Learning to work with clients : a quantitative study on educational pathways for social workers working with psychotropic medication

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ABSTRACT

The current study explored how clinical social workers working with patients who are

prescribed psychotropic medication went about developing the knowledge and skills to work

with the population. The study identified training activities that contribute to the development of

practice skills, and examined the relationship between these activities and self-rated practice

competency levels. A snowball sample of 28 clinical social workers whose scope of practice

included collaborating on the care of patients who are prescribed psychotropic medications were

recruited. Participants completed a brief, anonymous, online questionnaire that was developed

for the current study, and informed by the work of Bentley, Walsh, and Farmer (2005).

The major findings indicated that along with years of experience in the field, the number

of settings worked had the greatest effect on the social workers' self-rated competency levels.

Among 34 choices, participants most frequently selected "consultation with psychiatrists",

"interactions with clients", "research done on the internet", and "peer consultation" as most

useful. Finally, this study concluded with recommendations for training and implications for

future research.

LEARNING TO WORK WITH CLIENTS: A QUANTITATIVE STUDY ON

EDUCATIONAL PATHWAYS FOR SOCIAL WORKERS WORKING WITH

PSYCHOTROPIC MEDICATION

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CHAPTER I

Introduction

In order to work effectively with clients who are prescribed psychotropic medications, practicing clinical social workers must be aware of these medications, their effects on their clients, and the influence they have on the "counseling environment" (Dziegielewski & Leon, 1998, p. 31). Since the 1960's during the deinstitutionalization movement, social workers have been increasingly asked to take a more active role with clients who are prescribed psychotropic medications in the community (Bentley & Walsh, 2006). More recently, over the past 20 years, the use of psychotropic medications as a mode of treatment within the mental health field has expanded exponentially in accordance with higher prescription rates and a wider variety of medication options (Dziegielewski& Leon, 1998; Cohen, 2010). Working with clients who are prescribed psychotropic medications is a practice reality for clinical social workers.

Clinical social workers play an important role in the client's medication experience and are uniquely positioned to "assess and intervene at all levels of the clients' biopsychosocial functioning" (Dziegielewski& Leon, 1998). Social workers make up 60 percent of the mental health services workforce and are the largest mental health services provider group in the United States (NASW Mental Health Statistics, 2013). Clearly, working with medicated clients is within the scope of practice of many clinical social workers, particularly those practicing in mental health settings. Therefore, the importance of acquiring the specialized knowledge and skills to work with this population cannot be overestimated.

Despite 40 years of research-backed recommendations, however, there is no coherent national strategy for educating social workers on this topic (Hankoff & Galvin, 1968; Thale, 1973; Libassi, 1990; Wise, 1986; Dziegielewski & Leon, 1998; Bentley, Farmer, Phillips, 1991; Berg & Wallace,1987; Bentley, Walsh, & Farmer, 2005; Bentley, Walsh, & Farmer, 2006; Matrion & De Chillo, 1984; Bentley & Walsh, 2006; Moses and Kirk, 2008; Moses, 2008; Cohen, 2010). Information on psychotropic medications in formal social work education programs is limited as are professional continuing education courses (Dziegielewski & Leon, 1998; Dziegielewski, 2009; Bentley *et al.*, 2006; Austrian, 2005). Research into the psychopharmacology training that social workers have access to at both levels (student and professional) indicates that these practitioners feel this training must be expanded and over the past 15 years have called for more (Dziegielewski & Leon, 1998; Bentley *et al.,* 2006; Dziegielewski, 2009). Subsequently, clinical social workers whose scope of practice includes the treatment of medicated patients must find their own ways to develop practice competencies in this area (Berg & Wallace, 1987; Dziegielewski, 2009; Bentley *et al.*, 2006; Davis-Berman & Pestello, 2005).

This research stems from my own experience as a clinical social work student. In my clinical internships I have found that work with clients, particularly in inpatient settings, required knowledge of the psychotropic medication they were prescribed, collaboration with their psychiatrist, and watchful monitoring of clients' symptoms and side effects from medications. Yet, graduate level social work coursework was not offered in preparation for this practice reality. As I prepare to enter the profession realm, I have wondered how clinical social workers acquire the knowledge and skills to work with medicated patients. Furthermore, what pathways to acquiring this knowledge are most effective?

This aim of this study is to explore how clinical social workers whose scope of practice includes working with patients who are prescribed psychotropic medication go about developing the necessary knowledge and skills to work within this specialty. The goal is to identify formal and informal activities and learning opportunities that contribute to the development of practice skills in this area and to examine the relationship of these activities to perceived practice competency.

The methodology for this study is informed by the work of Bentley *et al.* (2005) whose national survey of National Association of Social Workers (NASW) enrolled practitioners identified the medication-related activities performed in day-to-day work with patients. This study and the activities it outlined, in conjunction with a review of historical literature, led Bentley and Walsh (2006) to define five ethically sound roles that social workers can and should perform when working with medicated clients. These include: "consultant, counselor, monitor, advocate, and educator" (Bentley & Walsh, 2006, p.15). For purposes of this study, these roles were used to assess participants' self-ratings of development and have been framed as "practice competency domains". The relationships between these perceived practice competencies and the formal and informal learning opportunities, which Bentley *et al.* (2006) have termed "knowledge sources," were examined (p. 36).

In order to assess this, a sample of 28 clinical social workers whose scope of practice included collaborating in the care of patients who are prescribed psychotropic medications (heretofore referred to as medicated clients) were recruited using snowball sampling. These volunteering participants completed an online survey developed for this study, which consisted of multiple choice questions and one narrative response which gathered information in the following areas: 1) scope of practice, 2) academic preparation, 3) perceived practice competency,

4) personal pathways to knowledge development, and 5) personal characteristics. The survey included a list of Likert items which formed the rating of self-assessed practice competency. These ratings where assessed in conjunction with the knowledge sources that the participants identified access to in order to assess which factors contributed to practice competency development. Findings informed recommendations regarding the development of curricula and supports the need for practice standards in this area. They can also help to better define the depth to which social worker practice with this population and can speak to the resources currently available to develop the necessary skills.

The following chapters detail the process, design, and results of this study. Chapter II is a review of relevant literature including a definition of psychotropic medications, their history, the history of the role of social workers with medicated patients, the history of social work education around psychotropic medications and finally, the current state of the social work role and scope of practice regarding these medications. The chapter will also lay out the definitions of the terms used to formulate this study's survey. The Methodology section, Chapter III, gives an overview of survey construction, participant recruitment, and survey procedures. Findings are presented in Chapter IV and implications of the findings for clinical social work education and practice as well as conclusions are discussed in Chapter V.

CHAPTER II

Literature Review

Overview

Clinical social workers are on the front lines of co-treating clients who are prescribed psychotropic medications. Their unique perspectives on social systems, their person-in-environment approach, and in particular, their focus on the client's right to self-determination make them uniquely suited to offer clients special advocacy and support with regard to psychotropic medications (Dziegielewski, 2009). Social workers make up 60 percent of the mental health services workforce (NASW Mental Health Statistics, 2013). Since the prescription of psychotropic medication to treat mental health issues continue to rise, it is even more important for social workers as the largest group of mental health service providers in the United States to be knowledgeable about the medications prescribed for their clients and to have the skills needed to work with this population (Hughes & Cohen, 2010; Gu, Dillon & Burt, 2010). Yet, the formal training offered if limited for social workers on psychopharmacology and their role with clients prescribed or looking to be prescribed medication (Bentley & Walsh, 2006). The following literature review is presented in four sections. A description of psychotropic medications and their uses and side effects is presented first followed by the history of the social workers' role with medicated patients, the history of social work education around this topic, the current state of social workers' roles with medicated clients, research that has helped to define

the current state of this role and finally, the influences that affect a social worker's knowledge of psychotropic medications.

Psychotropic Medications: Definition and Impact

Spiegel (2003) notes that psychopharmacology refers to the study of drugs that affect a person's thoughts, emotions and/or behaviors. Typically, psychotropic medications are used to treat symptoms associated with mental illness by altering chemical levels in the brain. This alteration in turn can help increase or decrease the prevalence of certain thoughts, emotions, or behaviors associated with a given mental illness and can help significantly improve an individual's level of functioning (Spiegel).

Categories of medication: There are five predominant categories of psychotropic medications; antipsychotics, antidepressants, mood-stabilizers, anti-anxiety medications and psychostimulants. Antipsychotics are used to reduce psychotic features for diagnoses such as schizophrenia. Antidepressants are used for increasing serotonin levels and addressing symptoms most often associated with depression and various anxiety disorders. The Center for Disease Control report of 2010 (Gu, Dillon & Burt) cites antidepressants as the most commonly utilized prescription drug among adults between the ages of 20 and 59. Mood-stabilizers such as Lithium are used to treat bipolar disorders by decreasing the intensity of perceived emotions and mood changes. Anti-anxiety medications are used for reducing stimulation in areas of the brain thought to be connected with emotions, and are also used for reducing seizure activities (Bentley & Walsh, 2006). Finally, psychostimulants are used to treat Attention-Deficit Hyper-activity Disorder, which the CDC (2010) notes are the most commonly utilized prescription drugs amongst adolescents (12 – 19 year-olds). There is significant overlap between medication categories and the diagnoses they are prescribed for; however prescribing psychotropic

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medications "off-label" is still a complicated yet often utilized decision (Cheung, Sacks, Dewa, Pong, & Levitt, 2008; Spiegel, 2003).

Negative side effects: Psychotropic medications, despite their many positive effects, can have significant negative side effects and their efficacy may vary based upon symptom presentation and severity. Some adverse physical side effects include; anticholingergic effects (i.e. dry mouth, blurred vision, constipation), extrapyramidal symptoms (relating to inhibited muscle functioning and involuntary body movements such as those associated with tardive dyskinesia), neuroleptic malignant syndrome (a serious and potentially fatal effect that creates instability in the autonomic nervous system), orthostatic hypotension (drop in blood pressure), sedation, changes in sexual functioning, tachycardia (increased heart rate), and weight gain (Bentley & Walsh, 2006, p. 78).

Discussion: It is argued by Bentley and Walsh (2006) as well as Hughes and Cohen (2010) that psychotropic medications can impact those who use them on many levels including biological, chemical, and neurological. While these medications have the potential to improve social functioning and relatedness, decrease psychotic symptoms, and reduce anxiety and the severity of intense emotions, they can also make psychological or behavioral symptoms more severe, increase suicidal thoughts, decrease perceived efficacy, and increase social stigma (Cheung *et al.*, 2008; Spiegel, 2003).

It is important to note that positive changes as well as adverse effects do not exclusively affect the brain and body. Taking psychotropic medications can also have relational consequences as medications can "equally affect the psychological and social concerns of clients and their significant others" (Bentley & Walsh, 2006, p.7). As such, both positive and negatives drug effects can spill over to affect the prescribed individuals and their relationships. In light of

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its far reaching consequences, clinical social workers today must be prepared to assist their clients and their family members to process the many challenges faced by those prescribed with psychotropic medication, upon being diagnosed with a mental illness.

History of the Social Work Role with Medicated Patients

The onset of the deinstitutionalization movement in the 1950's marked the beginning of modern social workers' role with medicated patients. The role of social work expanded exponentially as the introduction of psychotropic medications made it possible to treat and care for previously hospitalized psychiatric patients in the community (Bentley, 2004; Kensinger, 2007; Hankoff & Galvin, 1968; Bentley, *et al.*, 2006). Patients' mental health care and medication monitoring, once strictly in the hands of physicians and nurses, are now increasingly becoming part of social workers' responsibilities as they become the primary providers of outpatient community mental health services (Hankoff & Galvin). In this expanded role with the care of medicated patients, social workers need to enhance their knowledge about psychiatric/psychotropic medications, engage in increased communication with prescribing physicians, and develop the ability to understand side effects of prescribed medication in order to educate families accordingly (Hankoff & Galvin, Bentley, 2004; Austrian, 2005).

Role expansion: The early literature on the expanding role of social workers with medicated patients emphasized collaboration with physicians and a knowledge of psychotropic medications in order to assist the physician with client compliance to the prescribed regime (Weissman, 1972). However, deinstitutionalization was not the only factor that contributed to the expanding role of social workers with medicated patients; during the same period that social worker's employment rates were on the rise in mental health, the number of practicing psychiatrists was shrinking (Bentley & Walsh, 2006). In 1972, the number of social workers

employed in mental health was 17,687; twenty years later that number more than doubled to 41,326 (Bentley & Walsh, 2006). In this same 20-year period of massive expansion for social workers in mental health, there was conversely more than a 50 percent decrease in the number of psychiatrists in the field. In 1972 psychiatrists made up 14.1% of those employed in the mental health field and by 1994 that number had dwindled to 5.9% (Bentley & Walsh, 2006). Social workers were providing mental health care to an ever increasingly number of clients with fewer psychiatrists available for consultation, thereby necessitating an even greater expansion of the social work role with medicated clients (Bentley, 2004; Kensinger, 2007; Bentley & Walsh, 2006). Now social workers are the largest mental health service provider group in the United States, and we make up 60 percent of the mental health services workforce (NASW Mental Health Statistics, 2013).

Influences affecting changes in social work roles: Starting in the 1980s there was an exponential increase in medication options for psychiatric patients. This increase pushed social workers, now the prominent clinical work force in community mental health centers, to expand their knowledge and roles in the treatment of medicated patients. More medication options meant greater options for consumers, more side effects and potential benefits to consider, and brought an increase in the number of prescriptions being written (Bentley *et al.,* 2006).

In the 1960s the social work literature regarding medicated clients focused on the assistance clinicians usually provided to prescribing physicians (Austrian, 2005; Bentley *et al.*, 2005; Hankoff & Galvin, 1968). In the 1970s, literature on the social work role expanded to include the importance of social workers being educated about how and why it is important to maintain compliance with medication and to consider how the client's personal views of medication can affect compliance (Thale, 1973; Weissman, 1972). Literature from 1980s during

the proliferation of medication options, required clinical social workers to embrace education

focused on training about specific medications, their side effects, and on expanding their roles

with regard to monitoring side effects (Wise, 1986). Bentley and Walsh (2006) note that the

1980s brought a shift in thinking about the social work role with medicated clients from the early

vision of a social worker as a "physician's assistant" to the more value appropriate role as an

"advisor" to the client (p. 212).

As the medical model began to recognize and shift towards patient collaboration, the

unique perspectives and client relationships social workers could offer led to expanded

responsibilities for them with their clients to include consultation, education, monitoring, and

most importantly advocacy for client rights to receive and refuse medications (Berg & Wallace,

1987; Matorin & De Chillo, 1986; Wise, 1986). The recognition by the medical field of the

importance of social work values such as self-determination and assessment and intervention

based on a person-in-environment foundation, facilitated an increase in the demand for social

workers in settings where psychotropic as well as other types of medications were being

prescribed (Berg & Wallace, 1987; Bentley, *et al.*, 2006; Bentley & Walsh, 2006); Matorin & De

Chillo, 1986; Wise, 1986; Dziegielewski, 2009).

The social work literature of the 1990s brought increased focus to the psychological and

social impacts of taking psychotropic medication, and how this could be experienced by the

client in a myriad of ways, including the potential for social stigma (Libassi, 1990;

Dziegielewski & Leon, 1998; Bentley and Walsh, 2006; Bentley, 2004). The 1990s also brought

what Bentley *et al.* (2006) call a "knowledge explosion" in neuroscience, genetics, and biology

that "revolutionized" not only psychiatry, but social work as well (p.212). Scientific

developments that started in the 1990s continue to be explored today and include information on

brain development, effects of trauma on brain functioning and development, genetic predispositions for diagnoses, functioning of neural pathways and their relationship to addiction and pleasure sensations, and biochemical changes that produce physiological as well as emotional response to stimuli (Bentley and Walsh, 2006; Bentley, 2004).

This explosion of scientific knowledge has changed how we understand mental health diagnoses, environmental factors, and effective treatment and interventions for clients. Knowledge continues to expand at exponential rates in all fields, particularly neuroscience, biology, and genetics, and in the field of clinical social work as a response. As practitioners, clinical social workers are ethically bound by the NASW Code of Ethics to "continually strive to increase their professional knowledge and skills and to apply them in practice" (NASW, 2005). Similarly, the Canadian Association of Social Workers (CASW) holds the same ethical standard, thus expansion of knowledge around psychotropic medications is not only an international practice reality, but also an ethical obligation (2005).

Summary: In contemporary practice, there is an ethical imperative for clinical social workers to have at least a basic knowledge of psychotropic medications in order to effectively work with clients at this time of psychotropic drug prescription expansion (Bentley, Farmer, & Phillips, 1991; Bentley, *et al.*, 2005, Dziegielewski & Leon, 1998; Dziegielewski, 2009; Bentley, *et al.*, 2006; Berg & Wallace, 1987; Bentley and Walsh, 2006; Libassi, 1990). Indeed, Dziegielewski and Leon (1998) note that when social workers are "knowledgeable or know where or how" to get information on psychotropic medications, they are able to engage in more "effective treatment planning and better client services" for their patients and families (p. 38). The development and expansion of this role has been documented for forty years and the importance of social workers' unique insights and client-focused perspectives have been shown

to be important for the effective treatment and advocacy for clients and their rights.

Social Work Education on Psychotropic Medications

Clinical social workers play a critical role in the client's medication experience; they are uniquely positioned to "assess and intervene at all levels of the clients' biopsychosocial functioning" (Dziegielewski & Leon, 1998). Research examining the role of social workers with medicated patients has argued for an increase in psychopharmacology education for social workers (Hankoff & Galvin, 1968; Thale, 1973; Wise, 1986; Dziegielewski & Leon, 1998; Bentley, Farmer, & Phillips, 1991; Bentley, *et al.*, 2005; Bentley, *et al*., 2006; Bentley & Walsh, 2006; Berg & Wallace, 1987; Bentley and Walsh, 2006; Libassi, 1990; Bentley, 2004; Austrian; 2005). Formal education is needed to develop clinical social workers' competency around the use of psychotropic medications and the influences of these medications on the patient, the practitioner, and the "counseling environment" (Dziegielewski & Leon, 1998, p. 31; Bentley *et al.*, 2006; Moses & Kirk, 2008).

Research on social work education: Bentley *et al.* (2006) in their comprehensive review of social work education on psychopharmacology found that most social workers learned about psychotropic medication from sources other than social work literature. Most writing referenced the role social workers should play, but did not go into specifics about medication use and side effects. It was not until the 1990s that social workers became more active in writing about specific psychotropic medications and interventions that their colleagues should be aware of (Dziegielewski & Leon, 1998; Bentley *et al.*, 2006; Bentley & Walsh, 2006). Curricula began to emerge in the 1970s and 1980s at the bachelors and masters level of social work training, but this was highly limited (Bentley *et al.*, 2006; Austrian, 2005; Bentley, 2004; Dziegielewski, 2009). Neither the Council on Social Work Education (CSWE) or the Canadian Association for

Social Work Education (CASWE) currently require MSW programs to offer courses on psychopharmacology as part of their accreditation standards (CSWE, 2008; CASWE, 2012). Despite 40 years of research-backed recommendations, there is no coherent national strategy in the United States or Canada for educating social workers on this topic (Hankoff & Galvin, 1968; Thale, 1973; Libassi, 1990; Wise, 1986; Dziegielewski & Leon, 1998; Bentley, Farmer, Phillips, 1991; Berg & Wallace,1987; Bentley e*t al.*, 2005; Bentley e*t al.*, 2006; Austrian, 2005; Dziegielewski, 2009; Bentley, 2004; Matrion & De Chillo, 1984; Bentley & Walsh, 2006; Moses and Kirk, 2006; Moses 2008).

The National Institute of Mental Health response: The National Institute of Mental Health's (NIMH) requested that the CSWE look at the psychopharmacology curriculum available to social work students. In response, Libassi (1990) analyzed the course offerings of accredited MSW and BSW programs. Of the 59% of institutions responding, Libassi (1990) found that less than half (44%) reported some content in psychopharmacology, yet 100% of the programs' staff believed that content on psychopharmacology should be included in social work curriculum. Fifteen years later, another group took up the challenge of assessing psychopharmacology curricula in schools of social work. Bentley *et al.* (2006) were contracted by a small number of schools to present their proposals for psychopharmacology curriculum. Similar to their predecessors' findings, their study indicated that time alone has not changed the way social workers are educated, and only a small percentage of the schools' curricula addressed psychopharmacological content.

Continuing education: Continuing education for social workers about psychotropic medication has been examined by Dziegielewski and Leon (1998) who assessed participants' knowledge of medications and experience with continuing education on this topic. Of the 135

respondents, 115 "agreed" that social workers need to understand the use of psychotropic medications as "part of the counseling process" (Dziegielewski & Leon, 1998, p. 32). Furthermore, 98.5% of participants "felt strongly" that some form of education around psychiatric medication use and its impact on patients and practitioners should be mandated which further demonstrated the need to "formally train social workers on medication content" (Dziegielewski & Leon, 1998, p.38). Similarly, Bentley *et al.* (2005) found in their national survey of NASW social workers that participants called for increased "educational forums" on specific psychiatric medications for social workers practicing in the field. However, since these important early studies, only a smattering of literature addressed and assessed changes in social work curriculum and continuing education in the scholastic literature (Dziegielewski, 2009; Bentley *et al.*, 2006).

NASW and CASW practice standards: Almost all of the NASW and Canadian Association of Social Workers (CASW) practice standards promote the need for social workers to engage in effective referral and interdisciplinary collaboration around medication use. However, specific educational requirements on psychopharmacology training and education are not included (NASW, 2005; CASW, 2005). Consequently, clinical social workers involved in the treatment of medicated patients must find their own way to develop practice competencies in this area (Berg & Wallace, 1987; Bentley *et al.*, 2006). This evidences that there is still more to be considered regarding the needs and views of social workers on their knowledge acquisition process in order to develop competency in working with clients who are prescribed psychotropic medication.

Current Social Work Role and Scope of Practice with Medicated Clients

Forty years of research has outlined, discussed, and defined the expanded roles that clinical social workers have with medicated patients. Early work defined these roles on a theoretical basis; since the 1980s, research has taken up the challenge of analyzing social work roles from the perspective of how accurately they reflect real-life practice, and how social workers perceive these roles and activities. Berg and Wallace (1987) looked at how attitudes towards medication could affect knowledge development. Dziegielewski and Leon (1998) looked at continuing education and also analyzed comfort with regard to roles and activities performed with medicated clients. Bentley *et al.* (2005) surveyed the actual activities that clinical social workers perform when co-treating medicated psychiatric patients.

