Analysis of Behavioral Health Workforce Competencies Among Professions

March 2017

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KEY FINDINGS

Behavioral health is among the fields that have developed professional competency statements to describe expected levels of knowledge, skills, and abilities for a specific area of practice. Professional competencies are important, as they establish standards and benchmarks that help inform curricula and advance the profession; however, little information is available about alignment of competency sets across the field of behavioral health. This study seeks to identify common competency sets used across the behavioral health workforce and assess the alignment of competency statement content across behavioral health occupations.

This study assessed the content of competency statements retrieved online for nine behavioral health professions: social work, clergy, marriage and family therapy, medicine, psychiatry, psychology, counseling, nursing, and paraprofessionals. Thirty-two publicly available competency statements were analyzed; 1,731 practice behaviors were extracted from the competencies and coded into 273 domains. The domains were themed and grouped into 28 competency categories with common content.

When comparing content across competency statements, categories of *Professionalism* and *Science, Knowledge and Methods* were most commonly aligned across the field, with 72% and 56% of competency statements covering these categories, respectively. The same two categories were most commonly emphasized across the 9 professions (89% and 100%, respectively). Overall, study findings show a lack of content standardization among competency statements and across professions, yet it is unclear whether competency alignment is meaningful. Future research should consider whether competency alignment is associated with high quality care and effective professional development.

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BACKGROUND

Behavioral health is among the fields that have developed professional competency statements to describe expected levels of knowledge, skills, and abilities for a specific area of practice. Professional competencies are important, as they establish standards and benchmarks that help inform curricula and advance the profession. The need for professional competency statements is particularly important for the behavioral health workforce as it expands in size and scope to help ensure it can meet increasing service demands and new methods for service delivery for a diverse population.

Competency statements are often prepared by professional groups, organizations, and societies. Prior researchers have reported how competencies affect the professions to which they belong.[1-3] Some work has been done to identify, categorize, and compare competencies across a variety of health care workforce professions, including behavioral health[4-8], but there has been disagreement about the relationship of competencies across multiple professions. Some have argued that that challenges arise when health professionals work in silos and are not able to practice alongside each other effectively.[9] The concern amongst these researchers is that competencies which overlap across professions are more apt to create generalists rather than the specialists who might be required in the provision of care.[10] Others have argued that professional health care providers should not be too specialized, rather suggesting a broad range of competencies as key to ensuring highly-skilled professionals are knowledgeable in a breadth of areas [11-13]. For this group of researchers, competencies are about creating a more flexible and mobile labor force to increase productivity [13]. Because the behavioral health workforce comprises a vast array of professions and types of patients, the workforce needs to be proficient in a wide variety of professional circumstances and have a set of competencies which allows it to meet the needs of a diverse clientele.

The development of a set of agreed-upon competencies for the behavioral health workforce is not solely sufficient for the provision of safe, high-quality, and effective care for patients. Rather, researchers have identified two further changes to increase the impact of competencies on improving the workforce and provision of care. First, assessment measures must be developed and improved [11], especially to identify when a member of the workforce becomes proficient in a competency category. Second, competency statements need to be transparent, have clearly defined goals to ensure advancement of the profession and the protection of the public, [14-16] and be more clearly connected with practice. [17]

This study seeks to identify common competency sets used across the behavioral health workforce and to assess the alignment of competency statement content across behavioral health occupations. The

absence of uniformity across competency statements could be a potential limiting factor for monitoring and advancing the education of service providers and ensuring the competencies are aligned with the scopes of practice within each discipline. To help us understand the extent of alignment, or lack of standardization, among the behavioral health competency statements, a research team at the University of Michigan Behavioral Health Workforce Research Center collected, coded, and analyzed publicly available competency statements related to nine occupations within the behavioral health workforce.

