	.075	.142	**.588**
Imp_Engaging_Client	.139	-.075	.093	**.583**
Imp_Crisis_Intervention	-.041	.008	-.219	**.578**
Imp_Facilitating_Self_Help	.122	.268	-.013	**.457**
Imp_Handling_NonCompliance	.323	-.124	.017	**.440**
Imp_Integrating_Theory_Practice	.264	.150	.244	**.403**

Professional Behaviors

Advocacy

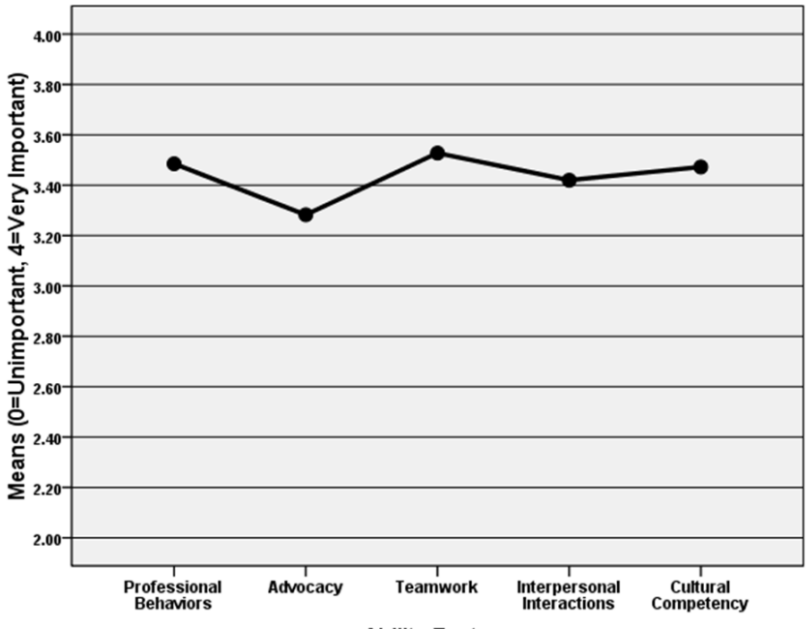
Teamwork

Interpersonal Interactions

Cultural Competence

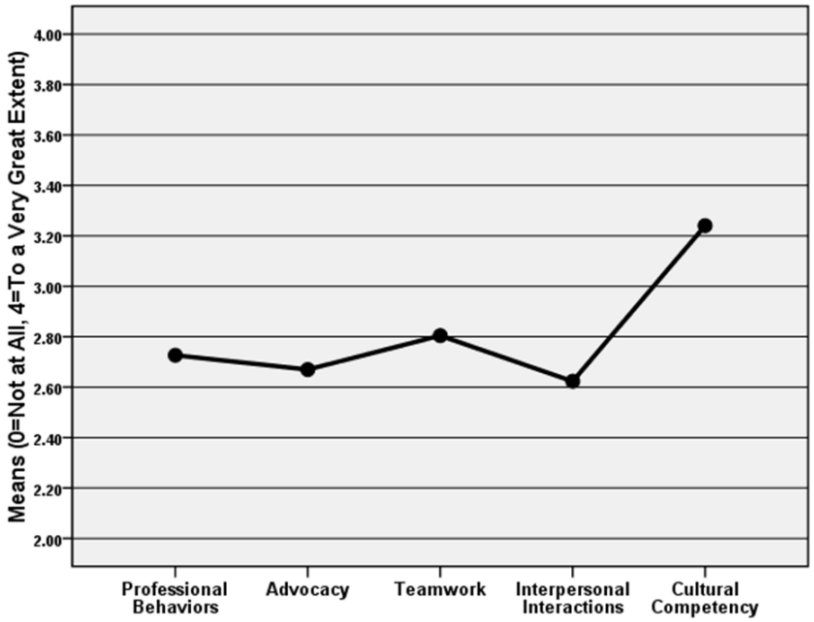
Graduates: Importance vs. Provision of KSA Abilities Content