Medication related activities: Bentley *et al.* (2005), whose methods inform this study, conducted a national survey of NASW-enrolled clinical social workers to identify the psychiatric medication-related activities performed in their day-to-day work with patients. Seven activities for clinical social workers emerged in their analysis of daily tasks. These included: discussing with patients their feelings about taking psychiatric medication and advocacy, educating clients on combined effects of medication and psychosocial interventions, consulting with patients and their families about problems with medication and how to talk to their physicians, monitoring compliance, assisting patients to consider pros/cons of medication use, discussing possible side effects, and making referrals to a psychiatrist based on thorough biopsychosocial assessments of patients (Bentley *et al.*, 2005).

The activities of advocacy, assessment and referral, and interdisciplinary collaboration, were rated as "essential" for work with medicated clients. They were described as "frequently performed", and "highly appropriate" (Bentley *et al.*, 2005 p. 299). These findings led Bentley

and Walsh (2006) to propose six ethically prescribed roles that social workers can and should perform when working with medicated clients: consultant, counselor, monitor, advocate, educator, and researcher (p. 14). While there is some overlap between the roles/practice competencies defined by Bentley and Walsh (2006), each offers a specific service to the client that is important to their medication experience. The definitions they propose serve as the operational definitions of practice competencies that clinical social workers are asked to self-rate as part of this study. However, only the first five of those roles have been isolated and framed as *practice competencies* in this study. This is done purposely to focus our investigation on the clinical social worker's practice experience with clients in the field.

Consultant role: The consultant role involves diagnostic assessment, establishing treatment goals, discussing referral for medication consultation (including exploring the patient's perspectives about how medication may or may not be helpful or desirable), and collaboration with the treating psychiatrist or prescriber (Bentley & Walsh, 2006).

Counselor role: The counselor role involves such skills as being able to validate the client's perspectives about and experience with their medications; discussing medication issues and potential barriers to progress and assisting the client with developing skills by engaging with the client in problem solving (Bentley & Walsh, 2006).

Monitor role: The monitor role includes such skills as the clinical social workers' ability to "observe and help the client observe" both the positive and negative effects their prescribed medication has on their "psychical, psychological and social" health and assisting the client to monitor their responses to the medication, including monitoring side effects, symptom presentation, and adherence to the prescribed schedules (Bentley & Walsh, 2006 p. 16).

Advocate role: The advocate role includes such skills as the ability of the clinical social worker to explore with patients their feelings about taking medication as well as to support discussions about the right to access, receive, change, and/or refuse medication. This includes having a "working knowledge" of mental illnesses, psychotropic medications, laws and regulations about medications, and patient rights (Bentley & Walsh, 2006 p. 17).

Educator role: Finally, the educator role includes such skills as the ability to provide basic information about relevant medication issues, with the goal of enhancing the patient's and family's knowledge about the roles medication may play in their treatment. To provide basic information regarding the effects and side effects they may encounter and to engage in training with clients and families about how to effectively communicate with their prescriber regarding their medication issues and needs (Bentley & Walsh, 2006).

Factors Influencing Knowledge about Medications and Practice

There are several prominent studies about the most common factors that affect access to knowledge sources about medication and work with medicated patients (Berg and Wallace, 1987; Dziegielewski & Leon, 1998; Bentley *et al.*, 2006; Dziegielewski, 2009; Libassi, 1990).

Practice setting: Berg and Wallace (1987) looked at how social workers perceive their role, their attitudes towards medication, and the factors that can affect role performance. They note that the setting in which the clinical social worker practices has a significant effect on their knowledge of and attitude towards psychotropic medication. They compare inpatient and outpatient clinical social workers and note that those who practice in inpatient settings have greater access to knowledge sources including access to psychiatrists and regular case discussions and consultations. These social workers also identify felling more "comfortable" engaging clients around medication referral and use (Berg & Wallace, 1987, p. 146).

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Access to continuing education: Dziegielewski and Leon (1998) looked at continuing education and also analyzed comfort with regard to roles and activities performed with medicated clients. Respondents reported that "comfort" with role performance increases with access to knowledge and respondents also overwhelmingly reported that they felt courses should be required as part of their continuing educational training and their formal social work degree training, after participating in such programs on psychopharmacology (Dziegielewski & Leon, 1998; Dziegielewski, 2009).

Academic curricula: Bentley *et al.* (2006) and Libassi (1990) both examined academic curricula on phsychopharmocoly written for or by social workers. Both found that formal education on psychopharmacology at the graduate level was limited and advocated for increased learning opportunities. Bentley *et al.* (2006) also found in their review of professional literature that few papers on the subject have been written for social workers and concluded that courses/curriculum on the subject in social work programs was scarce prior to the 1990s. Their review also indicated that population-specific literature, particularly the use of medications in behavioral health with children and adolescents, was even more limited (Bentley *et al.*, 2006). Their findings suggest that access to knowledge sources such as literature and course material may vary in accordance to the respondents' graduation year and their number of years of practice in the field.

Employment-based learning: Access to knowledge sources during employment such as supervision and in-service trainings are likely to increase with the number of years of work experience. Bentley *et al.* (2006) note that social workers can gain knowledge through field placements and practice classes that help clinical social workers build their skills with respect to advocating for and discussing needs with their patients; however, they also note that training in

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these areas is highly variable and lacks the consistency necessary to be effective. In their 2005 study of clinical social workers' activities around psychiatric medications, Bentley *et al.* (2005) questioned respondents about their "knowledge sources" and described them as formal or informal educational opportunities where social workers could gain knowledge about psychiatric medications (p. 297). The researchers listed "collaboration with physicians, interactions with clients, conversation with peers, professional workshops" as primary knowledge sources (p. 216). Similarly, Berg and Wallace (1987) reported that clinical social workers utilized in-service trainings, case conferences, "medical texts and articles," and formal supervision as knowledge sources for information on psychotropic medication (p. 148).

Summary and Hypotheses

A perusal of existing literature suggests that there are many pathways for social workers to access for gaining practice skills and competencies on psychotropic medications. As identified in the aforementioned discussion, various settings and pathways for skills development have been explored by different researchers (Libassi, 1990; Dziegielewski & Leon, 1998; Berg & Wallace, 1987; Bentley *et al.*, 2005; Bentley *et al.*, 2006; Bentley & Walsh, 2006). However, none of the studies have directly examined social workers' own perception of competency in the sub-specialty of co-treating medicated psychiatric patients. To address this literature gap, the following survey study has been set up to determine the correlative relationship between a social worker's knowledge sources selected (both formal and informal) and self-described level of competency.

Based on the literature reviewed, several hypotheses have been generated:

1. Among competency domains, the role of advocate will correlate positively with all respondents because this is a role social worker have been trained to perform within their scope of practice regardless of their sub-specialty and their practice-settings.

2. The number of years in the field will have a positive correlation with one's competency ratings.

3. There will be a positive correlation between settings worked and overall competency rating. Furthermore, work in inpatient settings will be positively correlated with competency ratings while work strictly in outpatient settings will not be.

4. Knowledge sources within the delineated activity groups that are most frequently selected will have a stronger relationship to competency rating.

5. The knowledge sources involving consultation will be reported most frequently.

Next, the following chapter will describe the methodology adopted for this study. The chapter will discuss the design for the study, the rational for the methodology, and the strengths and limitations of such an approach. Last, the chapter will also address this researcher's biases and interest on the project.

CHAPTER III

Methodology

Overview

In the following chapter, we will address the research design and methodological considerations for the current study. To reiterate: the aim of this study is to explore how clinical social workers, whose scope of practice includes working with patients who are prescribed psychotropic medication, develop the necessary knowledge and skills to work within this specialty. The goal is to identify activities and groups of activities that contribute to the development of skills for practice with medicated clients and their families, and to examine the relationship of these activities to perceived practice competency.

In brief: this online survey study recruited up to 28 clinical social workers whose scope of practice includes collaborating in the care of patients who are prescribed psychotropic medications. Volunteering participants completed a brief, anonymous, online questionnaire developed for the study (Appendix B). The survey included a list of Likert items which, when totaled, formed ratings for five domains of self-assessed practice competency. The online inventory took about 20 minutes to complete, during which participants were asked a series of questions about knowledge sources they have accessed in order to develop these competencies.

The methodology for this study is informed by the work of Bentley, Walsh, and Farmer (2005) whose national survey of NASW-enrolled social workers identified the day-to-day medication-related activities performed by its membership. Their study's outcomes suggested

that practice competency for working with patients prescribed psychotropic medications includes a number of roles with specific skill sets, which this research has labeled "Practice Competencies."

Formulation

As noted in the literature review, several other studies have looked at the impact of factors such as setting (Berg & Wallace, 1987), learning opportunities (Dziegielewski & Leon, 1998), and formal MSW education (Bentley, Walsh, & Farmer, 2005; Libassi, 1990). They have also inquired about the knowledge sources participants accessed, but have not looked at how these factors relate to competency which is important in real world practice.
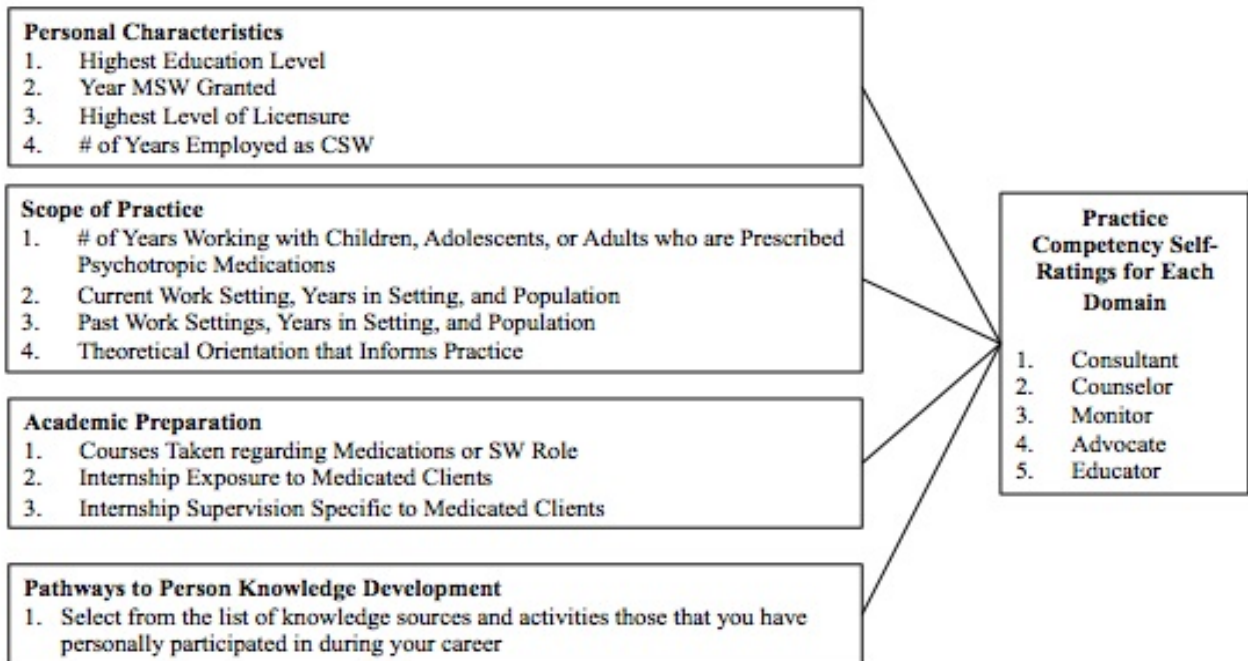
Competency has been analyzed by Bentley *et al.* (2005), yet this was done in the context of perceived competency with regard to day-to-day activities performed around psychotropic medication. Competency was shown to be related to the frequency of activity performance and perceived appropriateness of activity for a social worker, but competency was not analyzed in relation to knowledge sources accessed.

Bentley *et al.* (2005) termed the phrase "knowledge sources" and described them as formal or informal educational opportunities where social workers could gain knowledge about psychiatric medications (p. 297). For the purposes of this study, the term "knowledge sources" and the description provided by Bentley *et al.* (2005) has been used as the operational definition. These knowledge sources were then broken down into what this researcher has termed "formal and informal activity groups" to reflect additional literature and the expansion of knowledge sources since 2005. Formal learning opportunities include specific coursework offered during social work degree programs and continuing education programs where an instructor or defined curriculum is involved. Informal learning opportunities include activities such as on-the-job

training, personal inquiry, supervision, consultations, etc. where formal curriculum and profession instruction does not dictate learning. Experiential factors refer to learning that occurs over time through direct interaction with clients and work settings throughout the years of employment. These knowledge sources and activity groups have then been considered with regard to their impact on what this researcher has termed "practice competencies."

Bentley and Walsh (2006) proposed six ethically sound roles that social workers can and should perform when working with medicated clients which include: consultant, counselor, monitor, advocate, educator, and researcher (p. 14). In this study only the first five roles have been used as they refer to direct practice with clients, while "researcher" refers to the obligation social workers have to contribute to the knowledge base of their profession with specific attention to issues around psychotropic medication, which this study in its entirety addresses (Bentley & Walsh, 2006, p. 19). For purposes of this study, these five of those roles have been utilized and framed as practice competencies. These are clearly within the ethical scope of practice according to the NASW and CASW code of ethics as well as the practice standards that clinical social workers should be competent in when working with patients who are prescribed psychotropic medication (Bentley & Walsh, 2006; NASW, 2005; CASW, 2005).

This study aims to assess the relationship between competency and knowledge sources as this relationship has been proposed, but not specifically explored as a means to identify the most influential activities and activity groups that are associated with higher levels of perceived competency rating. The association between self-competency ratings and reports of knowledge sources will be examined to identify the factors that contribute to competency development. Figure 1, below shows how these aforementioned factors are hypothesized to impact competency ratings.

| Personal Characteristics |
| 1. Highest Education Level |
| 2. Year MSW Granted |
| 3. Highest Level of Licensure |
| 4. # of Years Employed as CSW |

| Scope of Practice |
| 1. # of Years Working with Children, Adolescents, or Adults who are Prescribed Psychotropic Medications |
| 2. Current Work Setting, Years in Setting, and Population |
| 3. Past Work Settings, Years in Setting, and Population |
| 4. Theoretical Orientation that Informs Practice |

| Academic Preparation |
| 1. Courses Taken regarding Medications or SW Role |
| 2. Internship Exposure to Medicated Clients |
| 3. Internship Supervision Specific to Medicated Clients |

| Pathways to Person Knowledge Development |
| 1. Select from the list of knowledge sources and activities those that you have personally participated in during your career |

| Practice Competency Self-Ratings for Each Domain |
| 1. Consultant |
| 2. Counselor |
| 3. Monitor |
| 4. Advocate |
| 5. Educator |

Research Design

The study examines factors that are associated with development of perceived practice competency in five knowledge/skill domains: consultant, counselor, monitor, advocate, and educator (Bentley & Walsh 2006). The goal is to identify knowledge sources that contribute to the development of practice skills in these areas and to examine the relationship of these activities and activity groups to perceived practice competency among a cohort of clinical social workers who are currently working with medicated patients.

Sample: A non-probability convenience sample of clinical social workers practicing in North America whose scope of practice currently involves them with medicated patients was recruited using snowball techniques. 28 volunteering social workers who agreed after reviewing the informed consent participated in an anonymous, cross-sectional survey with primarily closed ended questions and one short answer. The survey was conducted online via SurveyMonkey and took 20 minutes to complete. Data was collected using a survey tool developed by the researcher

and informed by the work of Bentley *et al.* (2005) whose national survey of NASW-enrolled social workers identified the medication-related activities performed in day-to-day work with patients (Appendix B).

Inclusion criteria: Participants were required to meet the following criteria; 1) earned MSW degree, 2) at least 4,000 hours (2 years equivalent) of work experience post MSW, 3) at least 1 year of clinical experience working with patients who are prescribed psychotropic medication, 4) identify their mode of practice as clinical social work, 5) identify their field of practice as mental/behavioral health, 6) currently work with patients who are prescribed psychotropic medication, and 7) read and write in English.

Exclusion criteria: Social workers who did not identify their practice as clinical or their field as mental/behavioral health were excluded. Similarly, those who did not meet the experience requirements or were not currently working with patients prescribed psychotropic medications were not included.

Recruitment Procedures

A non-probability convenience sample was gathered using snowball techniques. Social workers known to the researcher were contacted about the study using an invitation email. These contacts were then asked to pass on the recruitment email to colleagues who meet study enrollment criteria.

The recruitment email contained a brief description of the study and a link to the anonymous online survey. No direct contact with the researcher was required in order to participate. This recruitment technique was chosen to enhance feasibility given time and resource constraints. Recruitment was conducted for 4 weeks after the receipt of Human

Subjects Review Approval (Appendix A). Respondents who completed the survey and submitted it within that time frame were included in the study.

Ethics and Safeguards

      Risks of participation: The nature of this survey is to explore perceived practice competency and identify knowledge sources accessed to develop competency. There was a potential for participants to feel conflict about discussing their development within the practice competencies, particularly if they did not feel that they had reached their desired level of development. It was also possible that participants could feel pressure to rank their development at a higher level due to personal pressure as they were currently working with medicated clients. To account for this, survey instructions emphasized that each participant's journey to skill development and knowledge acquisition is different and that there are no right or wrong answers when rating self-development or knowledge sources accessed.

      Participants were offered access to additional information about specific skills, skills development, interventions, and knowledge that might assist them with further development in this area of practice. A list of resources was provided at the end of the survey that participants could choose to print or save as a PDF. These resources included relevant literature, links to NASW ethics and standards, and a link to the NASW continuing education webpage where participants could look for training opportunities in their area on psychotropic medication and working with clients prescribed them (Appendix B).

      Benefits of participation: Participants did not receive any tangible benefits for participating in this study. Participants could benefit from the insight gained through the self-assessment of their practice competencies. They could also benefit from reflecting on their own personal journey. This introspection was aimed at allowing participants to be more aware of

their own learning style and needs. Participants could gain satisfaction in the knowledge that the data collected in this study could be used to justify further research directed toward improving the educational opportunities of clinical social workers who work with patients prescribed psychotropic medications.

Voluntary nature of participation: Participation in this study was entirely voluntary. The participant could choose not to open the survey linked to the recruitment email. Participants could also choose not to agree to the Informed Consent, skip any question they wish, and choose not to submit the finished survey. Once the participant choose to submit the survey and associated Informed Consent, their data could not be removed from the study as the data was anonymous and it was not possible to find and remove their completed survey.

Informed consent procedures: Participants had an opportunity to review and print a copy of the Informed Consent.   After reviewing the informed consent, they were asked to agree or decline to participate in the study.   To consent, the participant checked the "I AGREE" box. Once the participant agreed to the informed consent, they were directed to the survey. Those who declined participation did do so by selecting "I DO NOT AGREE." Selecting this option automatically took the participant to an exit screen which thanked them for their time and interest and informed them that they are not eligible for the study.

Precautions taken to safeguard confidential and identifiable information: Data for this study were collected anonymously through an online survey using SurveyMonkey. In order to protect each participant's identity, data was gathered without tracking names, e-mails or IP addresses. Secure Sockets Layer (SSL) encryption has been enabled to further protect participant information using server authentication and data encryption.

Participants' data was associated with an automatically generated code number, therefore the data gathered through this survey preserved anonymity to the researcher as well as to the research advisor and data analyst who also handled this data. Furthermore, the anonymous data has been and will continue to be presented in aggregate form during MSW thesis presentations and publication.

All electronic data will be stored for three years on password protected file on a personal password protected laptop, accessible only to the researcher, until which time it will be destroyed according to Federal guidelines. Furthermore, this researcher's laptop has been equipped with antivirus and antispyware software for the protection of electronic data. Any physical documents have been stored in a locked cabinet in the researcher's possession and will be kept for the minimum three years as required by Federal guidelines and then destroyed. If the data are needed for ongoing research after the 3 years, they will be maintained as described above and will be destroyed when no longer needed for research.

Human Subjects Review Board: The Human Subject Review Board (HSRB) at Smith College, Northampton, MA. approved this study after assuring that all materials met the Federal and college standards for protection of human subjects (Appendix A).

Data Collection

Overview: Participants could complete the survey at their convenience and in a location of their choosing that had a computer and internet access. The survey was offered through SurveyMonkey on a dedicated webpage using SSL encryption. This encryption ensures the protection of data collected through this site. Once collected, data was downloaded into an excel spreadsheet. After the data had been gathered, transferred, and reviewed, the survey was removed from the internet.

The survey took approximately 20 minutes to complete and must have been completed in one sitting as data could not be saved and accessed during a subsequent session. Participants could, however, choose to close or exit the survey and start from the beginning at a later time, during the 4 week availability window.

Participants were directed to click on the survey link which was embedded in the recruitment email. Once the link was selected, a screen opened containing a brief description of the study as well as the inclusion criteria screening questions. If the potential participant answered "No" to any of the inclusion criteria questions, they were directed to a screen thanking them for their interest and explaining that they were not eligible to participate in the study.

Participants who meet all of the inclusion criteria were automatically directed to a screen informing them that were eligible to take the survey. This screen also displayed the electronic Informed Consent (Appendix B). On this screen, they were advised to print or save the Informed Consent for their records. Each participant was asked to read the Informed Consent carefully and indicate their consent by selecting the electronic box, "I AGREE." Once they had agreed, they advanced directly to the survey questionnaire (Appendix B). If the participant chose to click the electronic box, "I DO NOT AGREE" they were directed to a screen thanking for their time and interest, and informing them that were not eligible for the study.

The online survey consisted of multiple choice questions and one narrative response which gathered information in the following areas: 1) scope of practice, 2) academic preparation, 3) perceived practice competency, 4) personal pathways to knowledge development (knowledge sources), and 5) personal characteristics.

During the survey participants could choose to skip a question or exit the survey by selecting "Done" on the screen. If they selected to exit the survey they were directed to a

"Thank You" screen acknowledging their participation and thanking them for their time and interest. Once the survey was submitted, when the participant selected "SUBMIT" on the final screen of the survey, they were directed to a screen thanking them for their participation and offering them a chance to review and print a list of further resources. Once the participant selected "Submit" their data could not be removed from the study as their information was anonymous and it was not possible to find their completed survey in order to remove the data.