METHODS

This study assessed the content of competency statements for nine behavioral health occupations: social work, clergy, marriage and family therapy, medicine, psychiatry, psychology, counseling, nursing, and paraprofessionals. Competency statements were retrieved from sources that were publicly available and published online. Because no central repository of competency statements exists, we conducted a literature search using a large number of keywords through commercial search engines, EBSCO, and ProQuest academic search engines in order to capture gray literature and peer-reviewed publications. After searching the publicly available and the academic search engines for competency statements, we conducted targeted searches of websites representing professional associations and discipline-specific accrediting bodies, such as the Council on Social Work Education (CSWE) and the American Psychological Association (APA). We also searched websites of federal government agencies that fund aspects of care for behavioral health and have also produced competency statements, including the Substance Abuse and Mental Health Services Administration (SAMHSA). Finally, we searched for statements put forth by non-profit organizations that advocate for specific groups, including the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) and National Association for Children of Alcoholics (NACOA). The targeted approach to collecting competency statements was designed to ensure a coverage of statements for all nine of the behavioral health occupations included in our analysis.

Inclusion Criteria

Competency statements were included for analysis if they provided specific instruction, direction, or advisement related to the provision of behavioral health services. Provision of behavioral health services pertains to all individuals who focus on mental and emotional well-being, and includes, but is not limited to, coping strategies, treatment of all classes of mental disorders, personality disorders, substance use disorders, and other forms of addictive behavior. The definition of behavioral health services also includes other closely related terminology including "behavioral medicine," "integrated care", or "clinical services."

Additionally, competency statements that included guidance related to services provided at the level of

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direct care (i.e., patient contact), preventive services, administrative activities (e.g., use of electronic health records), or organizational functioning (e.g., training requirements, organizational policies related to behavioral health care) were also included. We excluded statements if they only contained summaries or re-interpretations of a competency statement.

Coding

Each competency statement included rich text description of specific practice behaviors, which are the distinct levels of knowledge and skills that must be acquired by each worker in that profession. For example, the American Association for Marriage and Family Therapy (AAMFT) lists, "informing clients and legal guardians of limitations to confidentiality and parameters of mandatory reporting," as a practice behavior marriage and family therapists must acquire; this practice behavior was captured under the domain of 'Legal Issues, Ethics, and Standards.' Practice behaviors were themed and categorized into domains. A domain is a general collection of similarly constructed practice behaviors identified by the organization that produced the competency statement.

To code the elements of the competency statement, we constructed a database that listed the name of the organization from which it came, a text description of the practice behavior, and the domain under which the practice behavior was captured. An additional database was created for domains, which consisted of the domain name, name of organization, and name of profession. These two databases were used to link and cross-reference competency statements, practice behaviors, and the domains we established.
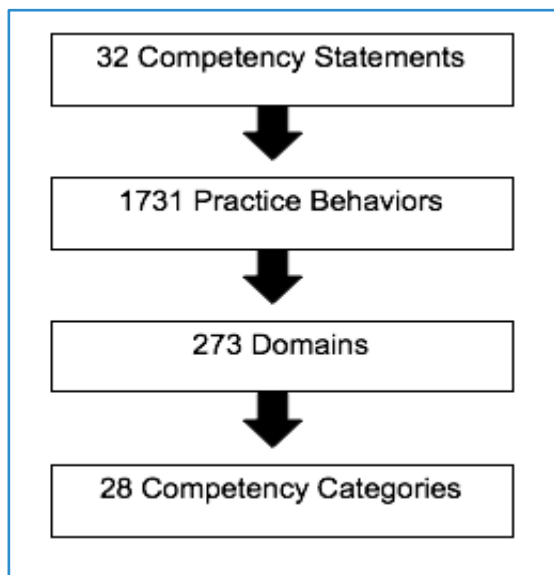
Analytic Strategy

The analytic strategy focused on finding alignment in competency statements across the various behavioral health professions by focusing on the domains under which practice behaviors were categorized. For the purpose of this study, alignment refers to areas where professions or competency statements share similar domains. Similarly, misalignment refers to areas where professions or competency statements do not share similar domains.

The first stage of analysis involved collapsing the domains with similar wording or major themes into competency categories. Domains were extracted directly from the practice behaviors comprising the competency statements; competency categories were constructed by the research team. For example, the domains titled 'Professionalism' and 'Professional Values and Attitudes' were grouped under the competency category titled *Professionalism.* Similarly, the domains titled 'Individual and Cultural Diversity'

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and 'Social and Cultural Diversity' were grouped under the competency category titled *Diversity.* Once competency categories were constructed, the study team was able to calculate different measures of the competency statements. Our results focus on the frequency, overlap, and gaps of competency categories across the professions.