Importance of Abilities Content



- Within subjects Importance factor
  - F (4,648) = 7.67, p < .001, eta² = .05
    - Professional Behaviors, Teamwork, & Cultural Competency > Advocacy

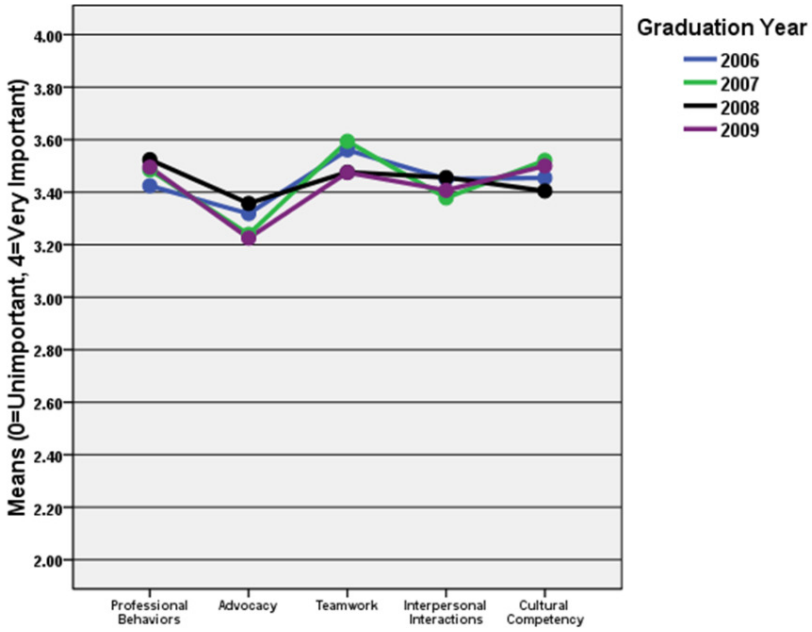
Provision of Abilities Content



- Within subjects Importance factor
  - F (4,844) = 34.00, p < .001, eta² = .14
    - Cultural Competency > Professional Behaviors, Advocacy, Teamwork, & Interpersonal Interactions
    - Teamwork > Interpersonal Interactions

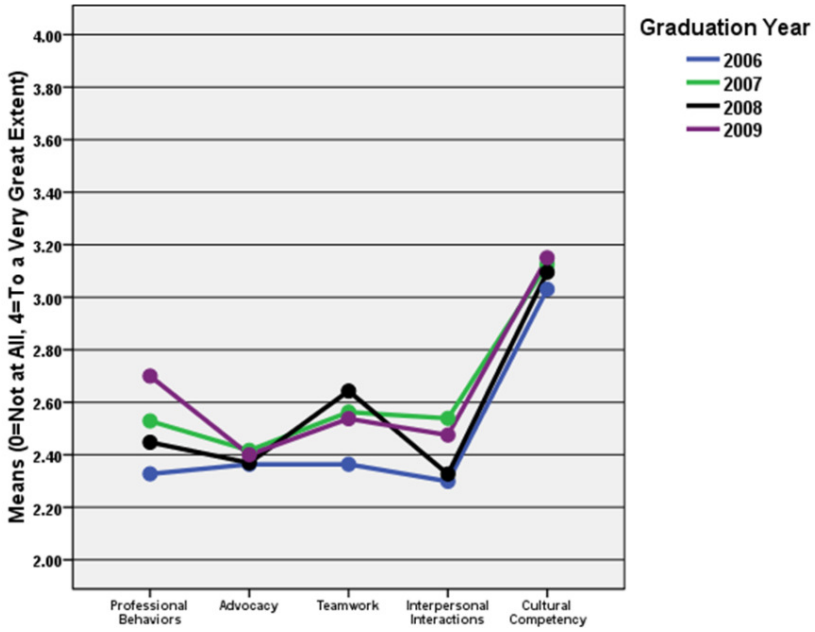
Graduates: Perception of KSA Abilities Content by Cohorts

Importance of Abilities Content



- Within subjects Importance factor
  - F (4,636) = 7.15, p < .001, eta² = .04
    - Professional Behaviors, Teamwork, & Cultural Competency > Advocacy