After exiting the survey the participant had no further obligation to the study and was not contacted again. The researcher's name and contact information were included in the Informed Consent should a participant wish to contact the researcher with questions or concerns during the data collection time frame.

Quantitative measures: After answering 6 screening questions to determine eligibility and agreeing to the letter of consent described above, participants entered into the primary section, a 35 -item questionnaire including open-ended, multiple choice, and one narrative response (Appendix B), including the areas listed below.

Personal characteristics: These nine questions covered demographic data as well as experiential factors including years in the field, highest degree in social work obtained, and license level (for those practicing within the United States to which it applied).

Scope of practice: Berg and Wallace (1987) noted in their study that the setting in which the clinical social worker practices has a significant effect on their knowledge of and attitude towards psychotropic medication. Questions in this section therefore probed into the participants' scope of practice within employment experience and asked for the type of settings the participant has worked in, both past and present (inpatient, outpatient, private practice, etc), as well as the number of years each position was held and the population with which they

30

worked. Population was included due to the fact that the bulk of the literature on social work role with medicated patients focuses on medication use with adults, leading to idea that it could be possible that clinical social workers who practice primarily with children there have less formal education around psychotropic medications (Bentley, Walsh, & Farmer, 2006).

Academic preparation: Literature indicates that training on psychotropic medications and social works role with these clients in formal social work education programs and professional continuing education courses are limited (Dziegielewski & Leon, 1998; Bentley, Walsh, & Farmer, 2006). This section asked participants about their formal coursework and curriculum they have had access to throughout their degree programs as well as in their employment and internship experiences.

Self-ratings of practice competency: Bentley and Walsh (2006) defined the five ethically sound roles that social workers can and should perform when working with medicated clients which have been framed for the purposes of this study as the five practice competency domains. Participants were asked to rate their development using a Likert scale within each of the following domains; consultant, counselor, monitor, advocate, and educator (2006, p. 14). Options for development levels included; none, emerging, basic, intermediate, and advanced. Participants were encouraged to answer honestly and it was emphasized that each journey is personal in order to account for potential response bias. These ratings were used to assess perceived competence and then where analyzed in conjunction with knowledge sources and experiential factors that were hypothesized the influence competence.

Learning opportunities: This section asked participants to identify specific knowledge sources and activities they accessed in reference to development for each practice competency. This list is as comprehensive as possible and brings together formal and informal learning

activities outlined by Berg and Wallace (1987), Dziegielewski and Leon (1998), Bentley *et al.* (2005), and Bentley and Walsh (2006). The list has also been expanded upon to reflect new learning opportunities that have increased due to technology and research within the field.

Data Analysis

Responses were examined to explore which factors are most highly correlated with higher practice competency ratings as well as which areas of training/experience may need to be expanded upon. Explanatory (predictor) variables in the study are divided into 4 groups, as depicted in Figure 1 above; 1) scope of practice, 2) academic preparation, 3) personal pathways to knowledge development, and 4) personal characteristics. Personal characteristics have been collected for further stratification of the sample into groups, including years of experience with medicated patients.

Explanatory variables have been examined to explore a correlation between perceived practice competency ratings and formal and informal activity groups, years of practice, and academic preparation. Bivariate analysis strategies have been used to examine the strength of the relationship between each of the explanatory variables and perceived practice competence ratings.

Strengths and Limitations of the Methods

Strengths: A primary aim of the study was to develop and pilot a methodology for examining self-ratings of practice competency among clinical social workers co-treating medicated clients. In this regard, the study was innovative and successful. The methodology that was piloted was based on a thorough review of the relevant literature, and informed by the work of Bentley *et al.* (2005).

Limitations: The primary limitation of this study is the small response size, which prohibited in-depth interrogation of the data. The 4 weeks allotted to collect data was insufficient for reaching a statistically viable sample and it is recommended that more time be allotted in future revision of this study.

Methodological bias: The study's methodology had some bias. First, selection bias was generated by the fact that the sample for this study was relatively small in size and nonrandomized. Further, only those with access to a computer with internet, who were able to navigate SurveyMonkey, and who could read and write in English could participate. Finally, due to the small sample obtained after the first two weeks and the need for greater response the sample was expanded to include a North American sample, including Canada rather than strictly a sample of respondents from the United States. In the end this actually helped to diversify the sample; however as several aspects differ with regard to clinical social work role and training that validity of some data relationships, for example licensure, will need to be considered in this context.

The following chapter, Chapter IV, will present the findings of the current study. Findings regarding each practice competency domain will be detailed followed by the results of correlational tests and descriptive data relating to each hypothesis.

CHAPTER IV

Findings

Overview

This study examined clinical social workers self-ratings of perceived competency in five specific competency domains for working with medicated and explored whether there were relationships between these ratings of competency (both for each domain as well as overall) and the knowledge sources and activities they have engaged in throughout their. The existence and strength of relationships between competency ratings and experiences were explored to determine whether specific learning opportunities correlated with higher perceived competency ratings.

Participants completed an on online survey (Appendix B) developed by the researcher and informed by the work of Bentley, Walsh, and Farmer (2005). The survey probed into 4 areas that the literature indicated had an effect on clinical social workers skill development with this population; 1) personal characteristics, 2) scope of practice, 3) academic preparation, and 4) knowledge sources and activities (Bentley & Walsh, 2006; Bentley *et al.*, 2005; Dziegielewski & Leon, 1998; Dziegielewski, 2009). Finally, participants were asked to respond to an open-ended question regarding the activities and knowledge sources they perceived to be the most influential in their development of skills and competency for working with medicated patients.

This chapter will present the major findings of this study. It will use descriptive as well as correlational data to present findings beginning with a description of the sample followed by a description of the perceived practice competency. This will be followed by the findings on each of the four focus areas of the survey 1) personal characteristics, 2) scope of practice, 3) academic preparation, and 4) knowledge sources and activities accessed and the associated hypotheses and exploratory questions in each focus area.

Personal characteristics and the factors associated with this will be reported first, followed by a description of findings within the scope of practice area. Scope of practice includes factors such as years worked with specific populations (child, adolescent, adult), practice setting experience, and theoretical orientation. The academic area focuses specifically on courses offered in BSW and MSW programs, and experience working with medicated patients during clinical internships. Rounding off the four survey areas of questioning, knowledge sources and activities is the largest section of findings, as it accounts for the largest amount of data collected through the survey. This section looks at the relationship between perceived competency rating and specific activities as well as seven commonly reported groups of activities. Finally, the chapter will review qualitative responses collected from the open-ended question at the end of the survey and will described themes and groupings of participant responses.

Sample

A total of 34 respondents logged into the survey and input data; however only the data from 28 respondents was used as only 30 selected "Submit" on the online inventory. Two of the 30 submitted surveys were more than 35% incomplete resulting in a sample of 28 respondents for the majority of the survey. One respondent skipped one of the questions regarding their

perceived competency rating, making their data unusable for some correlations; therefore the sample for descriptive statistics other than practice competency includes 28 respondents, while reports of correlations include 27.

The sample was diverse in age and years of experience in the field of clinical social work, but not with regard to race/ethnicity or gender. Respondents ranged from 26 years of age to 70 years of age with the highest concentration of respondents, 32%, reporting being in their thirties (n=9). Reported number of years of experience ranged from one to 46 years with 46% having less than 10 years of experience as a clinical social worker. Of the 28 respondents, 85.7% identified as white and 14.2% identified as Asian. Similar with regard to distribution was gender for which 82% identified as female and 18% (n=5) identified as male. This corresponds to NASW's (2006) reports of the percentages within the makeup of their membership group where 79% identify as female and 20% as male.

It is important to note that the sample is a North American sample and is not limited to respondents who are residing in the United States. Respondents include clinical social workers from Canada and the United States and while the governmental systems and guidelines for clinical social workers differ somewhat, both groups of clinical social workers work closely with clients who are prescribed psychotropic medications and have access to similar learning opportunities to further their practice and skill development with this population (Edwards, Shera, Reid, & York, 2006).

Practice Competency Ratings

Participants were asked to self-rate their perceived competency for performing specific roles related to working with medicated clients. Participants rated their competency with each role, referred to as practice competency domains. The five practice competency domains were

developed by Bentley and Walsh (2006) and included 1) consultant, 2) counselor, 3) monitor, 4) advocate and 5) educator. These five practice competencies are not standardized competencies in the United States and Canada as there is currently no national standard for knowledge or skill requirements with regard to medicated clients in either country (NASW, 2005; CASW, 2005). Rather, they are competencies that research suggests are necessary as well as ethically sound for effective practice with medicated clients (Bentley & Walsh, 2006).

It should be noted that practice competency ratings in the five domains were self-reported by participants. Competency was not objectively rated; rather the participants' subjective perception of their own competency and skill development level was self-reported. Participants self-rated their perceived competency levels on a Likert scale comprised of the levels 1) none, 2) emerging, 3) basic, 4) intermediate, and 5) advanced. There was the possibility of response ratings being higher than actual competency levels due to the fact that this was a perceived self-rating of competency. As this was a pilot study, it was not designed to determine actual competency through a standardized examination of skills, but rather to look at how competent participants experience themselves to be and if there were specific activities or groups of activities/experiences that contributed to their perception of competence. Standardized examinations of skill to determine competency within the five domains can and should be explored in future studies.

Scores were examined for each of the five domains as well as overall. The total practice competency score was calculated by averaging the scores across the five domains into one overall perceived competency score. The Likert scale options, none to advanced, were coded as 0-4 respectively. Each total competency score thus had the potential to range from 0 (meaning a respondent self-rated as none for each domain) to 20 (meaning they selected advanced for all

domains). Due to the small sample size, the total practice competency score was used for correlations as there was not enough variability among scores for the five domains and the risk of running into Type I error was significant. Scores within the five domains were used as descriptive data to formulate a basis for correlations to be run with total practice competency score as well as to examine and explore relationships through Cross Tabs.

Consultant: The consultant domain involved diagnostic assessment, treatment planning, client's perception on the potential or actual use of medication, referral to psychiatrist, and collaboration with prescribing psychiatrist (Bentley & Walsh, 2006). Of the five domains, Consultant was the domain in which participants most often rated their competency as intermediate. Table 2 illustrates the response frequency for self-ratings in this domain. 78.5% of respondents rated themselves as having greater then basic competency, making consultant that second highest rated domain in term of competency overall. As noted, the intermediate competency rating was selected most often by 50% of participants, followed by advanced (28.5%), basic (10.7%), emerging (7.1%), and none (3.5%, n=1).
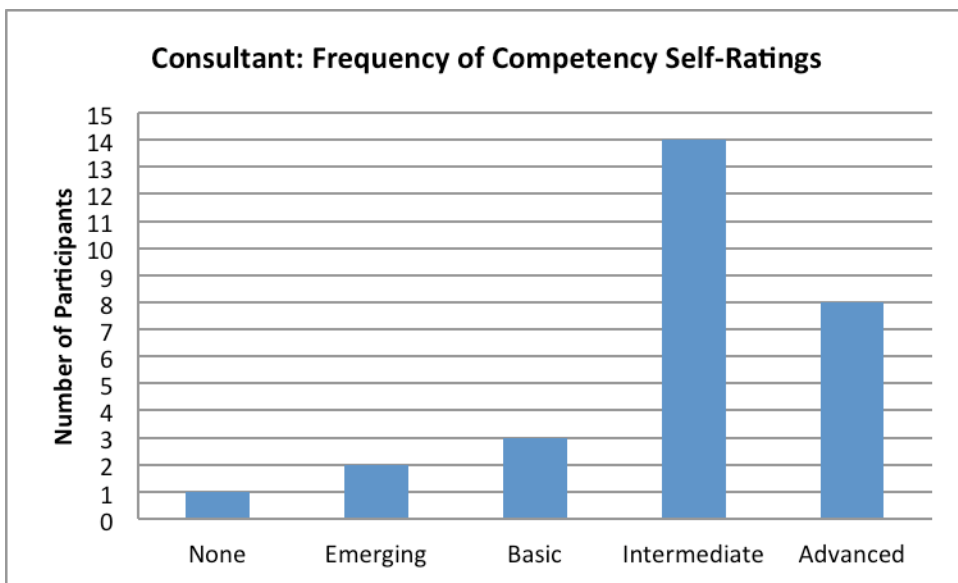
This domain had the widest spread of competency rating responses as it is the only domain in which a participant indicated that they perceived no competency in this area. A variance of 1.03 could indicate that of the five domains, consultant is the role and skill set with which there is the least consensus regarding skill development and competency. This indicates that this role should be a target for increased educational/learning opportunities for clinical social workers.

Counselor: The Counselor domain involved discussing the client's experience with medication, medication issues, barriers to progress and problem-solving (Bentley & Walsh, 2006). The most frequent response, as shown in Table 3 was advanced, with 53.5% rating themselves as such, 35.7% rating their level as intermediate, 10.7% as basic, and zero responses for emerging or none.
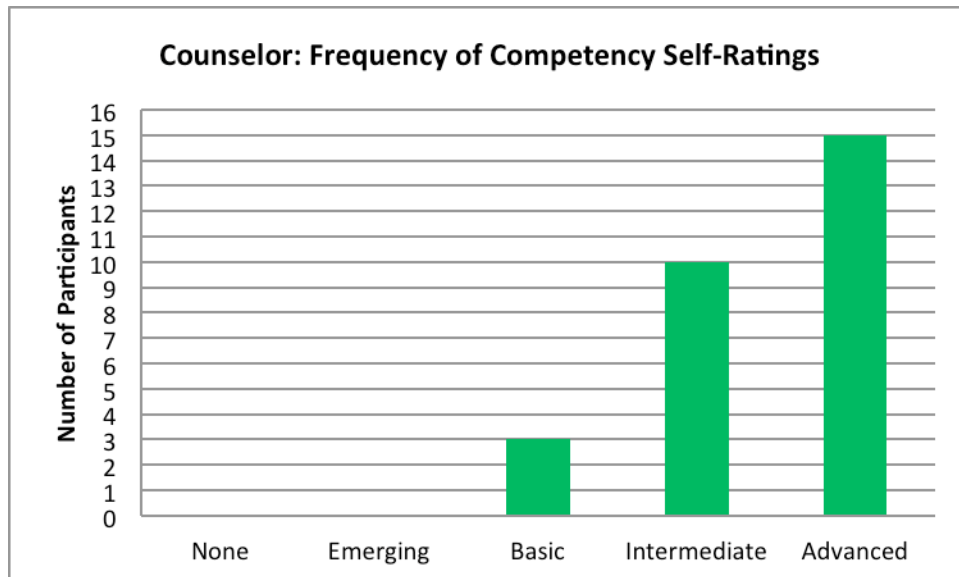
The counselor domain had the smallest standard deviation at .69 and the highest overall ratings of intermediate and advanced with 89.2% designating that most participants felt their competency level in this area was greater than basic, indicating that this is the role with which the greatest number of practitioners feel they are most competent.

Monitor: The monitor role included observing and assisting the client to observe their reactions (physical, mental, and social) to medication as well as helping to monitor side effects, symptom presentation, and adherence (Bentley & Walsh, 2006). In this domain the most frequent response was advanced with 37% of respondents indicating such. As show in Table 4, 70.3% of respondents rated themselves as having a competency level greater than basic, while 29.6% rated themselves as basic or emerging.
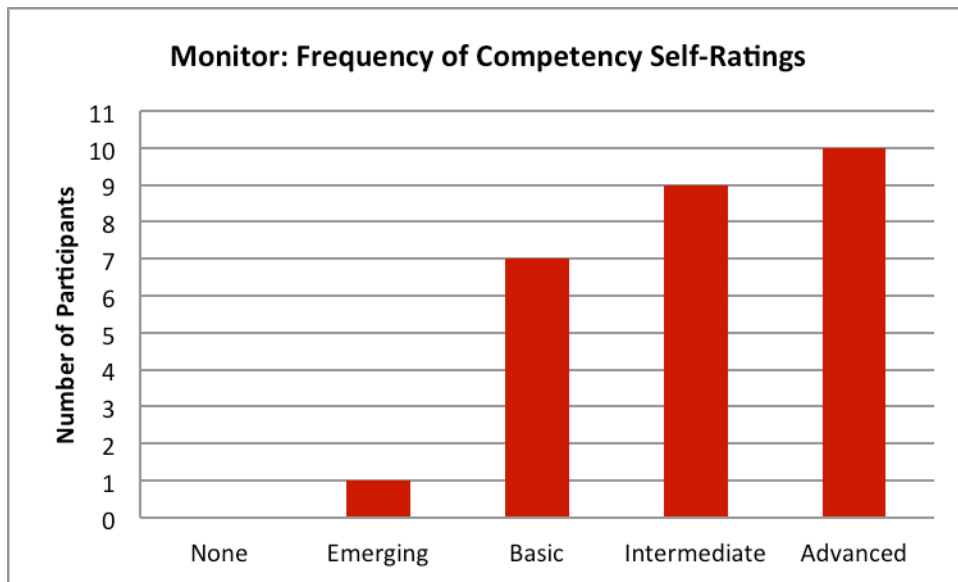

A skewness of -.39 indicates that the data is more evenly spread amongst advanced, intermediate, and basic than the other domains which could mean that while the monitor role is one in which clinical social workers identify some competency. The higher frequency of self-ratings of competency as basic shows that there is a need for increased learning opportunities in this area.

Advocate: The advocate domain included discussions with client's about their rights to receive, change, stop, or refuse medication, meaning the clinical social worker should be knowledgeable about not only patient rights, but also mental illness, psychotropic medications,

and laws and regulation specific to medication both federally and at the state level (Bentley & Walsh, 2006).

Hypothesis 1: It was hypothesized that advocacy would be the domain that was the most highly rated in terms of competency as advocacy is a core tenant of social work and is a focus in academic programs both in the United States as well as Canada (CSWE, 2008; CASWE, 2012). However as shown in Table 5, this was not the case as 74.9% rated their level of competency as greater than basic, 23.9% as basic or emerging, and zero as none.
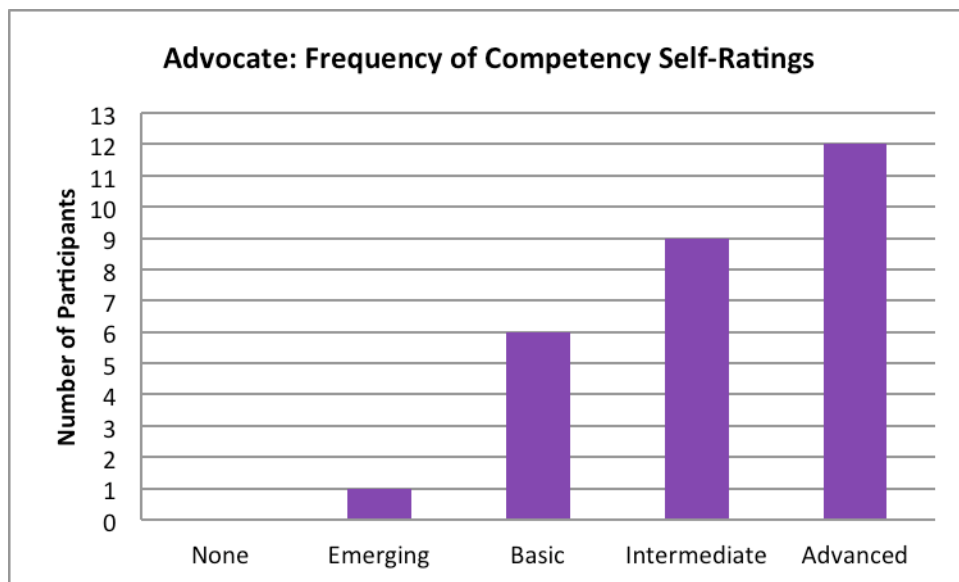
The advocate role came in second to the counselor domain in which 53.5% of respondents reported advanced competency while in advocate only 42.8% rated themselves as advanced. This could be because the advocacy skills necessary for working with medicated patients involves specific knowledge of medications as well as laws and regulations regarding medication which are not covered in most academic social work programs (Bentley & Walsh, 2006).

Educator: The educator domain involved the ability to provide basic information to clients and families about medications, effects, side effects, and effective means to communicate

observations and needs with psychiatrists (Bentley & Walsh, 2006). Table 6 shows that 74.9%
rated themselves as having greater than basic competency in the domain, 24.9% as basic and
emerging, and zero as none.
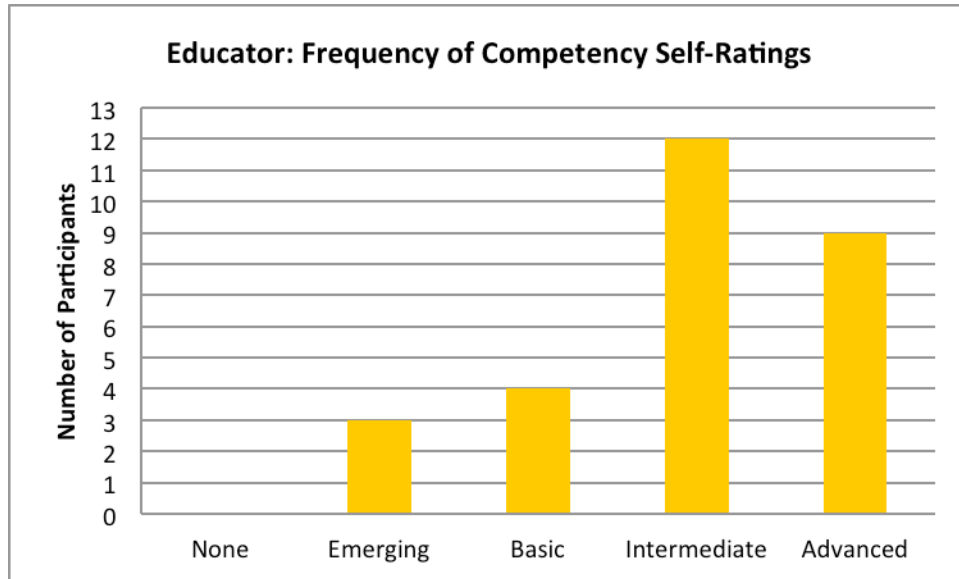
The most frequent response was intermediate with 42.8% of respondents selecting this
option. The educator domain also had the highest competency rating selection of emerging at
10.7%. This could indicate that along with the areas of consultant and monitor, educator could
be an area of focus for clinical social work education and training.