RESULTS

Competency statements were extracted from 32 documents obtained during our search (see Appendix for competencies included in the study). A total of 1,731 practice behaviors were identified from the competency statements. The number of practice behaviors extracted from the 32 competency statements ranged from 11 to 131 per statement. The mean number of behaviors for each statement was 53.1 (standard deviation=34.1). The practice behaviors represent competencies authored for 9 different occupations, including paraprofessionals (n=508), counseling (n=386), psychology (n=227), social work (n=149), psychiatry (n=139), marriage and family therapy (n=128), nursing (n=112), medicine (n=70), and clergy (n=12).

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┌─────────────────────────────┐
│  32 Competency Statements   │
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│   1731 Practice Behaviors   │
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│        273 Domains          │
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│  28 Competency Categories   │
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A total of 273 domains were identified from grouping practice behaviors within the competency statements. The domains were then grouped into 28 competency categories according to similar wording or themes. The number of domains categorized into each competency category ranged from 2 to 30. The mean number of domains represented in each competency category was 9.8 (standard deviation=6.7).

As shown in Table 1, there is wide variation in the number of competency categories included across the different competency statements we collected. Out of 32 total competency statements created by behavioral health organizations, we found *Professionalism* present in 23 of them (72%), the highest percentage of all of the competency categories. Just over half (n=18; 56%) of competency statements included a competency category related to *Science, Knowledge, and Methods.* Fewer than half of the competency statements had practice behaviors and domains that corresponded to the other competency categories, indicating some variation in the types of practice behaviors required across occupations. On the other end of the spectrum, we found that only 2 competency statements (6%) included *Referral* and *Engagement* categories. On average, each competency statement was represented by 8 competency categories.

Overall, there appears to be very little alignment in competency categories across the 32 competency statements. The *Professionalism* and *Science, Knowledge, and Methods* competency categories are included in more than half of the competency statements in this study, indicating some alignment. The remaining 26 competency categories are represented in fewer than 50% of the competency categories, showing little alignment or standardization of the practice behaviors comprising these competency categories across competency statements.

Table 1. Number of Competency Statements Corresponding to Each Competency Category (n=32)

Competency Category	n (%)	Competency Category	n (%)
Professionalism	**23 (72%)**	Evidence-Based Practice	7 (22%)
Science, Knowledge, and Methods	**18 (56%)**	Counseling	6 (19%)
Intervention	15 (47%)	Quality	6 (19%)
Systems-Based Practice	15 (47%)	Teaching	6 (19%)
Diversity	13 (41%)	Community	6 (19%)
Treatment Planning	12 (38%)	Management/Administration	5 (16%)
Assessment	12 (38%)	Career Development	5 (16%)
Relationships	11 (34%)	Supervision	5 (16%)
Legal issues, Ethics, and Standards	11 (34%)	Human Growth and Development	4 (13%)
Advocacy	10 (31%)	Documentation	4 (13%)
Research and Evaluation	10 (31%)	Policy Practice	4 (13%)
Clinical Care	10 (31%)	Consultation	3 (9%)
Interpersonal Skills and Communication	10 (31%)	Referral	2 (6%)
Reflective Practice/Self- Assessment/Self Care	9 (28%)	Engagement	2 (6%)

Competency categories included in more than 50% of competency statements.

The second focus of our analysis was on alignment of competency categories among the 9 occupations included in our study. We found relatively high alignment across the occupations but that gaps are also present. We considered competency categories represented by five or more occupations having fairly good alignment across behavioral health. Similar to our analysis of competency statements, *Science,*

Table 2. Number of Professions Corresponding to Each Competency Category (n=9)

Competency Category	n (%)	Competency Category	n (%)
Science, Knowledge, and Methods	9 (100%)	Quality	4 (44%)
Professionalism	8 (89%)	Community	4 (44%)
Interpersonal Skills and Communication	7 (78%)	Evidence-Based Practice	3 (33%)
Systems-Based Practice	7 (78%)	Teaching	3 (33%)
Clinical Care	7 (78%)	Documentation	3 (33%)
Intervention	6 (67%)	Counseling	2 (22%)
Legal issues, Ethics, and Standards	6 (67%)	Management/Administration	2 (22%)
Assessment	5 (56%)	Career Development	2 (22%)
Treatment Planning	5 (56%)	Supervision	2 (22%)
Diversity	5 (56%)	Human Growth and Development	2 (22%)
Relationships	5 (56%)	Policy Practice	2 (22%)
Research and Evaluation	5 (56%)	Referral	2 (22%)
Advocacy	4 (44%)	Consultation	1 (11%)
Reflective Practice/Self Assessment/Self Care	4 (44%)	Engagement	1 (11%)

Competency categories included in competency statements by at least 5 of 9 behavioral health professions.