Provision of Abilities Content



- Within subjects Importance factor
  - F (4,636) = 37.53, p < .001, eta² = .19
    - Cultural Competency > Professional Behaviors, Advocacy, Teamwork, & Interpersonal Interactions

The CQI Process: Phase III
Assessment of Educational Effectiveness

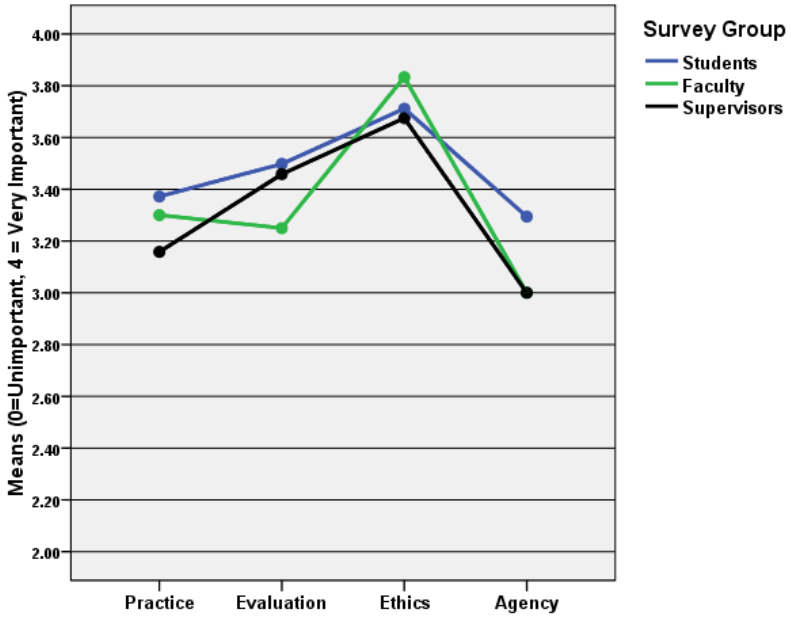
- ***Phase III:*** *Assessment of Educational Effectiveness*
  - Objective:
    - To establish a methodology to assess the educational effectiveness of the CalSWEC MH Program
      - Use of multiple measures to support data triangulation methodology
        - Data triangulation methodology supports the conditions for determining *Conclusion Validity - the degree to which conclusions reached about relationships in data are reasonable.*
        - These conditions include: a) the exact or conceptually the same content; b) reliability; c) independent samples; d) consistent/standardized implementation of methodology; and e) large sample size.
      - Develop initial indicators of educational effectiveness
      - Recommend next steps in the development of CQI process that would support statement of strong conclusion validity regarding educational effectiveness