Total competency rating: The perceived total competency rating was calculated by
averaging the competency scores across the five domains listed above for each participant. The
possible competency selections were recoded from 0 to 4 for ease of calculation as follows;
0=None, 1=Emerging, 2=Basic, 3=Intermediate, and 4=Advanced. Therefore scores for total
competency rating may vary from 0-20. The only firm answers that indicate the specific
selections are 0 (all selections of none) and 20 (all selections of advanced). When the coded
scoring (0-4) is converted total competency rating scores it reflects the following scale; 0=None,
5=Emerging, 10=Basic, 15=Intermediate, and 20=Advanced.

This total competency rating indicated that overall 29.6% (n=8) self-rated their competency as advanced in every category. 22.2% scored as exactly 15, putting them into the intermediate range. The majority of respondents, 70.3% were rated as intermediate or higher, while only 29.6% fell into the basic and below score range. This indicates that overall, clinical social workers feel at least somewhat competent in their skill development and work with medicated patients. Furthermore, though specific academic education and even continuing education courses are limited on this topic there are some activities and learning exposures that are effective in helping clinical social workers to develop the skills necessary to feel competent when working with this population.

Personal Characteristics

This section of the survey probed into the individual characteristics of each participant in their role as a clinical social worker. Questions in this section included highest education level, year MSW was granted, highest level of licensure, and total number of years of experience working as a clinical social worker. The responses for highest education level were similar, just slightly higher, to those found by NASW within their membership with 89.9% identifying their highest education level as an MSW and 10.7% identifying their highest degree as a PhD. (NASW, 2006). Highest level of licensure was included, however this data was not examined as the sample was expanded to include Canada, which does not have the same licensing requirements as the United States and thus held no validity for the study and therefore was eliminated (Edwards *et al.*, 2006).

While these personal characteristics help to describe the sample, it was not possible, due to the sample size to analyze the significance of all of these factors, therefore only years of experience as a clinical social worker was used for correlations as it was the most pertinent and

highly supported in previous literature. Future studies, with larger sample sizes, should look into the effects of these variables on competency if descriptive statistics indicate that there is a potential significance.

Hypothesis 2: There will be a positive correlation between years of employment and overall competency rating.

Literature indicates that skill development and length of experience with this population are linked, therefore a greater number or years of experience should have correlated with higher competency scores and in fact the correlation was significant (Bentley & Walsh, 2006; Bentley, 2004). A Spearman's Rho correlation was used and indicated a strong correlation between years of experience and overall competency rating ($r_s(27) = 0.51$, $p < 0.01$). Similar to the total competency rating, this correlation indicates that throughout longer careers there is increased opportunity to be exposed and to engage in effective activities and knowledge sources that help to develop skills for working with medicated clients.

The year MSW was granted was an interesting and related variable. There was a wide range of responses from 1967 to 2012 with the highest concentration of responses (39.1%) falling between 2007and 2011. It was thought that year MSW was granted could be negatively related to competency as literature shows that access to courses on psychopharmacology were more limited in the past. The earlier the year the MSW was granted the lower the competency score; however results of the correlation of years of experience and competency indicates the opposite. The greater the number of years of experience the higher the self-rated perceived competency scores; meaning the earlier the year of graduation the higher the competency. This is an important indication as it could mean that the skills and knowledge need to work with medicated clients are not found in the classroom, but rather through activities and knowledge

sources found elsewhere, potentially through work, personal study, direct service with clients, and/or continuing education. This potential is explored later in the survey in the activities and knowledge sources section.

Scope of Practice

Scope of practice included factors such as the number of years of work with medicated adults, number or years with medicated children/adolescents, previous work setting, current work setting, and theoretical orientation. There was a mean of 8.1 years of work with medicated children/adolescents among participants and a mean of 11.7 years for work with adults. This difference while small indicates that slightly more participants gained experience while working with adults. Literature indicated that clinical social workers who work with children have less access to literature around working with medicated patients than do those who work with adults as psychotropic medication prescription with children is researched less often and off-label prescriptions are utilized (Bentley *et al.*, 2006; Cheung *et al.*, 2008). Though correlations could not be run in this study, this relationship should be explored in the future. Theoretical orientation was not correlated with competency either, due to the small response rate; however 64.2% of respondents identified that they used a theoretical orientation in their work with medicated patients indicating that this orientation could impact the activities and knowledge sources accessed as well and should be explored further in future studies.

Settings Worked: Participants were asked to indicate their current work setting and previous work settings in two separate questions. The was some lack of clarity in the instructions and several participants listed their entire work career under the question that requested information about only the current work setting; because of this, past and current setting could not be explore separately and a new variable looking at the total number and type

of settings worked throughout the career was created. Total settings worked was calculated by adding the total number of settings a participant selected (past as well as current) and excluding duplicate selection between the past and current questions. As depicted in Table 7 the total settings worked ranged from 1-6 with the most frequent response being 2 settings with 42.8% (n=12).

Figure: Frequency of Total Settings Worked Throughout Career
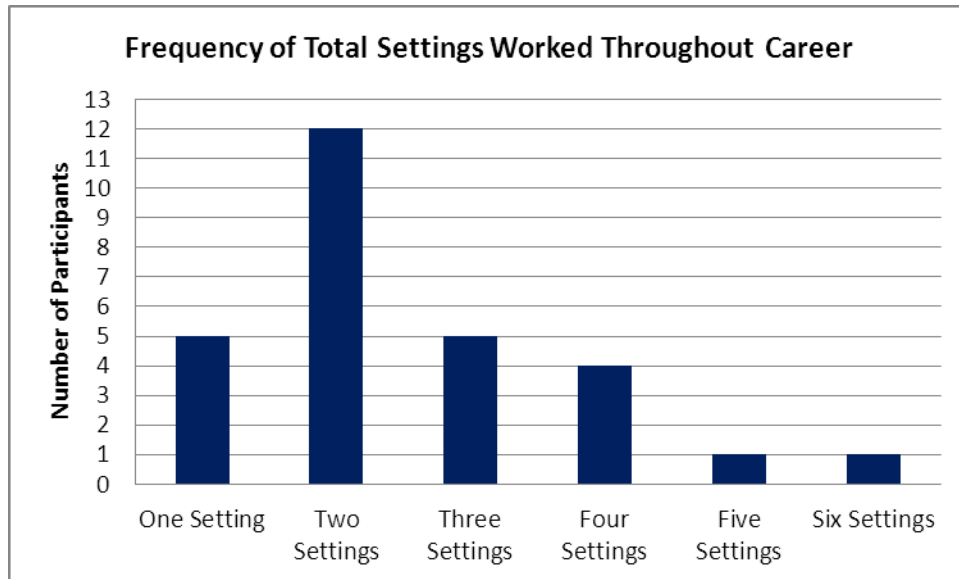
Hypothesis 3: There will be a positive correlation between number of settings worked and overall competency rating and there will be a stronger correlation between work in an inpatient setting and competency than between work in an outpatient setting and competency.

In order to investigate if there was a correlation between the total number of settings worked and perceived total competency, a Spearman's Rho correlation was calculated. The results indicated a positive, moderate correlation ($r_s(27) = .42$, $p < .05$). This finding shows that as the number of settings worked increases, so does the perceived total competency. This finding is significant for this study as it indicates that knowledge and skill acquisition around working with medicated clients occurs during on-the-job training and experience. It is important to note that this variable is also related to years of experience as those with larger numbers for

years of experience tended to have worked in a larger number of settings. In the future a regression analysis to examine the relationship of setting, years of experience and competency would be advised. Though these variables are linked, both point to the importance and effectiveness of the knowledge and skill development that occurs outside of the academic context.

The second part of the aforementioned hypothesis was that those who identified that they had or currently worked in an inpatient setting would have higher competency rates than those who identified working only in outpatient settings. Literature indicated that those who worked in inpatient settings generally had greater knowledge of medications than those who did not as they were exposed to medications, patients prescribed them, and psychiatrists more often (Berg & Wallace, 1987). The Wilcoxon Mann-Whitney test was used to examine the relationships between these variables as the dependent variable (total competency rating) is an ordinal variable and not considered normally distributed. This test is the non-parametric alternative to the T-test meaning it examines differences in the rank-sums of the groups rather than the means, as with the t-test.

Two Wilcoxon Mann-Whitney tests were run; one to investigate whether or not there were differences in perceived total competency between participants who worked in inpatient settings versus those who did not and the second to see if there were differences between participants' perceived total competency ratings who worked in outpatient settings versus those who did not. The Wilcoxon Mann-Whitney test revealed no significant differences between those who worked in inpatient and those who did not (Z=-0.16, p=ns). Similarly, there were no significant differences between the groups who worked in outpatient versus those who did not (Z=-1.03, p=ns). This second part of the hypothesis could not be proven; however the

correlation for inpatient work approaches significance more readily than work in outpatient settings.

Academic Preparation

Factors included in academic preparation included whether or not courses on psychopharmacology were offered in MSW programs, whether internships included work with medicated clients, and whether supervision around work with medicated clients was provided during internship. Currently there is no national standard in the United States or Canada around educating clinical social workers with regard to psychotropic medications and work with clients who take them (NASW, 2005; CASW, 2005). This is true at the MSW level as well as for continuing education. While both countries recognize the importance of education for clinical social workers around physical well-being and the link between mind, body, and society, it is not currently mandated that BSW or MSW programs offer specific courses on medications, neurology, or working with medicated patients (CSWE,2008; CCSWE;2012). Findings from this study support this information.

This study found that 75% (n=21) of respondents identified that the MSW programs they attended did not offer any course work on psychopharmacology or work with medicated clients. These results reflect the findings of Bentley *et al.* (2006). A Wilcoxon Mann-Whitley was calculated in order to examine differences in overall competency ratings between participants who did their MSW work at institutions were courses were offered versus those who did not. This test showed no significant differences between the groups (z=-0.31, p=ns).

Though the correlation was not found to be significant, descriptive statistics alone indicate that there is a gap in current academic social work training. Furthering this assertion is the fact that 75% of participants identified that no courses were offered on psychopharmacology

in their MSW program, yet 85.7% of participants identified that they had worked with medicated clients during their MSW internships as shown in Table 8.
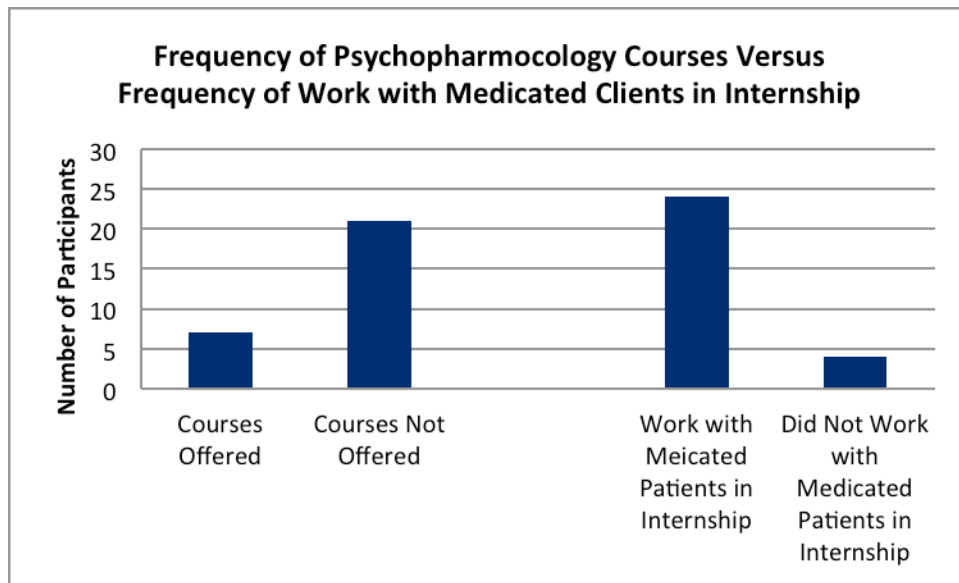
This Table illustrates an inverse relationship between psychopharmacology courses and work with medicated clients in internship. Whereas the relationship is expected to be proportional, it shows it is not. This indicates clearly that clinical social workers are working with medicated clients as early as the MSW level and are not receiving academic training on work with this population. Of the 85.7% of respondents working with medicated clients in internships only 64.2% received supervision around work with this population.

Knowledge Sources and Activities Accessed

It is clear that years of experience impacts overall perceived competency ratings. This finding while significant is only part of the overall goal of this study which also examined specific activities and groups of activities that clinical social workers engage in to develop skills and knowledge for working with medicated clients.

Exploratory question: Are there activities that are more effective than others for the development of perceived practice competency with medicated patients?

The knowledge sources and activities accessed section of the survey was aimed at exploring potential answer to this question. In this area of the survey participants were asked to select all of the knowledge sources and activities that they had engaged in with regard to each of the five practice competency domains. For each domain, participants could select from a list of 34 knowledge sources. These knowledge sources fell into seven distinct activity groups; 1) consultation, 2) observation, 3) direct service, 4) continuing education, 5) academic training, 6) self-directed, and 7) supervision/teams meetings. Originally, the knowledge sources were to be allocated in two separate groups (formal and informal learning opportunities); however in consultation with the data analyst and research advisor these groups were expanded to account for specific activity groupings rather than type of activity (formal/informal) as these more specific groupings more accurately reflected the purpose of the study and the exploratory question.

As it was not possible to run correlations for each of the 34 learning exposures as related to competency ratings in each domain due to the significant potential for Type I error, the data was reviewed and analyzed in several different ways. In order to present a more global picture of the findings, the total number of activities selected across all five domains was calculated and correlated with total competency rating. Furthermore, response frequencies were used to determine the specific activities most frequently selected in each activity group across all five domains. These specific activities were then correlated with overall perceived competency ratings. Finally, cross-tab analyses were used to explore relationships between the seven activity groups and competency self-ratings for each of the five domains.

Excluding total activity selection and competency ratings, findings have been organized and presented by activity group. Each activity group is defined and the specific activities that

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comprise the group enumerated and described. Each group will also discuss the following

hypotheses, detail the correlations that were run with regard to Hypothesis 4, and discuss

pertinent findings from Cross Tabs regarding Hypothesis 5.

Hypothesis 4: The top rated activity within each group will be positively correlated with

total competency rating.

Hypothesis 5: The selection of activities in the group of "Consultation" will correspond

to higher ratings of competency within each of the domains.

The top rated activity in each group is presented and the correlational results for this

activity and total perceived competency are reviewed. In order to investigate if perceived total

competency was related to the most frequently reported activity for each activity group, a

Spearman's rho was calculated. Spearman's rho was chosen as the non-parametric alternative to

Pearson's correlation coefficient due to the small sample size, the non-normality of the data, and

the dependent variable (total perceived competency rating) being ordinal. A description of the

top-ranked activity correlations is followed by a more specific discussion of how each activity

group relates to the five competency domains. Graphic representations of pertinent Cross Tab

results will be displayed to further discuss potential relationships between activity groups and

domain specific competency ratings.

Total number of activities selected and total competency: The total number of

activities was calculated by summing the total number of activities a participant selected across

all potential responses in the five domains. As there were 34 potential activities to be selected

within each of the 5 domains the total number of activities could have ranged from 0 (no

activities across all 5 domains) to 170 (yes to all activities across all 5 domains). Table 9 shows

the range of total selections that occurred.

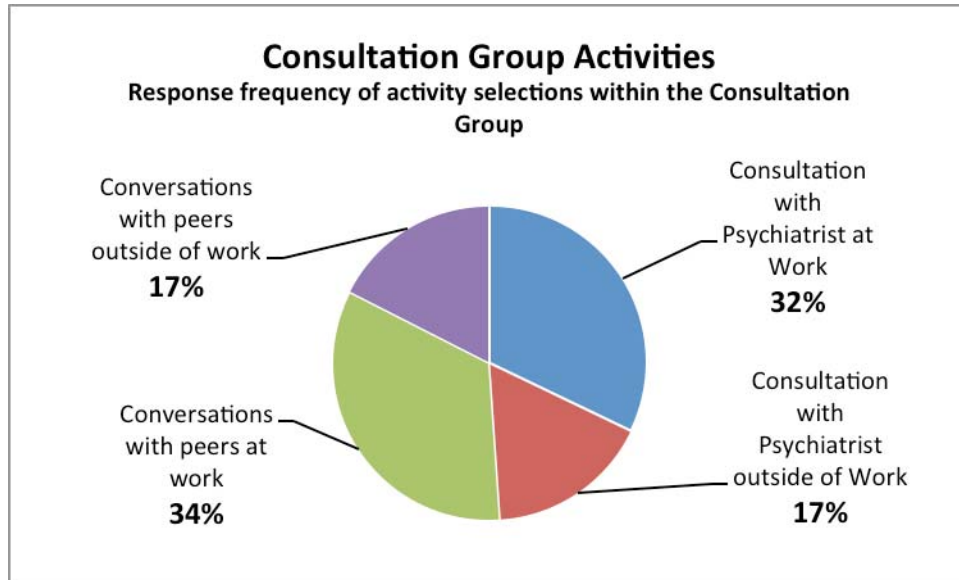**Overall Number of Activities Selected**
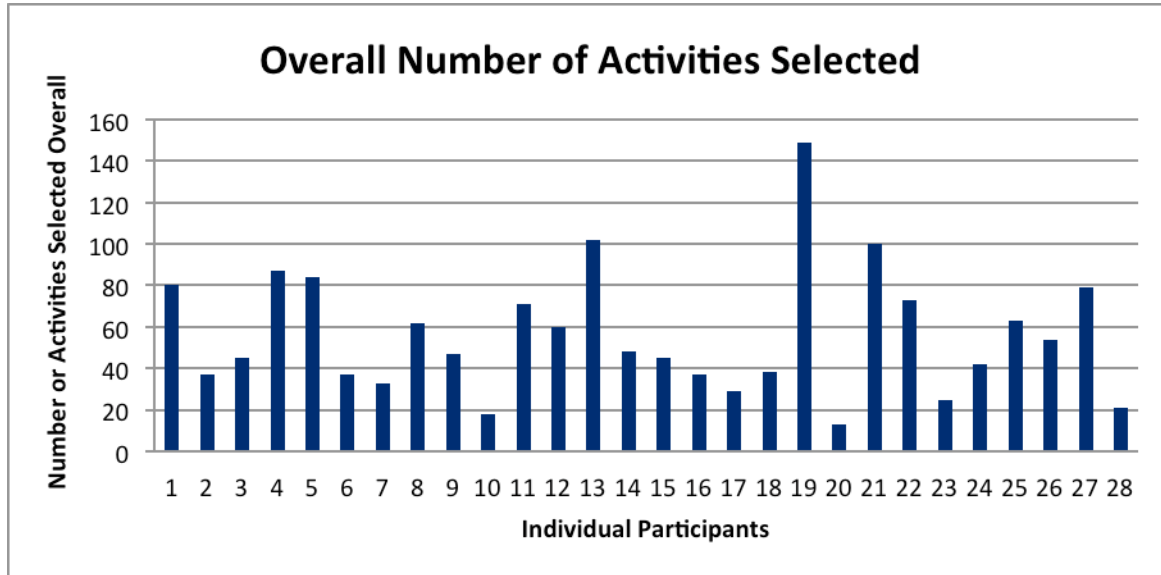
There is a very wide range of total number of activities selected from as low as 13 activities to as high as 149 activities with mean of 56 activities selected and a standard deviation of 30.3. It was not often that the same number of activities was selected among respondents with the highest percent of matching selections being 10.7 % (n=3). A Spearman's rho was calculated and found that there was no significant relationship between the overall number of activities selected the perceived total competency ($r_s(27) = 0.07$, p=ns). This could indicate that it is not the number of activities selected, but rather the effectiveness of specific activities or groups of activities that can influence competence.

Consultation: The consultation group includes those activities which involve specific conversations with individuals (psychiatrists or peers) that occur (at work or outside of work) with the expressed purpose of gaining knowledge, perspective, or skills regarding work with medicated clients. The consultation group includes the following activities: consultation with psychiatrists at work, consultation with psychiatrists outside of work, conversations with peers at work, and conversations with peers outside of work. As Table 10 indicates, out of the total

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number of activity selections made by all participants (n=1,582), the consultation group accounts

for 18% (n=274) of all selections. This was the second most frequently selected activity group

by respondents overall indicating that participants found these activities useful in their

development of skills and knowledge for working with medicated clients.
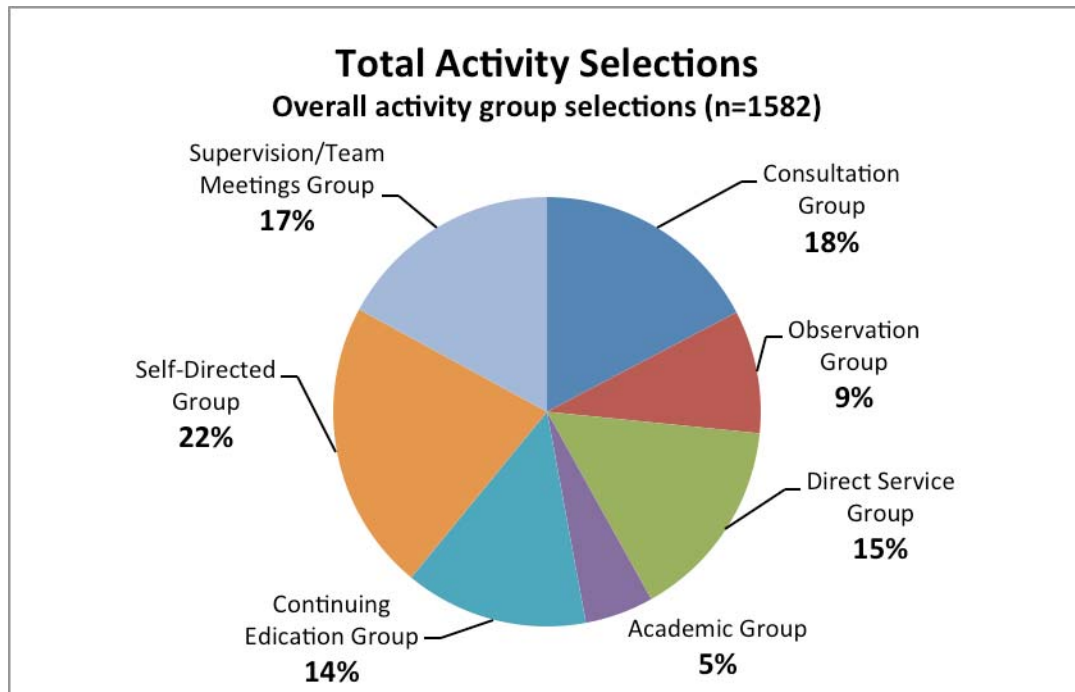
The activity most frequently selected in this group was conversations with peers at work

which accounted for 34% of the consultation group selections overall. Table 11 shows the total

selection frequencies for each activity with the consultation group overall. Conversations with

peers at work was the most frequently selected activity in the group (34%), followed by

consultations with psychiatrists at work (32%).