Knowledge, and Methods (n=9; 100%) and *Professionalism* (n=8; 89%), were the two competency categories with the highest representation across the occupations. Twelve of the 28 competency categories were present in at least half of the professions examined, while 16 categories were represented in fewer than half of the occupations. *Consultation* and *Engagement* categories were examples of discipline-specific competencies, as they were each represented by only one occupation.

CONCLUSIONS AND POLICY CONSIDERATIONS

Our analysis of alignment of core competencies across the behavioral health workforce yielded mixed results. Overall, our findings suggest that there is a foundation of shared competencies across the behavioral health professions; however, there is some misalignment, since many competency categories are not being uniformly included in all competency statements or occupations. Competencies related to *Science, Knowledge, and Methods* and *Professionalism* demonstrate a high level of use across the field,

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as they are both commonly emphasized across all disciplines and competency statements. In general, our findings point to a high level of competency overlap among categories that are largely standardized, are a central component to the workforce, and are applicable across a larger segment of the workforce. All behavioral health professions should aim for workers who are competent when interacting with patients. We would expect that *Professionalism* be a core component in providing behavioral health care, regardless of whether it is a physician providing care to the sick or clergy providing counseling to parishioners.

While the evidence of misalignment of competency statements is potentially troubling, some factors ameliorate the potential gaps amongst the competency statements and occupations. The lack of uniformity across the occupations, in particular, could be the product of differences in professional focus found within the behavioral health workforce. One of the strengths of the behavioral health workforce is its diversity of occupations, training, and experience. Services are offered to individuals along a continuum of care, from highly prescriptive medical interventions to other forms of therapy. It is expected that the competency statements might vary between a physician and a trained member of the clergy, for example. While both are providing behavioral health along the continuum of care, their training, role, and responsibilities vary greatly from each other. We did find evidence that suggests that competencies among similar types of occupations (e.g. nursing, psychiatry, and medicine) had a high level of overlap in competency categories, but varied when compared to other occupations. A significant amount of overlap may not be necessary for each occupation to perform its distinctive function appropriately.

Among the limitations of this study is that the assessment of competency alignment among the nine behavioral health occupations was largely driven by which competency statements are publicly available. We found eleven competency statements for paraprofessionals, while only one for clergy and marriage and family therapists. While our methods of finding and collecting competency statements are valid, it is possible that non-publicly available competency statements would influence our results. We were only able to identify two or fewer competency statements for five of the nine occupations. Thus, the lack of overlap found in this study may be attributable to a lack of available information.

There are several policy implications from our findings. Individuals who seek care from the behavioral health workforce have a wide variety of occupations from which to seek care. However, there is little overlap in key competency categories amongst the various occupations. Resistance to change by professional groups seeking to protect their discipline's autonomy could inhibit reforms meant to align competencies across the disciplines. Additionally, changes to responsibilities and capacities across the behavioral health workforce could be challenged by stakeholders. Members of the behavioral health

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workforce could be resistant to expanding their responsibilities without an increase in remuneration. Likewise, specific occupations could push back against perceived encroachment of certain patient responsibilities in an effort to stem the loss of authority. We found a startling lack of empirical literature and evidence detailing the types of competency changes and alignment which would lead to high quality care and effective professional development. While this analysis has pointed out evidence of lack of standardization among the occupations and across the competency statements, it is unclear if competency alignment is meaningful. We do not know which competency categories are essential for the development of a competent workforce. Further, we do not know which competencies are essential for providing high-quality and effective care. Funding organizations and organizations that formulate competency statements should consider further efforts at improving the assessment of competency statements for the occupations so that future research may focus on whether variability is associated with workforce or healthcare delivery measures of importance.