The CQI Process: Phase III
Assessment of Educational Effectiveness

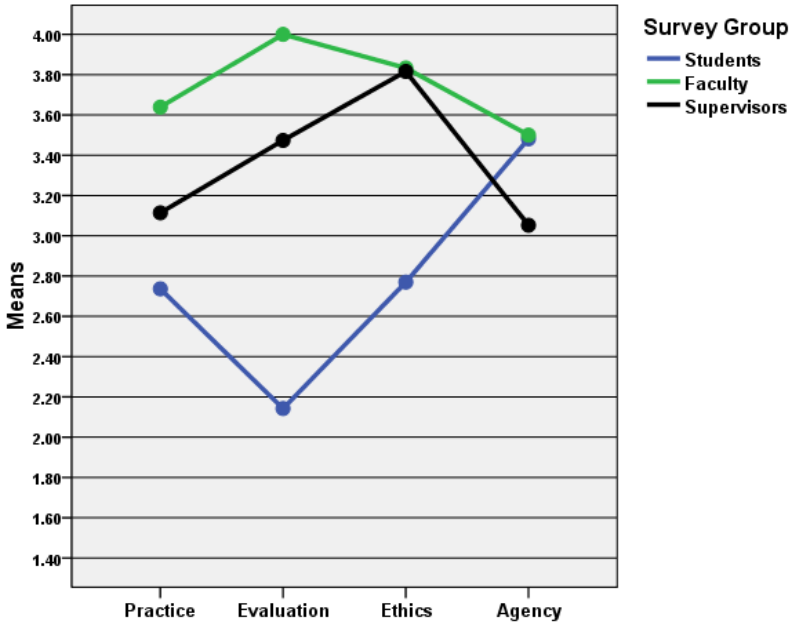
- ***Phase III:*** *Assessment of Educational Effectiveness*
  - **Study Methods**
    - CQI Instrument--Survey on Knowledge Skills and Abilities
    - Supervisors (N=44), Program Coordinators (N=12)
    - SurveyMonkey used for data collection
    - Data Analysis—Factor Analysis, ANOVA
    - Content Analysis of MH Syllabi from all schools
  - **Data Strengths and Limitations:**
    - Supervisor data-moderate sample size; Adequate for statistical analysis;
    - Program Coordinators data-minimal sample size; Statistically adequate, however larger sample would improve confidence of conclusions
    - Program Coordinators may not be the appropriate group to sample, i.e., they may be teaching courses and may not have a deep understanding of full program curriculum and academic assessment procedures
  - **Statistical Tests:**
    - Conducted with scales/measures that were directly comparable
    - Scale anchors same among groups on importance factors; clarification needed on some provision factors

Importance of KSA Knowledge Content by Groups (Graduates, Faculty, Supervisors)