Consultation Group Activities
Response frequency of activity selections within the Consultation Group

- Consultation with Psychiatrist at Work 32%
- Consultation with Psychiatrist outside of Work 17%
- Conversations with peers at work 34%
- Conversations with peers outside of work 17%

Correlations: As expressed in Hypothesis 4, it was thought that there would be a positive correlation between selection of conversations with peers at work and competency. The Spearman's rho calculation showed that there was no significant relationship between perceived total competency and the number of times a participant selected conversations with peers at work ($r_s(27) = 0.02$, p=ns)

A Spearman's rho correlation was also run between consultation with psychiatrists at work and competency as the percent that this variable was selected (32%) was closer to conversations with peers at work than any other variable. A positive correlation between consultation with psychiatrists at work and total competency was expected; however, similar to the previous result, there was no significant relationship found between perceived total competency and the number of times a participant selected consultation with psychiatrists at work ($r_s(27) = 0.03$, p =ns).

These findings could be due to the small sample size and future studies with larger sample pools should explore this further. Though the correlations were not significant the frequency of the selection of the activities, conversations with peers at work and consultation

with psychiatrists, coupled with the high selection rate of this activity group overall indicates that these activities hold some importance for skill and knowledge development even if they are not directly linked to total competency rating at this time.

     Cross Tabs between consultation group and competency domain ratings: Cross Tabs were run for the consultation group within each of the five domains (consultant, counselor, monitor, advocate, and educator) in order to explore the relationship between the selection of activities in this group and competency ratings for each role clinical social workers engage in with medicated patients. In reviewing the Cross Tabs for the Consultation group, it is clear that consultation activities appear to be related to competency in all of the five domains, as all participants overwhelmingly selected one or more activities in this group the majority of the time.

     With regard to Hypothesis 5, it is clear that selection of activities in the Consultation group, as literature suggested, did correspond to higher rates of competency in all domains. Between domains, however, there are some significant differences. As Table 12 shows, participants who self-rated their perceived competency as intermediate or advanced in the consultant domain most often selected two or more activities in this group indicating that for this domain perceived competency could be tied to regular executing of these activities.

Consultation Group and Competency Ratings for Consultant Domain
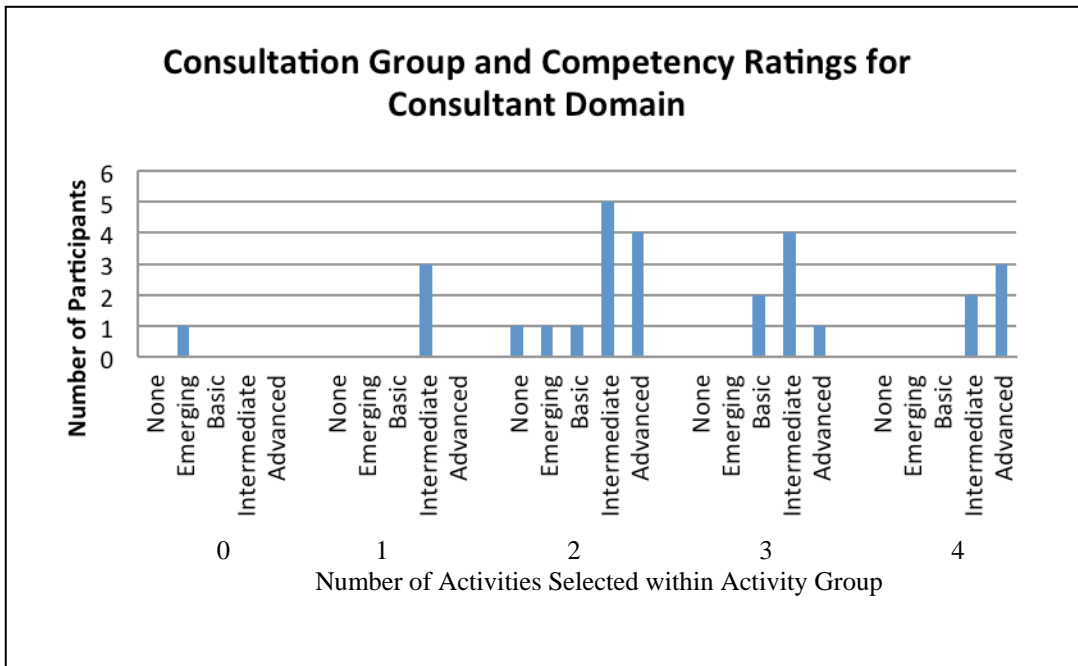
Similarly, in the Counselor domain, Table 13 shows that a significant number (60%) of individuals who rated their competency as advanced selected three or more activities in this group clearly indicating that those who perceive their competency to be advanced engage in activities within the consultation group frequently when performing the duties associated with the Counselor role with their medicated clients.

Consultation Group and Competency Ratings for Counselor Domain
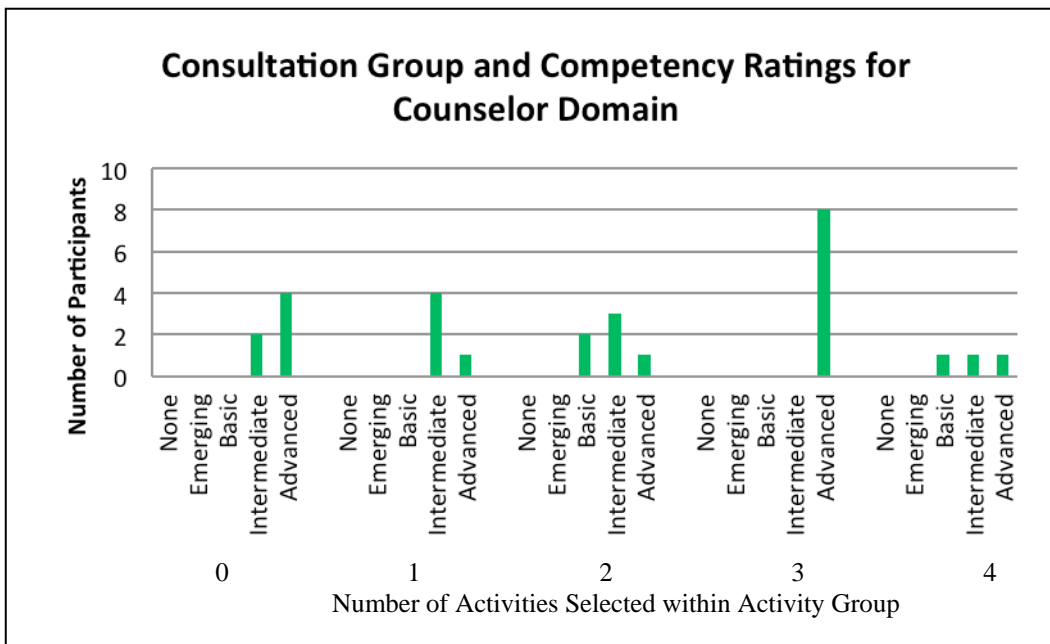
As mentioned previously, participants overwhelmingly identified engaging in one or more activities in the consultation group across all five domains. The Consultant and Counselor domains showed the most distinguishable connection between number of activities selected within this group and higher competency ratings indicating that this group of activities is more effective to engage in for developing competency than the observation, direct service, academic, continuing education, and supervision/team meetings groups. This is true not only for the Consultant and Counselor domains, but also the domains of Monitor, Advocate and Educator as well, however the spread between one and four activities selected is more evenly distributed in these cases. These findings could indicate that engagement in activities in the consultation group could be most effective in regards to developing skills and knowledge related to the Consultant and Counselor roles.

Observation: The observation group includes those activities that involve learning to work with medicated patients through active surveillance of the actions of individuals (psychiatrists, colleagues, or peers) that occur (at work or outside of work). The observation group includes the following activities: modeling provided by colleagues, observation of colleagues, and observations of psychiatrists. As Table 10 indicates out of the total number of activity selections made by all participants (n=1,582), the observation group accounts for only 9% (n=147) of all selections. This is the second least selected activity group overall indicating that engagement in these activities in order to develop skills and competency does not occur as frequently, possibly because these activities are not as effective or as valued

The activity most frequently selected in this group was observations of psychiatrists which accounted for 41% of the observation activity selections overall. Table 14 shows the total selection frequencies for each activity within the observation group.

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Observation Group Activities
Response frequency of activitiy selections within Observation Group
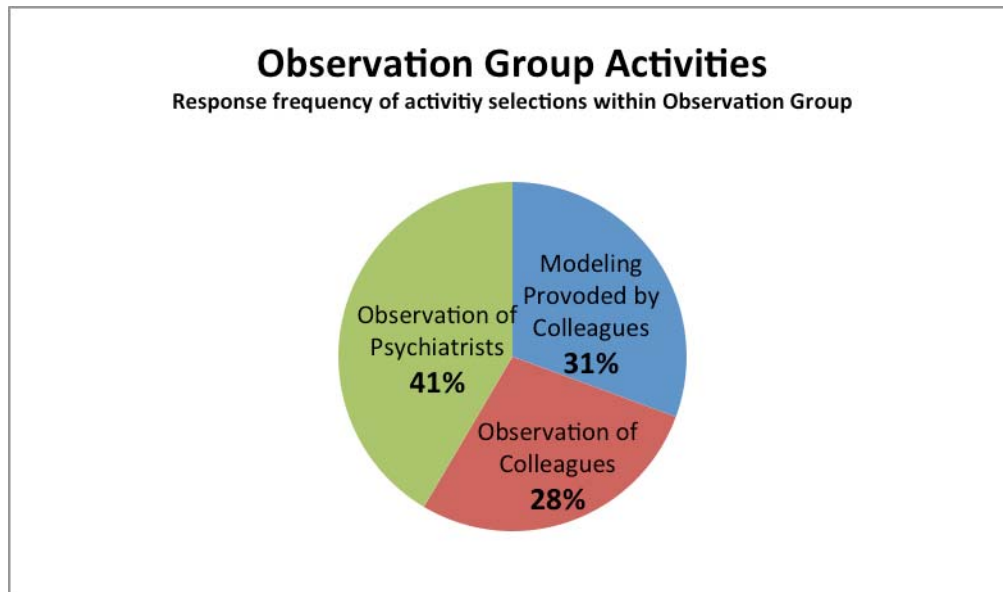
Correlations: Hypothesis 4 stipulated that as the most frequently selected activity of the group, observation of psychiatrists, would be a positively correlated with competency. The Spearman's rho calculation revealed that there was no significant relationship between perceived total competency and the number of times a participant selected observation of psychiatrists across domains $(r_s(27) = 0.03$, p=ns). This could be due to the fact that this activity group was not selected as often and therefore this activity has no relationship to competency or as mentioned previously this could be due to the small sample size and the lack of normative data with which to compare responses.

Cross Tabs: The Observation group showed close to (if not an exact) 50/50 split in the Counselor, Monitor, and Advocate domains between those who selected one or more activities in this group and those who selected none amongst participants who identified their competency as advanced. The Monitor domain is depicted in Table 15. Note that five advanced competency participants selected zero activities and five selected one or more.

Observation Group and Competency Ratings for Monitor Domain
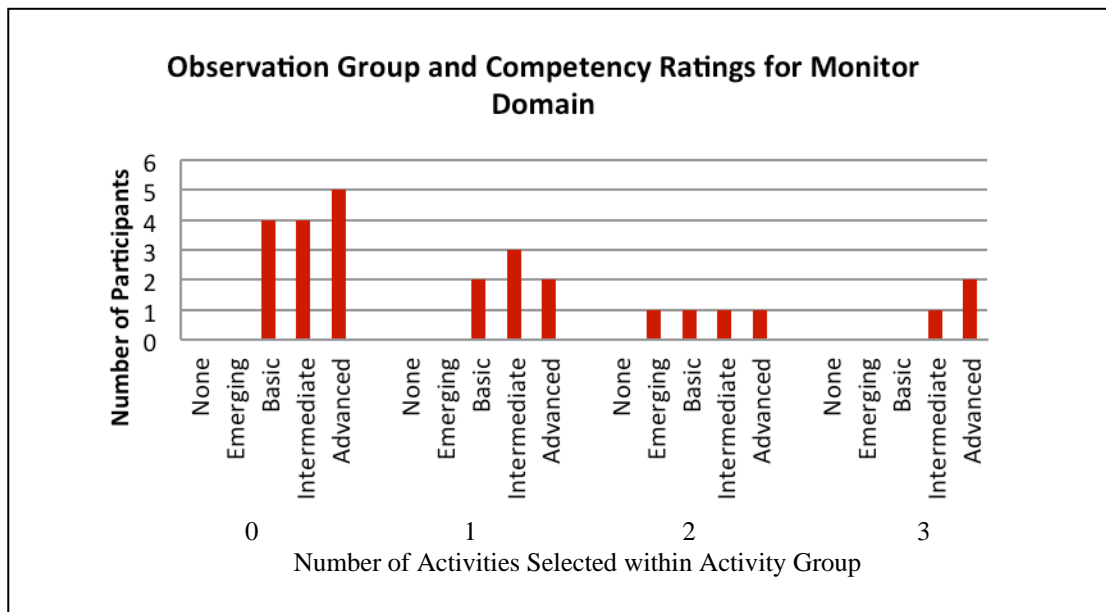
This indicates that in these domains engagement in activities of the Observation group does not have a clear relationship with advanced competency. In the Consultant and Educator domains a clear relationship was observed. For the Consultant domain, 75% of the advanced competency individuals selected one or more activities in the observation group. In the Educator domain 67% of advanced individuals selected one of more activities in this group. Table 16 shows the activity selection and competency ratings for the Consultant domain. The majority of the advanced and intermediate competency individuals selected one or more activities while those individuals who self-rated as basic or emerging strictly selected one activity or less.

Observation Group and Competency Ratings for Consultant Domain
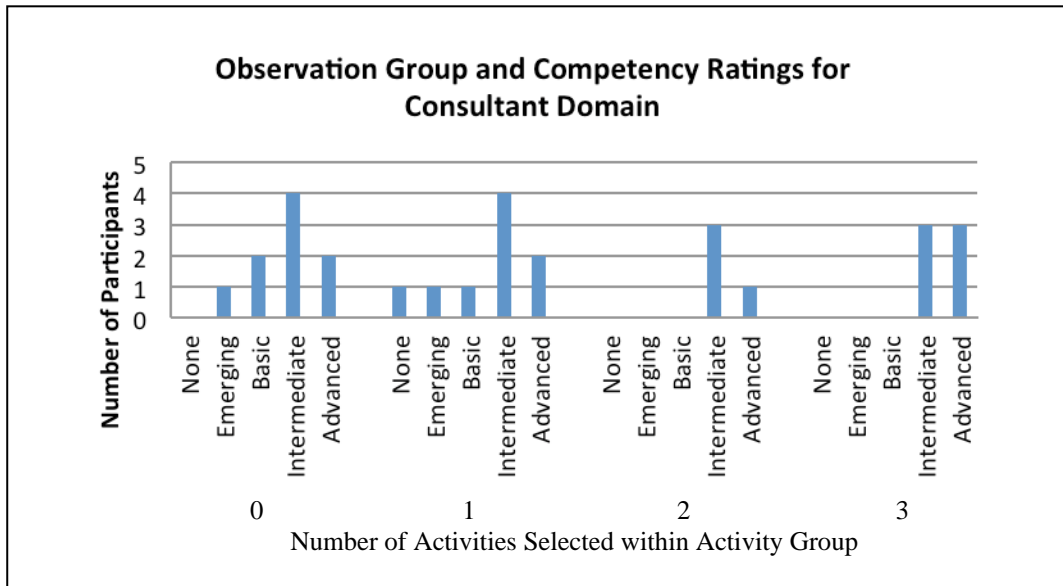
This indicates that participation in observation activities is related to higher competency ratings in the Consultant and Educator domains and could mean that these activities are more effective for developing skills in these domains than in others.
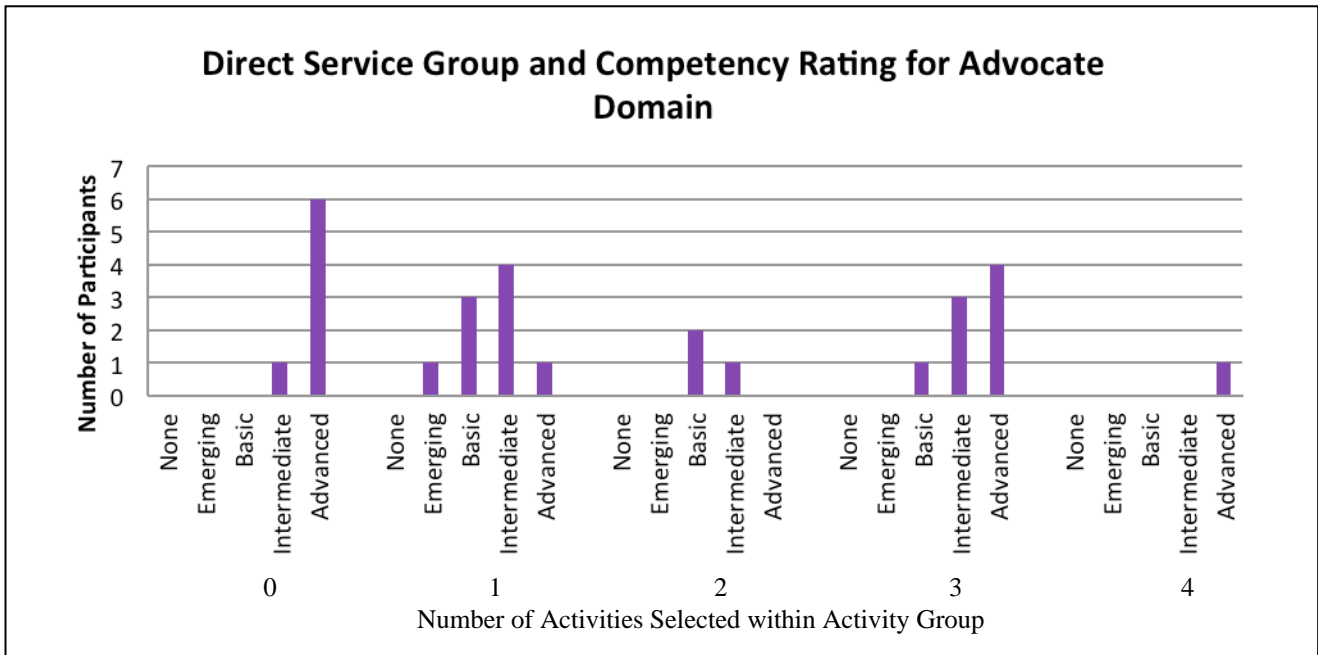
Direct service: The Direct Service group is defined as learning activities and exposures that involve hands-on work and interactions with clients, families, and groups. The activities in this group include; interactions with clients, role plays, family conferences, patient conferences, participating in medication psycho-ed programs designed for families, and participating in medication psycho-ed programs designed for patients. Table 10 indicates that the Direct Service group accounts for 15% of the overall activity group selections. This group is the fourth most often selected group which means if fall squarely in the middle of the seven activity groups.

Correlations: The activity most frequently selected in this group was interaction with clients comprising 45% of the total activity selections within this group. Per Hypothesis 4, a positive correlation between selection of interaction with clients and competency rating was expected. The Spearman's Rho calculation found no significant relationship between perceived total competency and the number of times a participant selected client interactions across the five domains ($r_s(27) = -0.24$, p = ns). However, frequency data indicates that interaction with clients

was the predominant choice among participants as shown in Table 17, meaning that it could hold some value in their learning and skill development overall.
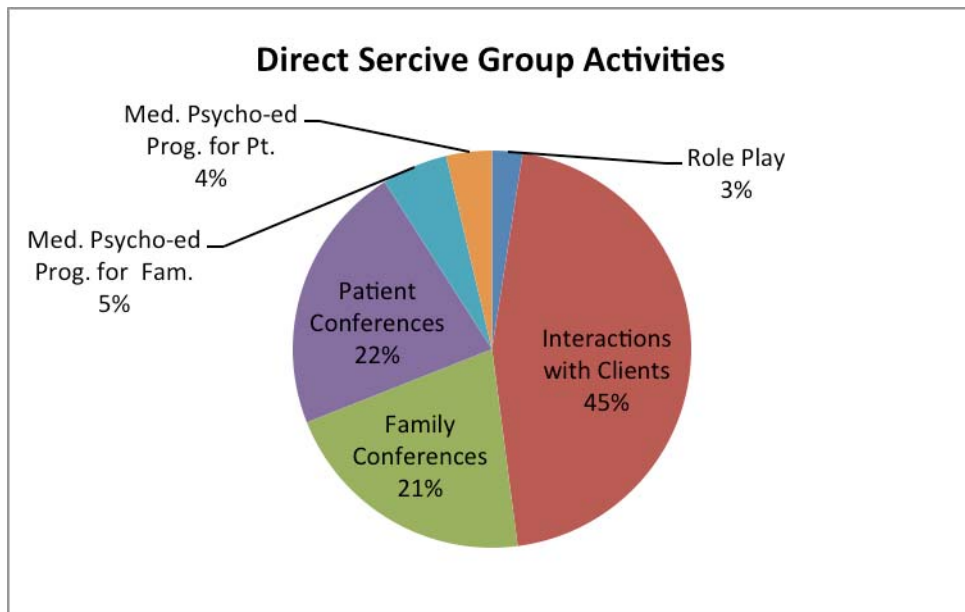
Cross Tabs: The Direct Service group was shown to be selected more often by those who identified advanced or intermediate competency ratings in all domains, except the Advocate domain. As shown in Table 18, 50% of advanced competency rated participants selected no activities in this group while the other 50% selected one of more in the Advocate domain. On the other hand, 88% of participants who selected intermediate as their competency rating in this domain selected one of more activities.