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Appendix: Competency Sets Included in Study

Profession	Organizational Sponsor	Competency Set Source
Alcohol & Drug Counselor	IC&RC	Candidate Guide for the IC&RC Alcohol & Drug Counselor Examination, 2016
Alcohol & Drug Counselor (Advanced)	IC&RC	Candidate Guide for the IC&RC Advanced Alcohol & Drug Counselor Examination, 2016
Behavioral health and primary care professionals and support specialists	Substance Abuse and Mental Health Services Administration	Core Competencies for Integrated Behavioral Health and Primary Care, 2014
Clinical Psychologists	American Board of Professional Psychology	Clinical Psychology Foundational Competencies
Clinical Supervisor	IC&RC	Candidate Guide for the IC&RC Clinical Supervisor Examination, 2016
Clinicians and public health workers	Interprofessional Education Collaborative	Core Competencies for Interprofessional Collaborative Practice, 2016
Co-occurring disorders professional	IC&RC	Candidate Guide for the IC&RC Co-Occurring Disorders Professionals Examination, 2016
Counseling Psychology	Council of Counseling Psychology Training Programs	Counseling Psychology Core Competencies, Essential Components, Behavioral Anchors, and Examples
Counselors	American Counseling Association, Association for Multicultural Counseling and Development Executive Council	Multicultural and Social Justice Counseling Competencies, 2015
Counselors	Council of Counseling Psychology Training Programs	Competencies in Professional Counseling and Related Human Services
Counselors	American Counseling Association, Multi-Racial/Ethnic Counseling Concerns Interest Network	Competencies for Counseling the Multiracial Population, 2015
Counselors	Association for Spiritual, Ethical, and	Competencies for Addressing Spiritual and Religious Issues in

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	Religious Values in Counseling	Counseling, 2009
Counselors	Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling	Competencies for Counseling with Lesbian, Gay, Bisexual, Queer, Questioning, Intersex, and Ally Individuals, 2012
Criminal Justice Addictions	IC&RC	Candidate Guide for the IC&RC Criminal Justice Addictions Professional Examination, 2016
Direct-support professionals who provide care for individuals with intellectual developmental disabilities/mental illness	National Association for the Dually Diagnosed (NADD)	NADD Competency-based Direct-support professional certification program
Marriage and Family Therapists	American Association of Marriage and Family Therapy	Marriage and Family Therapy Core Competencies, 2004
Pastoral Counselors	Substance Abuse and Mental Health Services Administration	Core Competencies for Clergy and Other Pastoral Ministers in Addressing Alcohol and Drug Dependence and the Impact on Family Members, 2003
Peer Recovery Specialists	IC&RC	Candidate Guide for the IC&RC Peer Recovery Examination, 2016
Physicians: Addiction Medicine	American Board of Addiction Medicine	Core Competencies for Addiction Medicine, Version 2, 2012
Prevention Specialist	IC&RC	Candidate Guide for the IC&RC Prevention Specialist Examination, 2016
Psychiatric Nurses	American Psychiatric Nurses Association	Psychiatric-Mental Health Nurse Essential Competencies for Assessment and Management of Individuals at Risk for Suicide, 2015
Psychiatric Nurses	National Organization of Nurse Practitioner Faculties	Psychiatric-Mental Health Nurse Practitioner Competencies, 2003
Psychiatric Rehabilitation Practitioners	Psychiatric Rehabilitation Association	Certified Psychiatric Rehabilitation Practitioner Knowledge, Skills & Abilities, 2014

Psychiatrists	American Board of Psychiatry and Neurology	Child and Adolescent Psychiatry Core Competencies Outline, 2011
Psychiatrists	American Board of Psychiatry & Neurology	Psychiatry Core Competencies Outline, 2011
Psychologists	American Psychological Association	Competencies for Psychology Practice in Primary Care, 2015
Psychologists	American Psychological Association	Competency Benchmarks in Professional Psychology, 2012
Registered Behavior Technician	Behavior Analyst Certification Board	Registered Behavior Technician Task List, 2013
Social Workers	National Association for Children of Alcoholics	Core Competencies for social workers in addressing the needs of children of alcohol and drug dependent parents
Social Workers	Council on Social Work Education	Advanced Social Work Practice Competencies in Mental Health Recovery,
Social Workers	Council on Social Work Education	Education Policy and Accreditation Standards for Baccalaureate and Master's Social Work Programs: Competencies, 2015