Importance of Knowledge Content



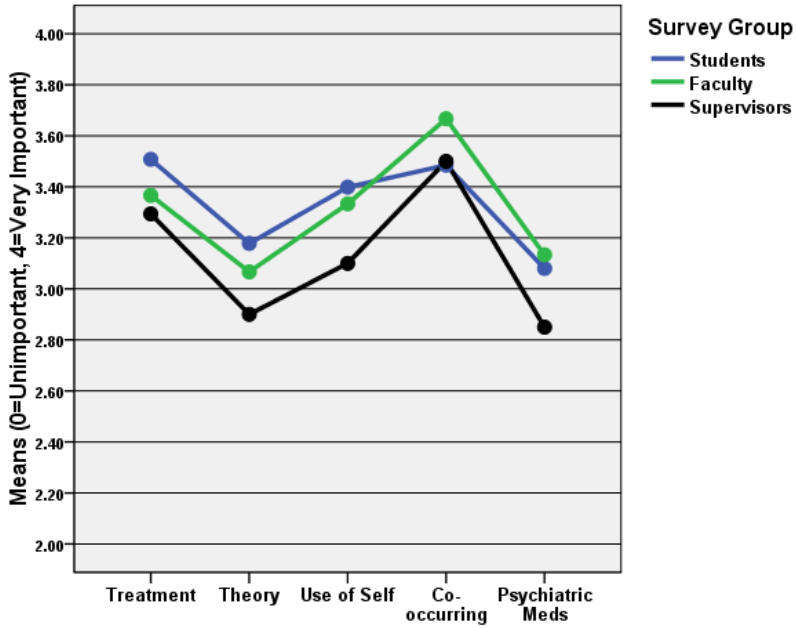
Provision of Knowledge Content



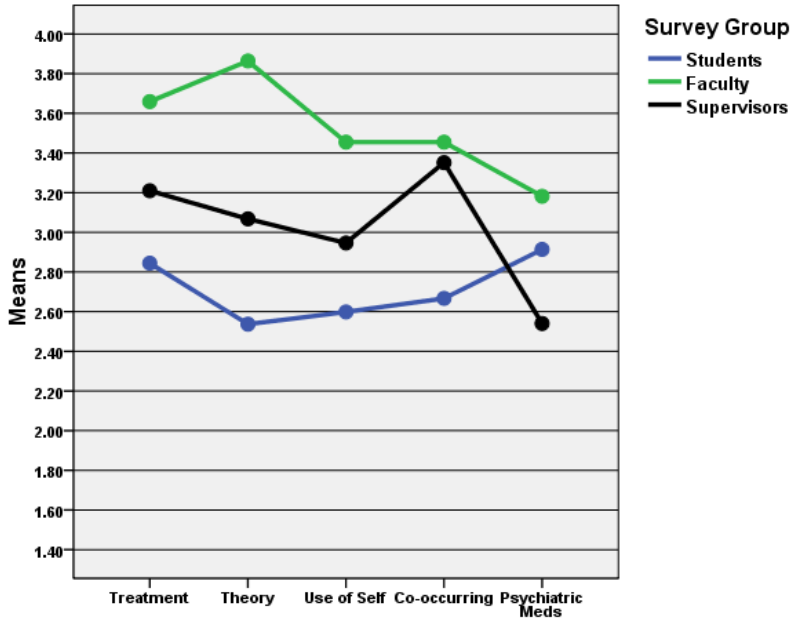
- Within subjects Importance factor
  - $F(3,648) = 29.68$, $p < .001$, $eta^2 = .12$
    - Ethics > Practice, Evaluation, & Agency
    - Practice & Evaluation > Agency

Perception of Select KSA Practice-Knowledge Content by Groups (Graduates, Faculty, Supervisors)

Importance of Knowledge-Practice Content



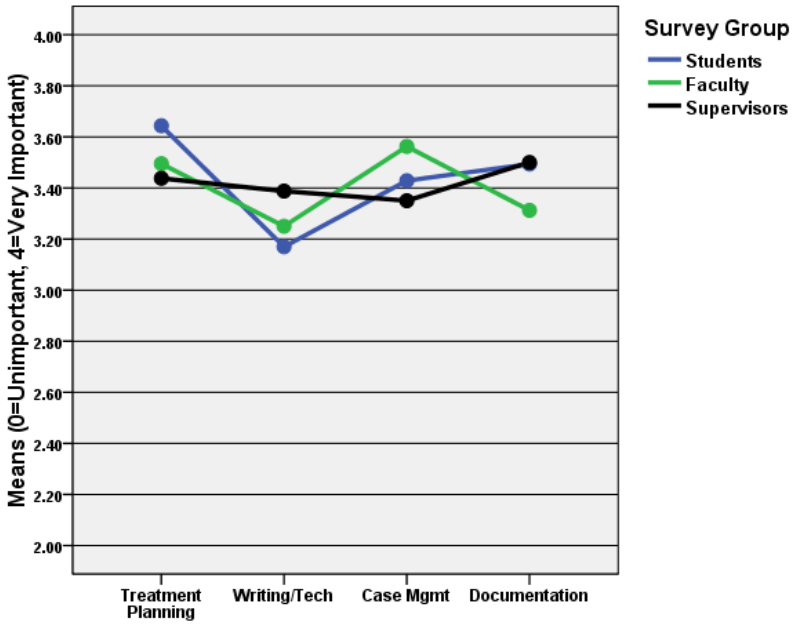
Provision of Knowledge-Practice Content



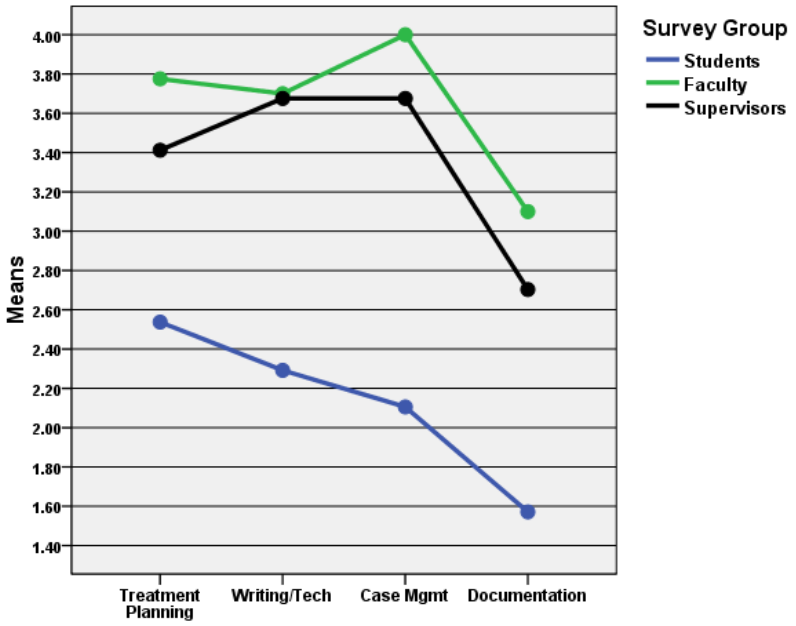
- Within subjects Importance factor
  - $F(4,860) = 16.09$, $p < .001$, $eta^2 = .07$
    - Treatment > Theory & Psychiatric Meds
    - Co-occurring Disorders > Theory, Use of Self, & Psychiatric Meds