Direct Service Group and Competency Rating for Advocate Domain

While the Consultant, Counselor, Monitor, and Educator domains all showed higher Direct Service Group selection rates, the most significant example is that of the Counselor domain. Table 19 shows that of those who selected intermediate or advanced as competency ratings (n=25), only 12% (n=3) selected no activities in the direct service group, while 88% selected one of more. 52% (n=12) of the 88% (n=23) who selected one of more activities selected one activity only.

Direct Service Group and Competency Ratings for Counselor Domain
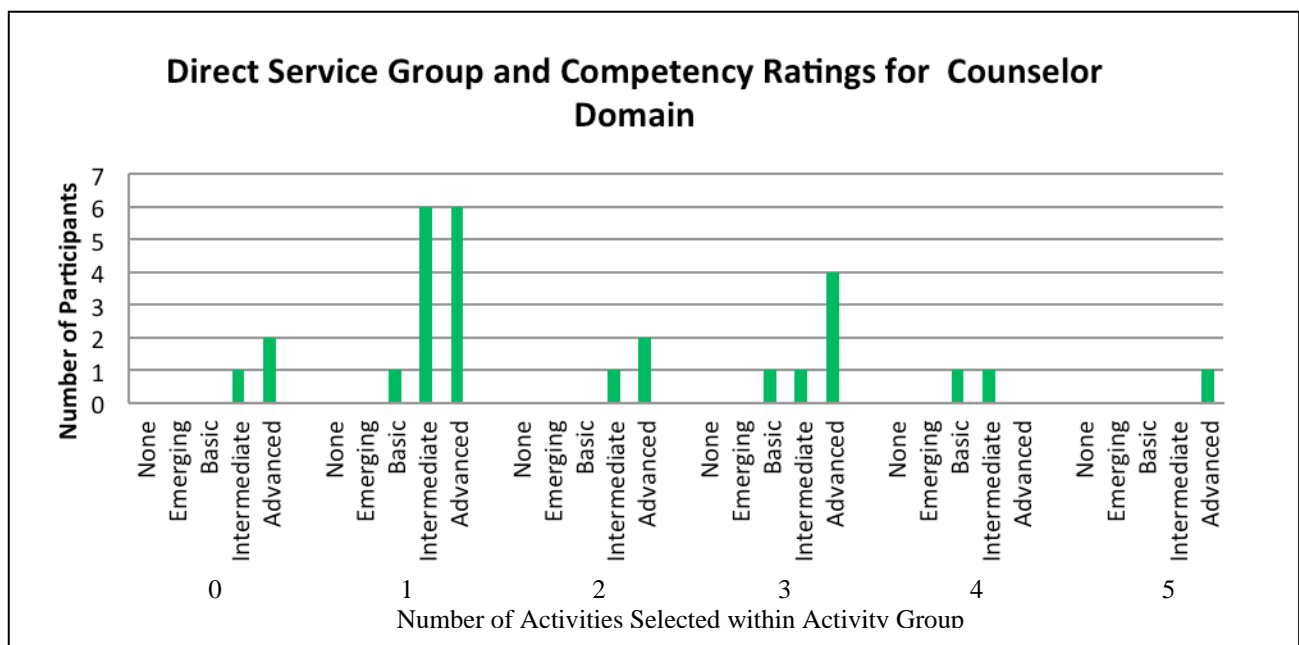
As the highest rated activity in the group was interactions with clients, this finding could indicate that in the Counselor domain the direct service group and specifically the interactions with clients activity could be important to skill development as it related to perceived competency.

Continuing education: The continuing education group was defined as those activities that were facilitated by individuals or groups (inside or outside of work) that involved specific curriculum or learning goals with the explicit function of enhancing professional skills and knowledge around issues specifically related to medicated clients. The activities in this group included; in-service trainings at work, workshops/trainings, skill-building workshops, continuing education courses, and Grand Rounds. As shown in Table 10, this activity group accounted for only 14% of the total activity selections meaning it was the third least selected activity group overall. This could indicate that overall this group was not found as useful as other groups, such as consultation. This finding is consistent with the literature as well which suggested that continuing education training for clinical social workers on this topic was limited (Dziegielewski & Leon, 1998).

Correlations: It was expected that there would be a positive correlation between selection of in-service trainings and competence ratings as noted in Hypothesis 4. In-service training was the most frequently selected activity in this group at 29% as shown in Table 20. This is low however given the number of activities in this group. This activity is followed closely by outside workshops/trainings (24%) and continuing education courses (26%) indicating that participants did not indicate their preference for one activity over the other with significant strength. This could also be due to the fact that these activities are similar in nature and should have been more clearly defined.

Continuing Education Group Activities

- Gand Rounds 11%
- In-service training at work 29%
- Continuing Education Courses 26%
- Skill-building Workshops 10%
- Outside Workshops & Training 24%
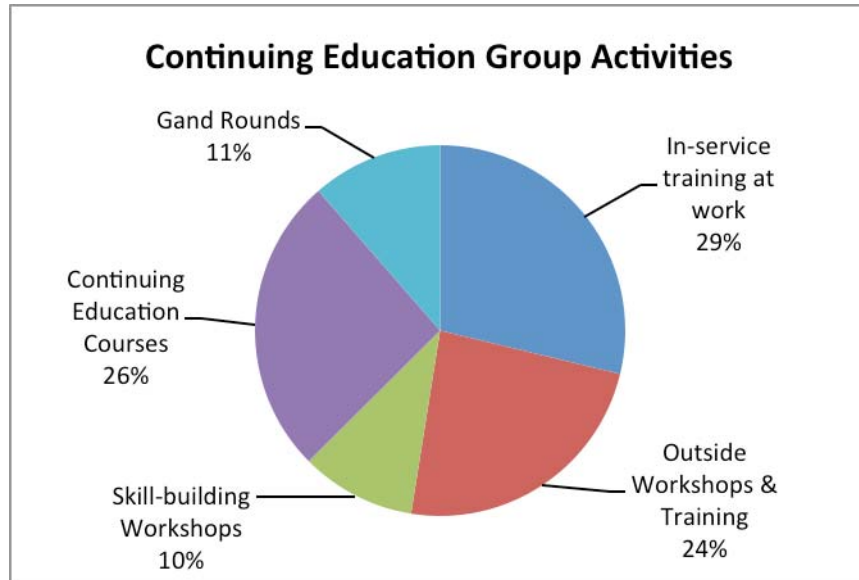
Spearman's Rho correlations showed no significant relationship between perceived total competency and the number of times a participant selected in-service trainings ($r_s(27) = 0.17$, p=ns). This was not unexpected as the response rate for this group overall was relatively low.

Cross Tabs: The continuing education group was selected less often by participants who rated themselves as intermediate or advanced in the Monitor and Advocate domains. As shown in Table 21, in the Monitor domain showed almost a 50/50 split between those who selected no activities in this group and those who selected one or more. Those who rated themselves in the Monitor domain as basic competency overwhelmingly selected no activities in this area.

Continuing Education Group and Competency Ratings for the Monitor Domain
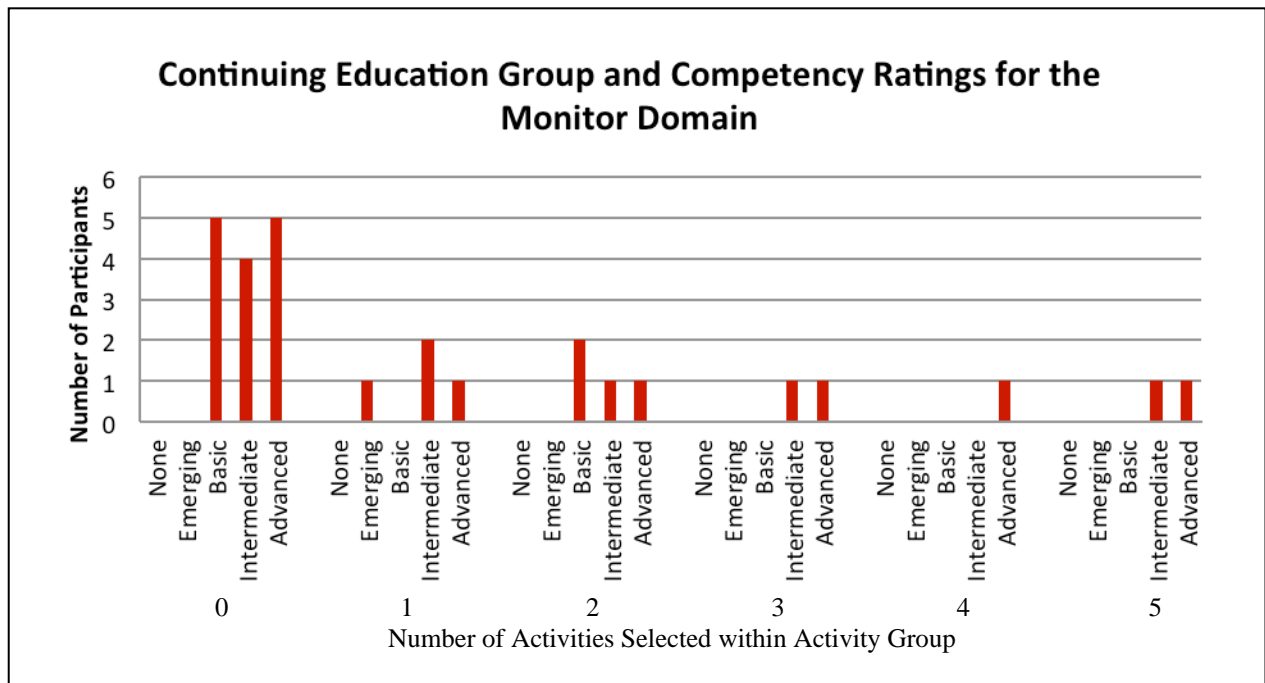
Similarly, as depicted in Table 22, the Advocate domain showed that most participants who self-rated their competency as basic did not select any activities in this group. The split amongst advanced competency self-ratings was skewed towards the selection of zero activities as 58% of the advanced group selected no activities in this grouping. On the other hand, those in the intermediate competency rating (n=9) chose one or more activities 77% (n=7) of the time.

Continuing Education Group and Competency Ratings for Advocate Domain
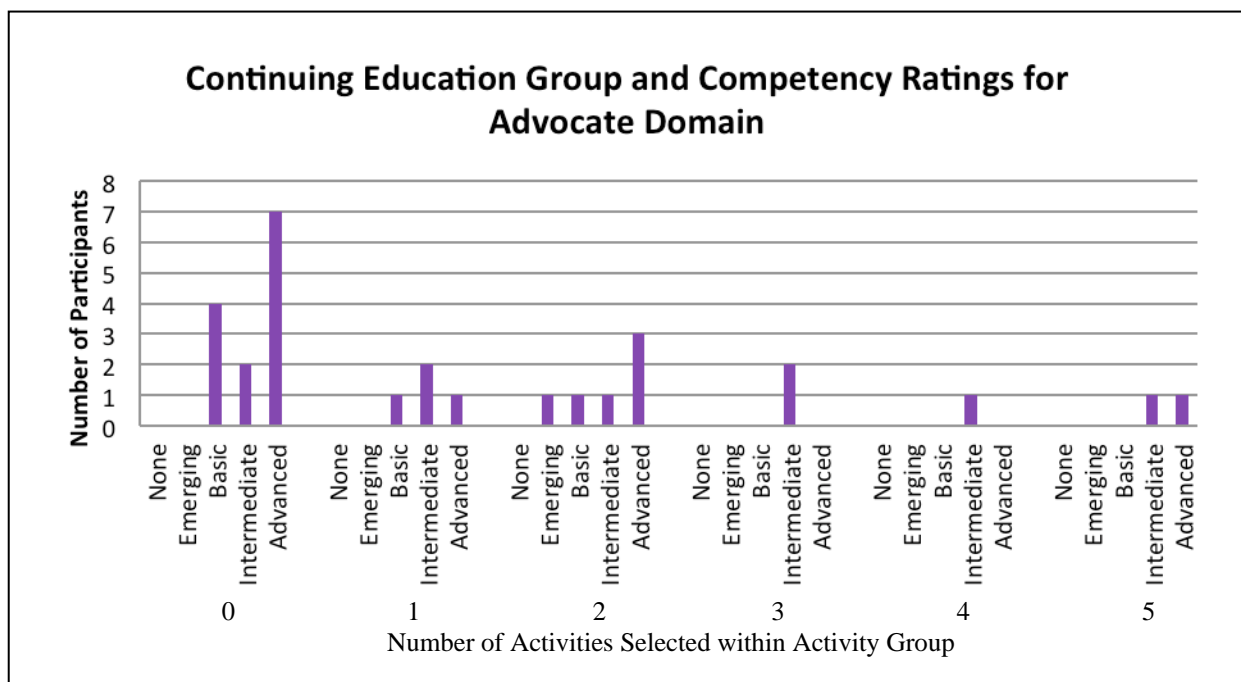
For the Consultant, Counselor and Educator domains the continuing education group was regularly selected one of more times by the majority of participants. As an example Table 23 shows competency ratings in the Counselor domain with number of activities selected in the continuing education group.
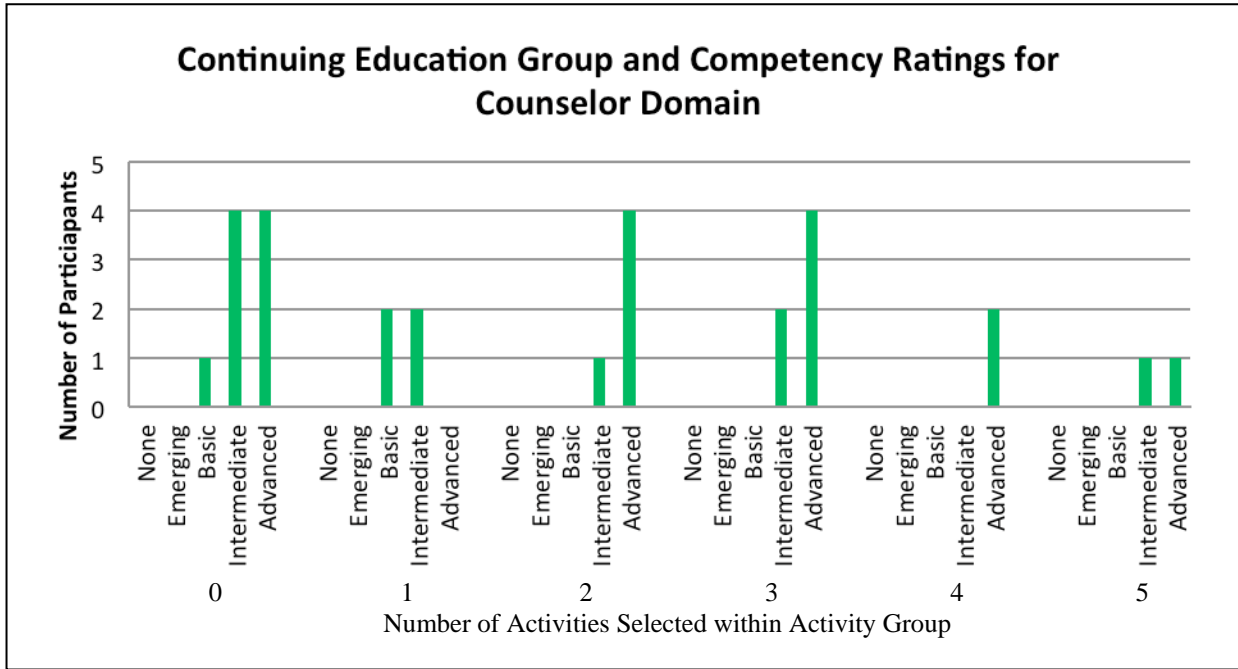

73% of participants who identified advanced competency in the Counselor domain selected two or more activities while only 27% selected no activities in this group at all. The participant who identified their competency in this area as basic selected no activities in this group. This could indicate that participation in one or more activities in this area contributed to higher perceived competency ratings.

Academic Training: Academic training accounted for the smallest number or total activity selections overall (5%) as shown in Table 10. This group was defined as those activities and learning exposures that focused on psychopharmacology or work with medicated patients that occurred in the formal academic context of BSW or MSW programs. The activities in this group included; BSW curriculum, BSW internships, MSW curriculum, and MSW internships.
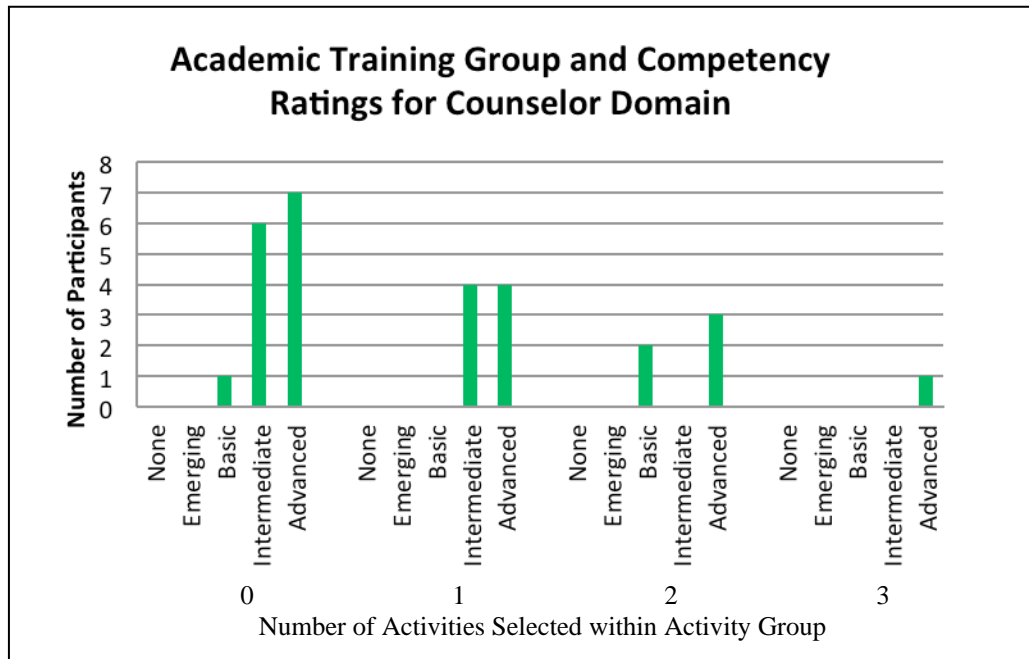
Academic Group Activities
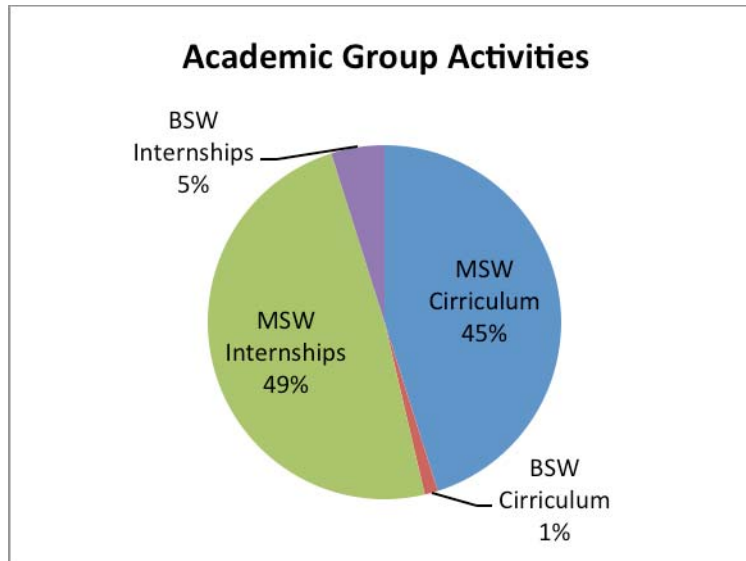
As depicted in Table 24 above, MSW internships was selected most often in this group (49%), followed closely by MSW curriculum (45%). BSW curriculum and internship were selected infrequently most likely due to the fact that a BSW is not necessary, while an MSW (or equivalent) is required in the United States and Canada in order to practice as a clinical social worker (NASW, 2005; CASW; 2005). As Hypothesis 4 stipulates, a positive correlation between selection of MSW internships and total competence was expected; however, the Spearman's Rho calculation showed no significant relationship between perceived total competency and the number of times a participant selected MSW internship across the five domains $(r_s(27) = 0.01, p=ns)$.

Cross Tabs: The academic training group had the lowest selection of multiple activities out of all of the activity groups. In three of the five domains (Educator, Advocate, and Monitor) the majority of participants at every competency level identified that they had engaged in zero activities in the academic training group. Table 25, shows the Educator domain which had the highest frequency out of the five domains of zero activities selected in the academic training group.

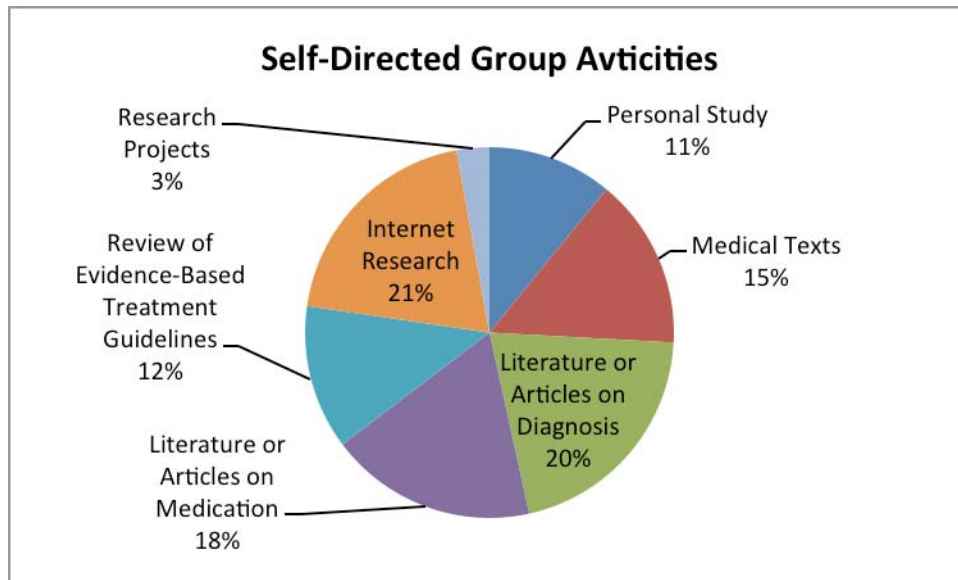Adacemic Training Group and Competency Ratings for Educator Domain
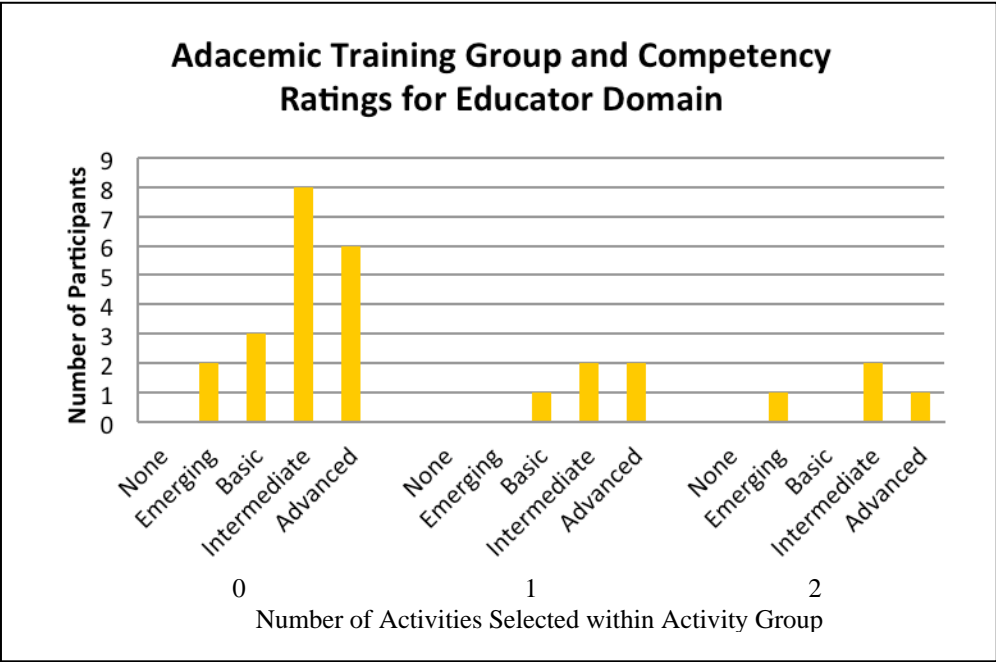
There were some differences for the Consultant and Counselor domains. In both domains, those who self-rated as intermediate selected zero activities more often; however in the Consultant domain those who self-rated as advanced were evenly distributed between the selection of zero activities and the selection of one or more. As shown in Table 26, the Counselor domain showed slightly higher selection rates of one or more activities for those with advanced (53%) as well as basic competency.

**Academic Training Group and Competency Ratings for Counselor Domain**

These responses overall are consistent with the literature and indicate that academic training is not a significant source of knowledge or skill development with regard to perceived competency.

Self-Directed: The activities in the self-directed group include those activities that involve personal research, independently accessing knowledge resources (reading materials, etc.), and autonomous selection of materials that enhance one's knowledge and capacity to work with medicated clients. This was the largest activity group and included; personal study, medical texts, literature/articles on a particular mental health diagnosis, literature/articles on a particular psychotropic medication, review of evidence-based treatment guidelines, internet research, and research projects. Table 27, details activity selection frequencies and shows that internet research was the most frequent selection (21%) followed by literature/articles on a particular mental health diagnosis (20%) and, literature/articles on a particular psychotropic medication (18%). There was a relatively more even distribution to the selections in the activity group. Similar to the continuing education activity group, this could be due to the similarity among some activity options.

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Self-Directed Group Avticities

- Research Projects 3%
- Personal Study 11%
- Internet Research 21%
- Medical Texts 15%
- Review of Evidence-Based Treatment Guidelines 12%
- Literature or Articles on Diagnosis 20%
- Literature or Articles on Medication 18%

Correlations: It was hypothesized that there would be a positive correlation between selection of internet use and total competency. It was found, through Spearman's Rho calculation, that there was no significant relationship between perceived total competency and the number of times a participant selected internet research across the five domains ($r_s(27) = -0.12$, p=ns).

Cross Tabs: In the self-directed activity group, one or more activities were selected by the majority of participants at all competency levels across all five domains. Of all the activity groups, the self-directed group had the highest selection rate of three or more activities by selected by participants. Table 28 shows the Consultant domain and competency ratings with self-directed activity selection frequency. This clearly depicts a trend for intermediate and advanced competency participant to choose a higher number of activities for this domain in this activity group.

Self-Directed Group and Competency Ratings for Consultant Domain
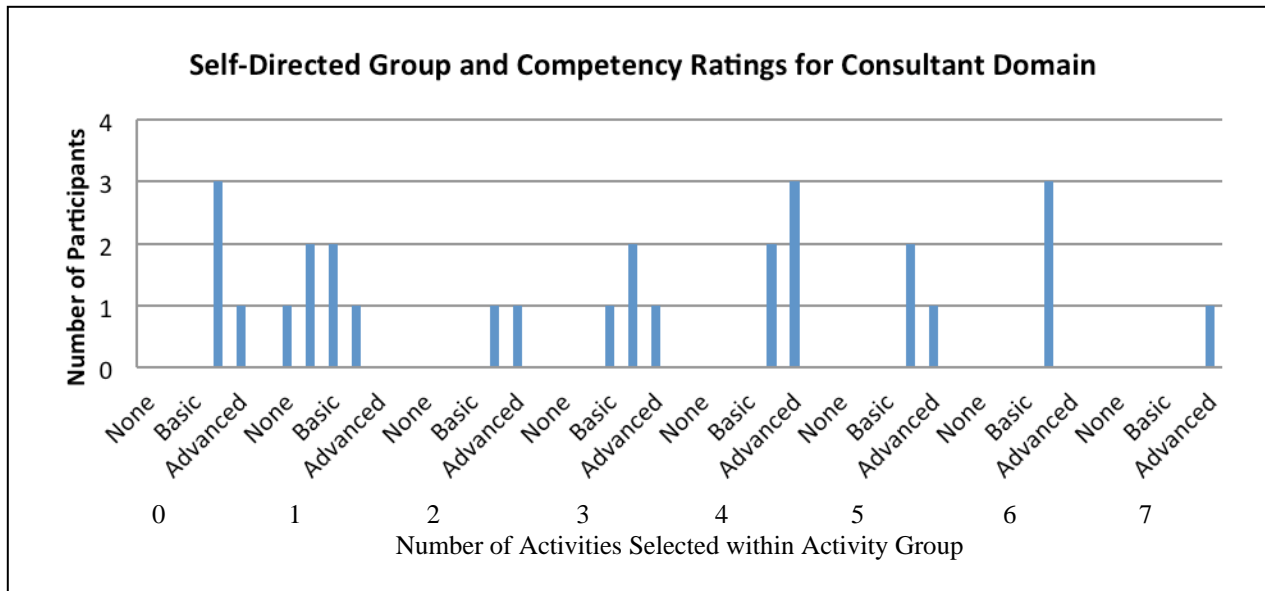
The domain with the lowest zero activity selection was the Educator domain as depicted in Table 29. Only one person in each competency rating selected zero activities and the most frequent number of activities selected was five by the intermediate group. This could indicate that self-directed activities are applicable to skill development in the Educator domain.

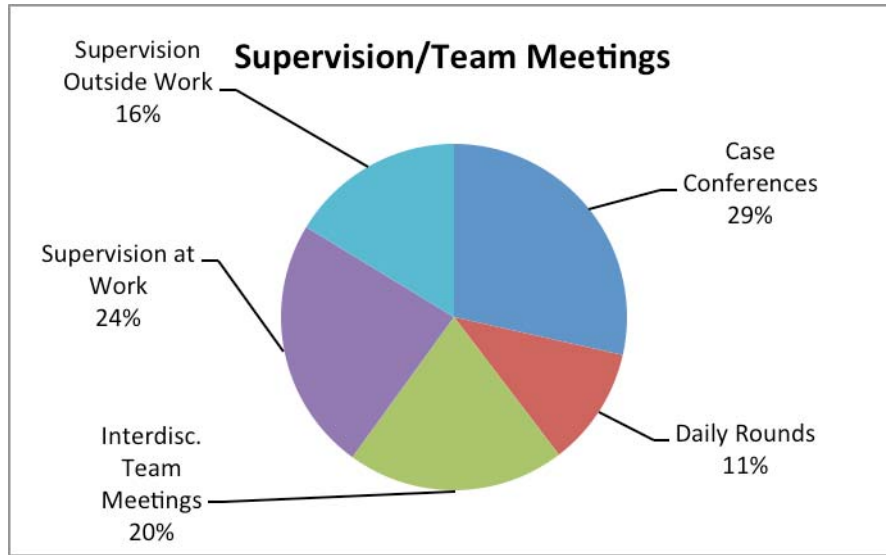Self-Directed Group and Competency Ratings for Educator Domain
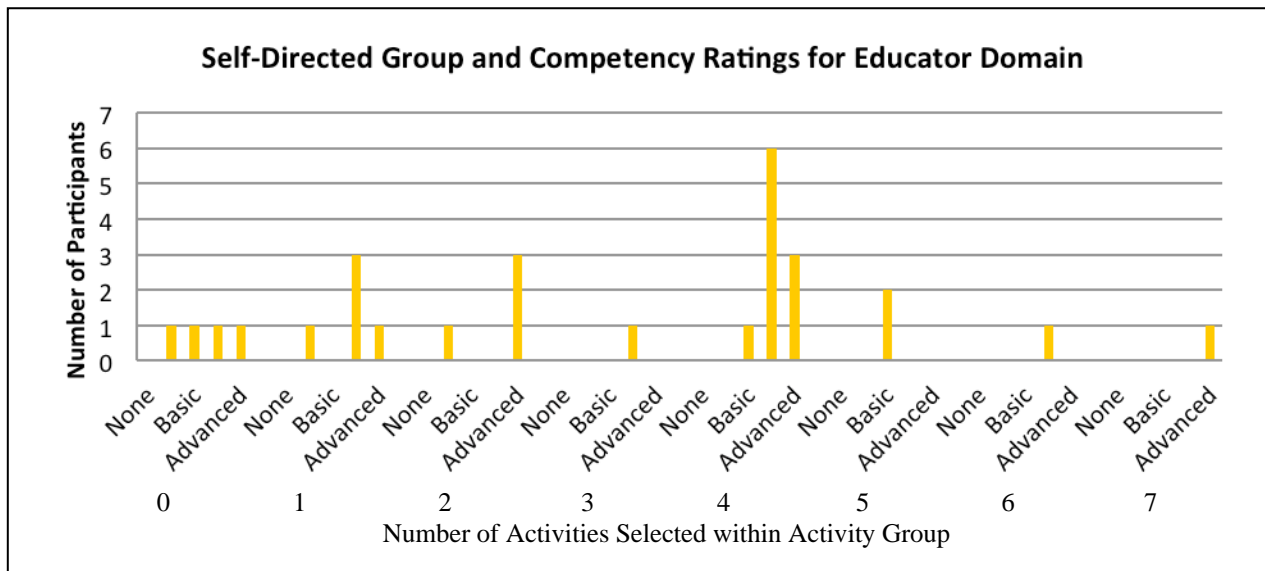
The domain with this highest response of zero activities selected was the Advocate domain. Table 30 shows that though the majority of intermediate and advanced competency participants still selected one of more activities about 33% of advanced and 33% of intermediate

selected zero.   Of those who selected basic competency in the Advocate domain 50% selected

zero activities. This could indicate that the self-directed group is the least applicable for this
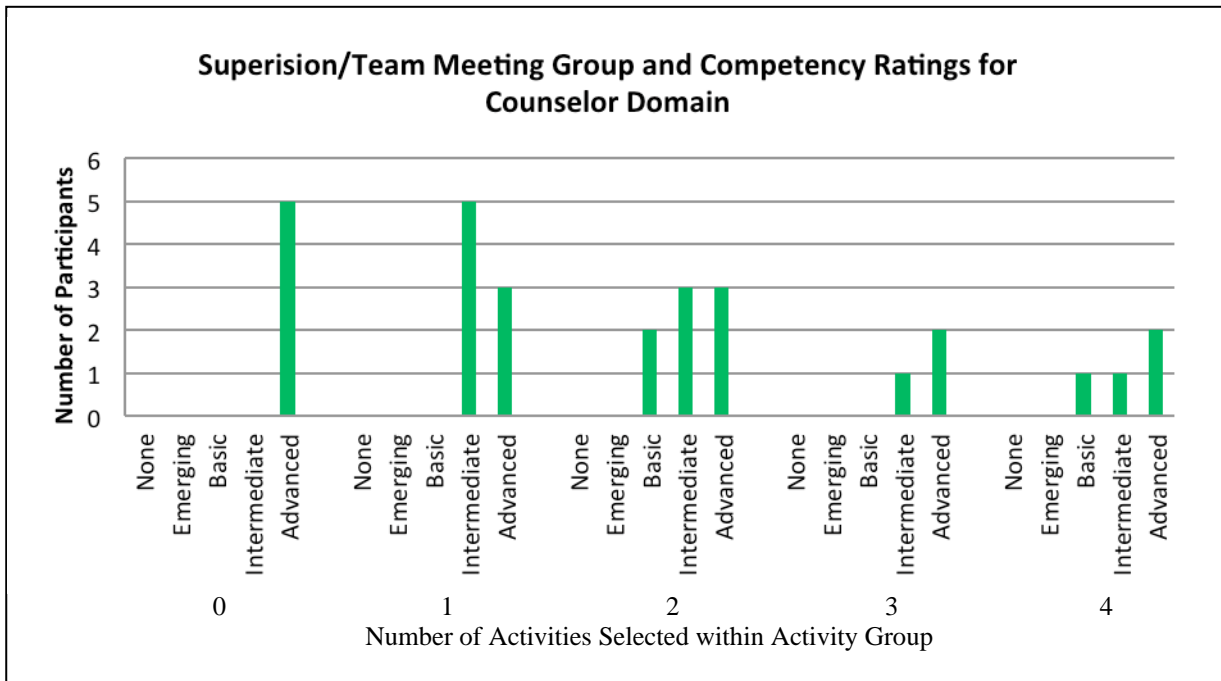
domain.
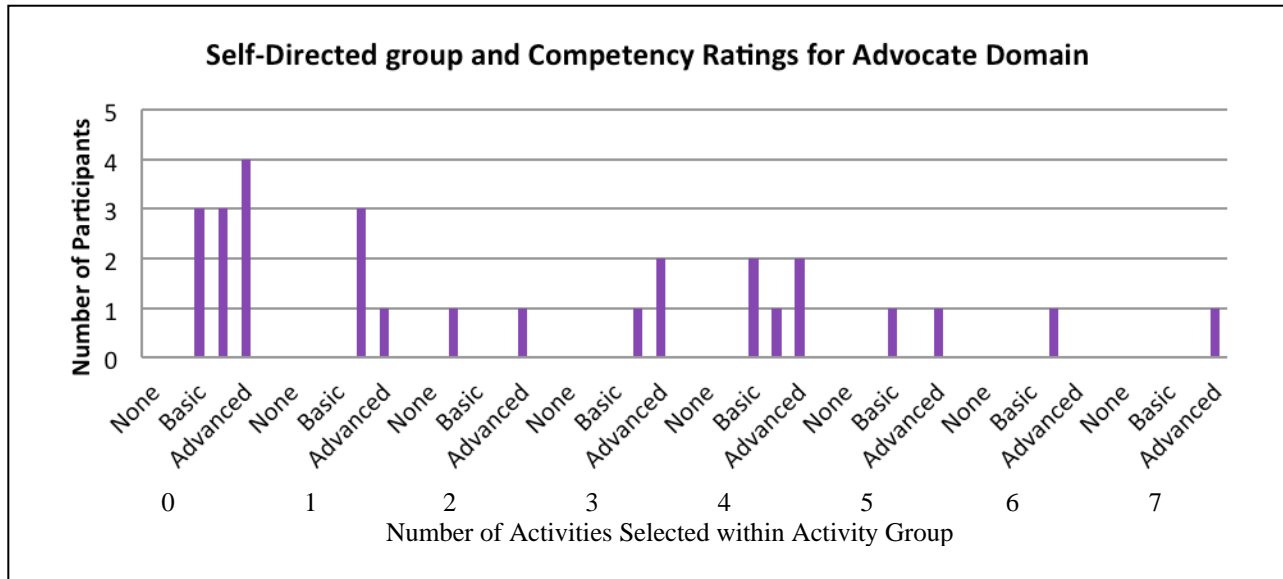
Supervision/team meetings: This activity group accounted for 17 % of the overall

activity selections made by participants meaning it was the thirst most highly selected group as

shown in Table 10. This group is defined as those activities that involve direction and feedback

from supervisors and co-worker inside and outside of the social work discipline. The activities

in this group included; case conferences, daily rounds, interdisciplinary team meetings,

supervision at work, and supervision outside of work. Table 31 shows the frequency of activity

selection within this group. This most frequently selected activity was case conferences (29%)

followed by supervision at work with 24%. The least frequently selected activity was daily

rounds (11%) which could be due to the fact that rounds do not occur on a daily basis in all

treatment settings.

Supervision/Team Meetings

- Supervision Outside Work 16%
- Case Conferences 29%
- Supervision at Work 24%
- Daily Rounds 11%
- Interdisc. Team Meetings 20%

Correlations: It was hypothesized that there would be a positive correlation between selection of case conferences and total competency rating as this activity was the most frequently selected of the group. The Spearman's Rho correlation indicated no significant relationship between perceived total competency and the number of times a participant selected case conferences across the five domains ($r_s(27) = -0.01$, p=ns).

Cross Tabs: In the supervision/team meeting activity group the majority of participants at all competency levels, across all five domains selected one or more activities in this group. There were some interesting differences however. Table 32 shows that the Counselor domain had the highest frequency of zero activity selection by those who perceived their competence to be advanced in this domain. However, no participants of any other competency rating selected zero activities in the Counselor domain.

Contrarily the Consultant domain, shown in Table 33, had participants who identified as intermediate and basic who selected zero activities, but no participants who perceived their competency to be advance in this domain chose less than two activities.
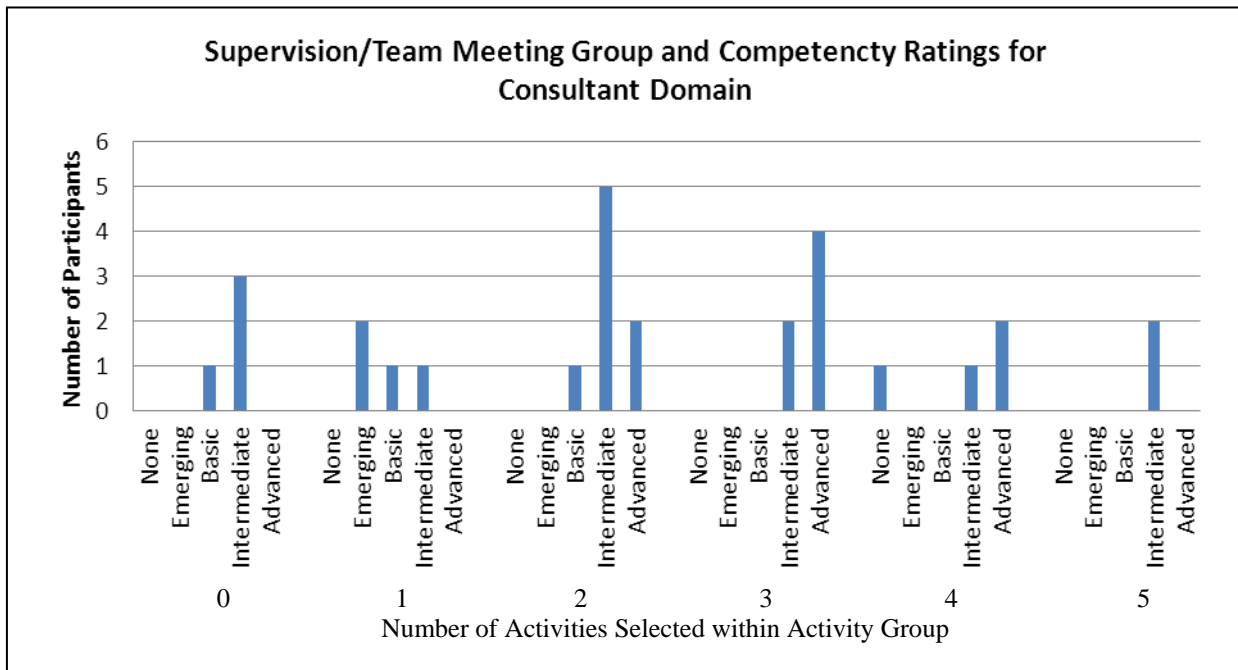
This indicates differences in the ways self-rated advanced and intermediate participants perceived this activity group in the Consultant and Counselor domains.

Narrative Data

At the end of the survey, participants answered one brief narrative question. Participants were asked to describe the three most influential knowledge sources they felt had contributed to their knowledge, skill, and competency development for working with medicated clients. They were not asked to rank these items in order, rather to simply list the three most influential activities.

Each of the 28 participants listed 3 knowledge sources resulting in a total of 84 responses. Of these 84 responses there were five activities that were endorsed multiple times. The activity most frequently mentioned in narrative responses was consultation with psychiatrists at 23.8 % (n=20). The second most frequently stated activity was interactions with client at 15.4% (n=13), followed by internet research at 9.5% (n=8), peer consultation at 8.3% (n=7), and continuing education training at 7.1% (n=6). Given that the narrative response format was not directed or limited as were the activity selections in the previous closed-ended questions, this replication of responses indicates that these activities are highly valued by participants.