Perception of KSA Skills Content by Groups (Graduates, Faculty, Supervisors)

Importance of Skills Content



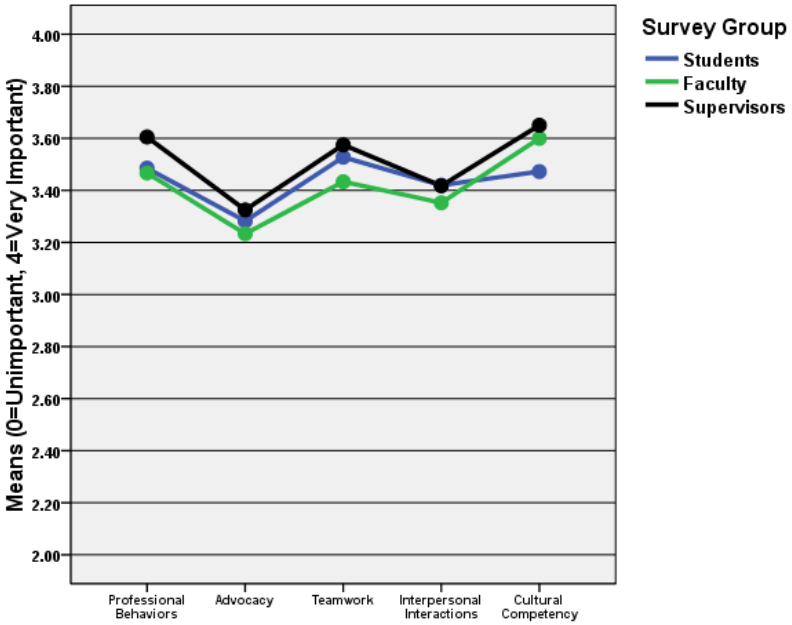
Provision of Skills Content



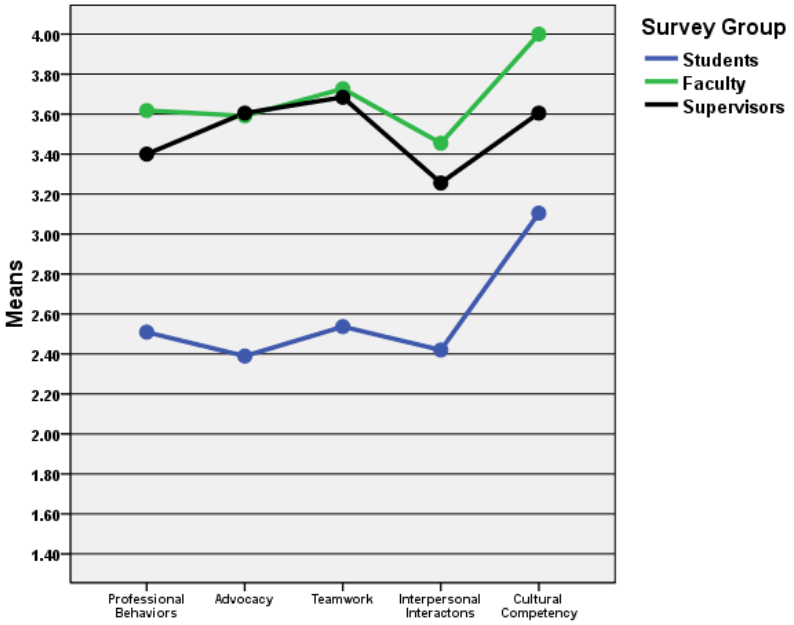
- Within subjects Importance factor
  - F (3,648) = 4.23, p = .006, eta² = .02
    - Treatment Planning > Writing/Tech

Perception of KSA Abilities Content by Groups (Graduates, Faculty, Supervisors)

Importance of Abilities Content



Provision of Abilities Content



- Within subjects Importance factor
  - $F(4,860) = 7.32$, $p < .001$, $eta^2 = .03$
    - Professional Behaviors, Teamwork, & Cultural Competency > Advocacy

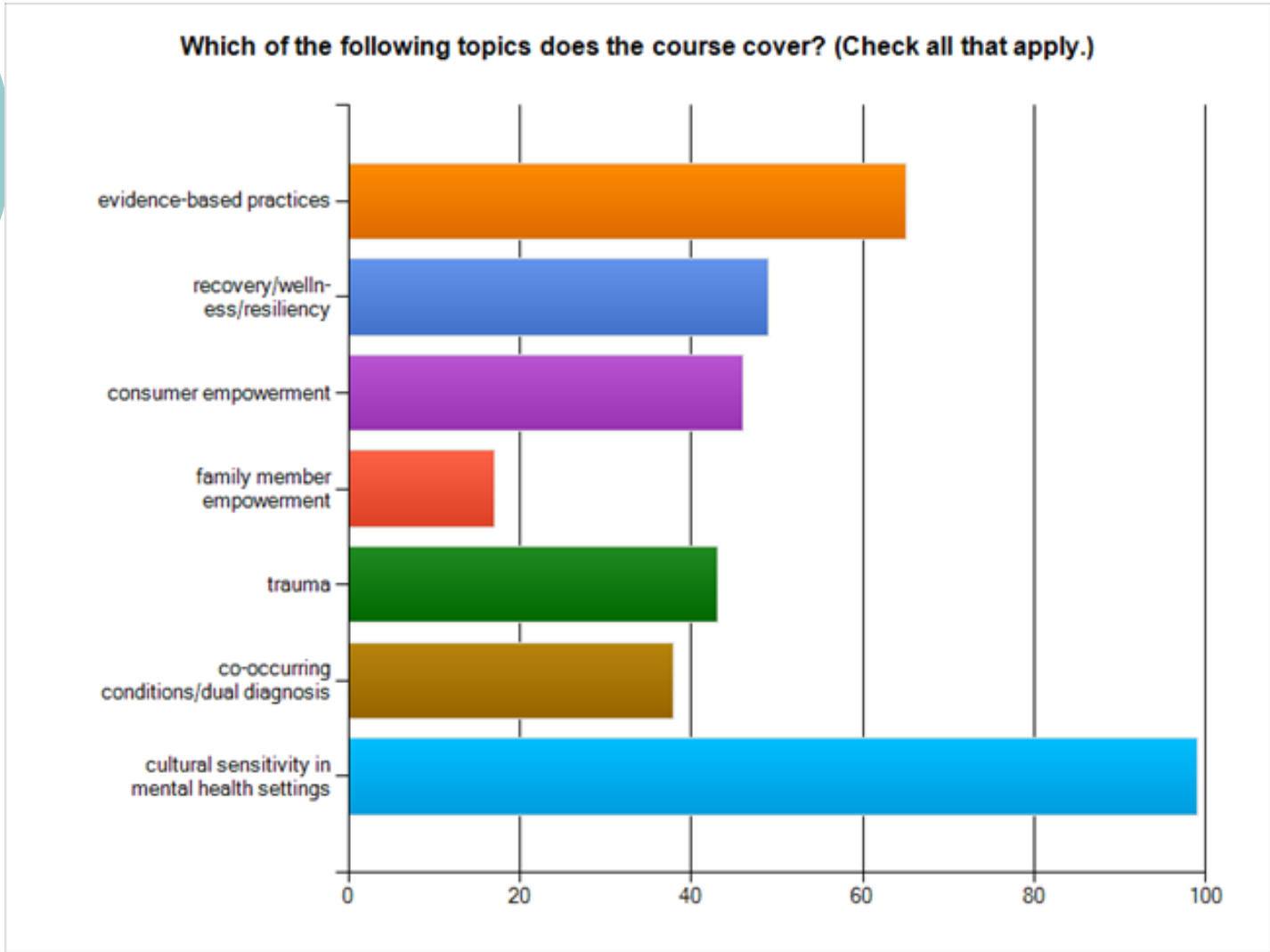
Syllabi Content Analysis: Overview

- ***Syllabi Content Analysis***
  - **Purpose**
    - Review of how CalSWEC schools are integrating KSAs (Key concepts from competencies)
  - **Methods**
    - Letter requesting syllabi sent late September 2010
    - 100% response rate (20 schools; ~115 syllabi)
    - Research team: 3 MSW Graduates + Sarah
    - Surveymonkey for data collection (www.surveymonkey.com)
    - Discovertext for word cloud and counts (www.discovertext.com)
  - **Study strengths and limitations**
    - Syllabi are a contract between Graduates and faculty
    - Study team included MSW Graduates, the consumers of MSW education
    - Syllabi are an incomplete portrait of what happens in the classroom
    - Schools interpreted call for syllabi differently

Integration of Knowledge, Skills, and Abilities (KSA) Areas

advocacy	42
social justice	50
agency	55
assessment	101
boundaries	25
case management	38
collaboration	44
communication	54
empathy	15
listening	13
conflict resolution	3
crisis	47
diverse	74
documentation	28
dsm	56
co-occurring	28
dual diagnosis	19
engagement	33
ethics	79
evidence-based practice	31
intervention	86
medication	32
mental illness	64
self-help	14
peer support	8
professional development	14
relationship building	9
rapport	6
recovery	56
motivation	20
motivational	28
resistance	13
self-care	10
software	7
supervision	23
theory into practice	41
trauma	51
treatment plan	23
use of self	91

Integration of Key Themes



Findings

- ***Perceived Importance:***
  - Strong and consistent data relationships identified by the triangulation of the three data sets
  - Strong construct validity enabling us to make statement of strong conclusion validity regarding agreement of the importance of KSAs in providing educational framework for training

Findings

- ***Perceived Provision:***
  - Overall data from graduates shows very high level of satisfaction on the curricular content in classroom and field experiences.
  - Detailed data from Graduates, Supervisors and Program Coordinators demonstrate variability in perceptions regarding the provision of select KSAs.
  - Content analysis of program syllabi as compared to graduates' overall view of classroom content suggests that what occurs in the classroom may not be thoroughly represented in course syllabi.
  - Triangulation of data supports the need to review the content of select curricular areas, including: theory; practice evaluation; co-occurring disorders; ethics; professional behaviors; advocacy (empowerment); teamwork; interpersonal interactions.
  - Triangulation of data support the need to examine rival explanations for data variability (e.g., data variations may be the result of the difference between practicum vs. job experiences; job expectations vs. job realities; changes in the job environment/roles due to funding changes; etc.)

Recommendations

- ***Recommendations:***
  - Rival explanations for data variability should be examined (e.g., data variations may be the result of the difference between practicum vs. job experiences; job expectations vs. job realities; changes in the job environment/roles due to funding changes; etc.)
  - Additional attention should be given to studying the variations in the perceptions of the provision of select KSAs by Graduates, Supervisors, and Program Coordinators, including modifying the methodology so that comparisons include faculty teaching MH courses.
  - Increased attention should be given to closer adherence to the language of KSAs in program syllabi.

CQI: Next Steps in Demonstrating Educational Effectiveness

- *Methodological Issues*
  - Sample size of all groups
  - Sample of faculty teaching MH courses
  - Instrument consistency
- *Consistency between competencies and measures*
  - Competencies should reflect KSAs
- *Development of performance criteria for KSAs*
- *Development of assessment rubric*
- *Explore applying assessment tools before and after graduation*