Furthermore, all of the activities stated by participants fell into the activity groups previously described in this chapter which speaks to the validity of these activity groupings as well as the influence of these activity groups on skill and competency development. Table 34 shows the activities stated by participants and the activity groups they were coded into based on the definitions stated earlier in this chapter. This table also shows the endorsement frequency of each activity group.

Activity Group	Activities Listed by Participants	% of Total Response Rate (n=84)
Consultation	Consultation with psychiatrists	34.50%
	Consultation with peers	
	Consultation with other professionals	
	Consultation with nursing staff	
Self-Directed	Internet	17.90%
	Readings	
	Personal research	
	Physician's Desk Reference	
Direct Service	Interactions with clients	15.50%
Continuing Education	CEU's	14.30%
	In-service training	
	Training programs	
	Skill building workshops	
Supervision/Team Meetings	Supervision	11.90%
	Case conferences	
	Treatment team meetings	
	Interdisciplinary meetings	
Academic	MSW internship	4.70%
	MSW curriculum	
	Undergraduate courses in psychology	
Observation	Observations at work	1.20%

These narrative findings for activity group selection differ slightly from the activity group selection frequencies noted in Table 10 which references the close-ended activity selection section of the survey. One consistency, as show above, is that the most frequently mentioned activity group for both closed-ended and narrative responses was the consultation group which is consistent with previous literature. Among the narrative responses, the consultation group with a 34.5% selection rate was far and away the most frequently mentioned by participants as the second most frequently mentioned group was self-directed which only accounted for 17.9% of

responses. This uneven distribution indicates that the consultation group is not only the most

frequently utilized group of activities, but also that it is the most influential.

The final chapter, Chapter V, will discuss the implications of the findings that have been

laid out in the current chapter. Chapter V examines the efficacy of activities and activity groups

in the context of each practice competency domain and then posits recommendations for

graduate level training as well as continuing education enhancement for clinical social workers.

Limitations of the current study are also explored and finally, recommendations for future

research and concluding thoughts are offered.

CHAPTER V

Discussion

This study explored how clinical social workers, whose scope of practice includes working with patients who are prescribed psychotropic medication, went about developing the necessary knowledge and skills to work within this population. The goal was to identify activities and knowledge sources that contribute to the development of practice skills in this area and to examine the relationship of these activities to perceived practice competency. Participants were asked to self-rate their perceived competency in five domains of practice - Advocate, Counselor, Monitor, Consultant, and Educator - that Bentley and Walsh (2006) argue are necessary for ethical work and collaboration with medicated clients. These competency ratings were examined with activity and knowledge sources selections made by each participant in order to determine if relationships between competency and activity selected could be observed. Finally, narrative responses were analyzed in order to gather a more in-depth perspective from participants regarding those activities they felt were most influential to their skill, knowledge, and competency development.

Competency Domains

Hypothesis 1 asserted that among competency domains, the role of advocate would have the highest number of participants that self-rated their competency as "advanced." This hypothesis was not confirmed. The Advocate domain had the second highest selection of "advanced" competency self-rating by participants. Contrary to expectations, it was the

Counselor domain that had the highest selection of "advanced" competency self-ratings by participants. Furthermore, the Counselor domain had the fewest participants who rated their competency as "basic" or below. This indicates that the Counselor domain is the area in which the largest number of participants feel the most competent in practice with medicated patients.

Conversely, the Consultant domain had the lowest number of participants who selected "advanced" as their competency level. On the other hand, the Consultant domain had the largest number of participants who selected "intermediate" as their competency level. This indicates that in the Consultant domain participants felt relatively confident in their knowledge and competency to execute this role with medicated patients. However, it can also indicate, through the lower ratings of "advanced" competency, that this domain is an area for potential growth. Knowledge and skills associated with the Consultant domain, such as "referral to psychiatrists" have appeared more frequently in the literature since 2005. Indeed, Bentley, Walsh, and Farmer (2005) created a set of best practices for referring clients for psychiatric medication which details many of the skills involved in the Consultant domain, and the knowledge and interventions that are best practice for this role. Though this is an area where more specific, effective intervention-focused literature is available, competency ratings found in this study still indicate that this is an area where increased training and potential access to specific literature could be helpful.

The finding that the Counselor domain had a higher number of participants who selected the "advanced" competency level than the Advocate domain could be due to the fact the Advocate domain involves more specialized knowledge and skills for effective work with medicated clients. Bentley and Walsh (2006) argue that advocacy is an ingrained function in the discipline of social work. It is a central tenet to which clinical social workers adhere and that which informs their work with clients on a daily basis. They also note that advocacy for

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medicated clients involves special skills, a knowledge of state and federal laws around rights to receive and refuse medication, a knowledge about specific medications, and strategies to help patients track symptoms in order to advocate for themselves with their psychiatrists (Bentley & Walsh, 2006).

As it is with the Advocate domain, both the domains of Monitor and Educator also involve having a specific knowledge of the uses and potential effects and side effects of medication in order to execute these roles effectively (Davis-Berman, & Pestello, 2005). The areas of Monitor and Educator both had very few participants who rated their competency in these domains as "advanced." Contrary to the results in the Monitor domain, fewer participants identified their competency level as "advanced" in the Educator domain; however the Monitor domain had the largest number of participants who felt their competency was "basic" or below. This indicates that the Monitor role is one where further training could be important and useful. Literature has indicated that psychopharmacology training at the graduate and professional levels are limited; given this fact in conjunction with the assertion that these domains (Advocate, Monitor, and Educator) involve a higher degree of specialized knowledge, it is unsurprising that participants did not frequently rate their competency in these domains as "advanced" (Bentley, Walsh, & Farmer, 2006; Bentley & Walsh, 2006; Bentley, 2004). As such it is recommended later in this chapter that these domains, Monitor, Advocate and Educator be a focus for future training and research.

Activity Groups and Specific Activities

Hypothesis 2 investigated if the number of years in the field would have a positive correlation with participants' overall competency ratings. This hypothesis was confirmed. There was a positive correlation between years of employment and overall competency rating. This

was expected as with increased years of experience comes greater access to a larger number of activities and knowledge sources where clinical social workers can learn about medication and working with medicated clients.

Hypothesis 3, which proposed that there would be a positive correlation between "number of work settings" selected and overall competency rating was confirmed. There was a positive correlation between "number of settings worked" and overall competency rating. However, the two sub-hypotheses examining the relationship between (i) "work in inpatient settings" and overall competency rating, and (ii) "work in outpatient settings only" and overall competency rating, showed no correlational relationship. Previous studies have indicated that "work in inpatient setting" is generally equated with increased knowledge about medications and more favorable attitudes towards medication use with clients (Berg & Wallace, 1987). This was not substantiated in the findings of the current study. It is important to note that this could be due in part to survey design complication and question confusion, as participants did not respond to the questions regarding "work setting" as expected. What may be confounding the results here could be that the two aspects - "years of experience" and "total number of settings" - of the participants' work history are linked. Participants who had more years of experience in the field have also had the opportunity to work in more settings over their longer career. In order to account for this connection, future studies designed with this in mind can use regression analysis to single out the affects of each of these factors on competency levels.

Specific Activities:

Hypothesis 4 asserted that the most frequently selected activity in each activity group would have a positive correlation with overall competency rating. This hypothesis was also not confirmed. The top rated activity within each of the seven activity groups of "consultation",

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"observation", "direct service", "academic", "continuing education", "self-directed", and "supervision/team meetings" were not positively correlated with overall competency rating. The activities that participants most frequently selected within each activity group were "conversations with peers", "observations of psychiatrists", "interactions with clients", "MSW internships", "in-service trainings at work", "internet research", and "case conferences". The statistical analysis in this study showed no significant relationships between any activity and overall competency rating. Though these correlational relationships were not significant, the frequency with which participants selected these activities and knowledge sources speak to their relevance and significance for skill development.

Previous studies indicated that "consultation with psychiatrists" was a primary learning resource for clinical social workers working with medicated clients (Bentley *et al*., 2005; Berg & Wallace, 1987; Dziegielewski & Leon, 1998; Bentley *et al*., 2006). Findings in this study confirm that this activity was one that clinical social use frequently. This study's findings also corroborated Bentley, Walsh, and Farmer's (2006) conclusions as their top four findings included collaboration with psychiatrists, interactions with clients, conversations with peers, and professional workshops. The only finding not replicated as the top five of this study was "professional workshops." Similarly, Berg and Wallace (1987) noted that in-service training and continuing education, as well as medical texts and research were learning activities accessed regularly in their study. While the current study has found that all of these activities were accessed by some participants, "medical texts and research" were selected more often than "in-service training" and "continuing education", which fitted with more current research indicating that academic and continuing educational opportunities to learn about medications are limited and often agency specific (Bentley *et al.*, 2006; Bentley & Walsh, 2006). Though this

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confirmation of highly selected activities does not speak to the efficacy of these specific

activities, the frequency with which they are selected indicates that these activities hold some

value for the majority of participants, and should be encouraged as a means to develop skills and

knowledge for working with medicated clients overall.

Activity Groups:

The selection of activity groups, while not correlated due to small sample size and time

constraints, offered important results via descriptive data. Hypothesis 5 suggested that the

activities in the "consultation" group will be reported most frequently across all five domains.

This hypothesis was not confirmed. Cross Tabs showed that while participants often selected

activities in the "consultation" group as contributing to their skill development in all five of the

practice competency domains (Consultant, Counselor, Monitor, Advocate, and Educator), it was

not the most frequently selected group in each domain. The selection of activities in the

"consultation" group did, however, correspond to higher ratings of competency in each of the

five domains.

Among the seven activity groups, the activities in the "consultation" group were most

often selected by participants who felt their competency level was "advanced." These

"advanced" participants usually selected two or more activities in the "consultation" group. This

is true for all five of the competency domains. Participants who felt their competency level was

"intermediate" or "advanced" tended to select a large number of activities from the "self-

directed" activity group for all five domains. This indicates that the "consultation" and "self-

directed" groups are the most consistently selected activity group across all five domains. This is

in keeping with the literature as both Bentley *et al.* (2006) and Berg and Wallace (1987) noted in

their studies that the most often frequently selected activities were consultation/collaboration

with psychiatrists, though only Berg and Wallace also noted that self-directed learning activities were of importance to their participants.

Exploratory Question: Are there activities that are more effective than others for the development of perceived practice competency with medicated patients? Though there was no correlational confirmation of the relationship between overall competency and the specific activities mentioned previously, descriptive data, Cross Tabs analysis, and answers to the final narrative question indicated that participants have found certain training activities particularly useful. This was shown through higher selection frequency thus indicating that participants felt that these activities had influenced their competency. As mentioned previously, the top five overall most frequently selected activities in the closed ended questions in order of significance were as follows: "interactions with clients", "conversations with peers", "consultations with psychiatrists", "case conferences", and "internet research". The top five responses that participants noted in the narrative response as the most influential in their development of competency are similar to those selected in the closed ended questions with "consultation with psychiatrists" selected most often, and then followed by "interactions with clients", "internet research", "peer consultation", and "continuing education activities".

The only activities that were not found in the top five for both closed ended and narrative responses were the "case conferences" and "continuing education" activities indicating that while both of these are important avenues of skill development identified by participants, the most influential as confirmed by the open narratives, as well as the closed end-responses, were "consultation with psychiatrists", "interactions with clients", "internet research", and "peer consultation". The first activity, "consultation with psychiatrists", confirms what the existing literature suggested (Berg & Wallace, 1987; Bentley & Walsh, 2006; Bentley *et al.*, 2006;

Bentley *et al.*, 2005; Dziegielewski & Leon, 1998). However, it is important to question the type of training social workers may receive from psychiatrists as both Bentley *et al.* (2006) and Berg and Wallace (1987) caution that medical personnel are often not trained to consider the whole-person and the psychosocial implications when working with clients, as thoroughly as social workers. Furthermore, psychiatrists too have their own biases, prejudices, strengths, and preferences when it comes to medication prescription. While social workers may develop useful medication knowledge when learning from psychiatrists, they may be developing inadequate advocacy skills if that is their only training pathway.

Similarly, internet research can be viewed as an updated means of reference when used cautiously and effectively. Early findings by Berg and Wallace (1987) who began to explore the area of self-directed learning with regard to psychotropic drugs and work with medicated patients are consistent with this view. Along the same line, Bentley *et al.* (2006) arrived at the same conclusions through their analysis. In their study, Bentley *et al.* identified "consultation with psychiatrists", "interactions with clients", "consultation with peers", and "professional workshops" (framed in this study as "continuing education") as the four highest activities selected. The fact that the narrative responses, where participants were asked explicitly to name three factors that influenced their skill and competency development related so closely not only to established research, but also to the closed ended response frequencies indicates that these findings - while not statistically significant - do have some validity and that these repeated activity selections indicate some level of efficacy for knowledge and competency development.

In summation, all of the descriptive data from this study confirmed the assertion in existing literature that academic training on psychotropic medications for social workers at the graduate level is too limited were confirmed (Libassi, 1990; Wise, 1986; Dziegielewski & Leon,

1998; Bentley, Farmer, Phillips, 1991; Berg & Wallace,1987; Bentley *et al.*; Bentley *et al.*, 2006; Matrion & De Chillo, 1984; Bentley & Walsh, 2006; Moses and Kirk, 2006; Moses, 2008). This study has found that 75% of the participants attended MSW programs where courses on psychotropic medication and work with medicated clients were not offered. This along with the low selection rate of the "academic" activity group indicates that this has not been an effective means of learning for participants. Cross Tabs analysis also depicted this training gap as they showed the academic activity group as the least selected overall across all five domains, and the activity group as a whole has a clear converse relationship with competency self-ratings.

As previously mentioned, correlations run between specific activities and overall competency were found insignificant; however Cross Tabs analysis relating activity groups and competency ratings within each domain showed subtle, but significant differences in participant responses that could indicate variations in activity group efficacy depending on the specific domain. Recommendations for learning within each domain, along with implications for activity group efficacy will be discussed further in the following section, Implications for Training.

Implications for Training

Overall, this study confirms the findings of Dziegielewski and Leon (1998). Dziegielewski and Leon (1998) asked specifically if participants felt courses about psychotropic medications should be mandated in graduate programs and found that the response was 94.9% affirmative. In the current study, 96.4% of participants responded positively when asked if they felt professional development learning opportunities for work with medicated clients should be increased. Participants in both studies answered overwhelmingly in the affirmative when asked if there is need for increased learning opportunities for clinical social workers around issues related to psychotropic medication and working with this population.

Given this call for increased learning opportunities, what follows are the implications for this study regarding effective training and activities and groups of activities that clinical social workers can seek to engage in to increase their skills and competency when practicing with this population. These are broken down into domain specific learning opportunities and overall development activities. Due to the limited access to academic training on psychopharmacology suggested in the literature and confirmed in this study, the "academic" group is not recommended as a learning activity for any of the five competency domains. Instead recommendations for the expansion of graduate course offerings on psychopharmacology are described at the end of this section.

Consultant: The Consultant domain showed one activity group that was clearly related to higher levels of competency. The "consultation" group of activities was selected by 100% of participants who rated their competency as "intermediate" or higher and often they selected more than one activity in this group. This indicates that engaging in the activities in the "consultation" group which include "consultation with psychiatrists" inside or outside of work and "conversations with peers" inside or outside of work are useful means for developing skills and perceived competency in the Consultant domain. While this is the only group with a 100% selection rate by both "intermediate" and "advanced" participants, the "advanced" competency participants also selected "supervision/team meetings" activities 100% of the time as well. Only one participant in the "advanced" competency group for this domain identified selecting zero activities in the "self-directed" group while the remaining 88% (n=7) selected at least two or more activities in this group. The remaining activity groups of the seven, with the exception of the "academic" group which had a converse relationship to competency, indicated some

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relationship to competency, but it was not as significant as the three activity group described above.

It is recommended that those who would like to develop further skills and knowledge that may contribute to perceived competency in the Consultant domain seek out, first and foremost, "consultation from psychiatrists and peers." Utilization of "supervision" and "self-directed" group activities are also highly recommended. In the second tier of activity choices are the "direct service", "continuing education", and "observation" groups.

Counselor: The "direct service" group was most consistently selected by "intermediate" and "advanced" competency participants within the Counselor domain. The next two most highly selected groups related to "intermediate" and "advanced" competency are "self-directed" and "consultation." The "supervision/team meetings" group was selected by 100% of "intermediate" participants, but only by 67% of "advanced" self-rated competency participants. This indicates that there may be some variation between how different competency groups may learn and develop skills across domains. "Continuing education" and "observation" were selected less frequently, with "observation" only being selected 50% of the time by "intermediate" and "advanced" participants. It is recommended to develop skills and competency in the Counselor domain that individuals engage in the "direct service" activity group occur often followed by activities in the "self-directed" and "consultation" groups. It is also recommended that "intermediate" or below competency self-rating individual also seek development through "supervision/team meetings" group activities.

Monitor: The Monitor domain had the most 50/50 selection of activity groups by participants meaning that participants who felt their competency was "intermediate" or "advanced" selected zero activities 50% of the time and one or more activities 50% of the time.

Both the "continuing education" and "observation" groups had only a 50% selection rate by higher competency participants which excludes them from recommendation as they are not actively selected to a rate that indicates contribution to competency rating. The most frequently selected group was "direct service" followed" consultation" and "supervision/team meetings." These are thus the three overall recommended activity groups for this domain. Specifically for the "intermediate" or below competency individuals, engagement in "direct service" activities are also recommended as 100% of "intermediate" participants selected this group as influential to competency development in the Monitor domain.

Advocate: The highest rated competency participants most frequently selected the activity group "supervision/team meetings" in the Advocate domain. This activity group is of particular importance to "intermediate" as well as "basic" self-rated competency participants who as they selected this group 100% of the time. Thus it is highly recommended for individuals who might rate their competency at these levels and be looking to expand their skills to engage in this activity group. "Direct service" group activities are recommended for "intermediate" self-rated competency individuals as well; however not for "advanced" individuals as the "direct service " group was not found to be a contributing factor to their competency level in this domain. The "consultation" group was similarly highly rated by "intermediate" and "advanced" participants and is recommended for competency development overall.

Educator: The most highly selected activity group by "advanced" and "intermediate" participants and thus the most highly recommended is the "self-directed" group for the Educator domain. Further recommended groups in this domain include "direct service" and "consultation." The "consultation" group is of particular significance for "advanced"

participants as it was highly rated and thus is recommended for all individuals who may be looking to increase their competency and skills in this domain.

Overall: Each activity group and specific activity has its merits for developing skills and expanding knowledge with regard to psychotropic medications and work with clients prescribed them. The most frequently selected activities in both closed ended and narrative responses were as follows; "interactions with clients", "conversations with peers", "consultations with psychiatrists", "case conferences", "continuing education activities", and "internet research." Engagement in these specific activities, particularly "consultation with psychiatrists and peers" is highly recommended. These activities has been shown to be important and effective through validation in four categories; 1) previous research, 2) direct selection in the current study as influential in narrative response, 3) high frequency of selection in closed-ended response, and 4) the leading activity in the given activity groups. As described above, certain activity groups such as "consultation" are effective for perceived competency development across domains and thus are recommended for overall skill development.

Agencies with an interest in furthering the training of social work employees would do well, given the results of this study, to offer training opportunities around medication and effective work with medicated clients. Continuing education courses and in-service trainings should focus on tapping into these training gaps around psychopharmacology and should utilize curriculum that emphasizes the worth of self-directed research. This could include offering employees access to materials/literature that focuses on specific knowledge about medications and their effects and side effects. State and agency specific information regarding advocacy issues such as the right to receive or refuse medication should also be presented as such specific

knowledge is not as easily accessed through activities that occur in the context of "direct service" such as "interactions with clients."

The current study also shows that a great deal of skill development occurs through experiential learning that happens "on-the-job" in activities without a set curriculum. Agencies that wish to further expand the overall skill base, not just specific knowledge base through courses or workshops, should seek to expand the opportunities for their social workers to interact with psychiatrists, more experienced peers, and other team members. Increasing the number of case conferences that involve issues with medicated clients as well as discussions of medication issues during staff meetings and interdisciplinary meetings are good places to start. Encouraging discussion of these topics in supervision is also recommended. Finally, a combination of approaches is most highly suggested. Agencies should seek to offer in-service trainings on specific medication and medication issues while expanding opportunities for learning from interactions with medicated clients and increased supervision and consultation with psychiatrists and other experienced team members who can offer guidance, support, direction, and clear recommendations.

Academic Training Recommendations: Several authors, including Bentley *et al.* (2005; 2006), detail recommended curriculum options and have describe best practice for client referral for medication in their articles (Bentley *et al.*, 2006; Bentley & Reeves, 1992). Dziegielewski and Leon (1998) further detailed curriculum for continuing education courses based on research regarding what was missing at the graduate level. Within the last ten years, several texts have been written where the expressed purpose of the authors is for these books to be utilized in the education of social workers around psychopharmacology (Bentley & Walsh, 2006; Bentley, 2004; Dziegielewski, 2009; Austrian, 2005).

Curriculums proposed by Bentley *et al.* (2006) as well as Bentley and Walsh (2006) generally progress through the following format: review social workers' roles in psychopharmacology, neurology and drug actions, introduce classes of psychotropic medication and types, highlight considerations for special populations, discuss ethical and legal issues, identify effective medication management interventions, and present models on effective collaboration with psychiatrists and other team members. These areas cover all five of the roles/domains proposed by Bentley and Walsh (2006) and the activities that they may encompass. Findings from this study show that 85.7% of participants worked with medicated clients in their internship, but 75% of participants had no courses offered in their program about psychopharmacology and the social work role. This supports the argument that such courses should be offered, if not mandatory at the MSW level and should include not only specific knowledge acquisition through readings, but also through coordinated hands-on experience in internships coupled with strong supervision in order to tap into the more experiential learning activity groups such as "consultation", "direct service", and "supervision/team meetings" that have been shown in this study to be influential to competency development.

Limitations and Recommendations for Future Research

The current study had many limitations. The preeminent limitation was the small sample size. This limited the depth to which the data could be analyzed and increased the potential for Type 1 error in running too many correlations. In comparison to previous research the sample collected was quite small, though the survey created for this study was more focused with regard to knowledge sources and activities. This study used a sample of convenience, which was spread between the United States and Canada and thus was not a nationally representative random sampling of clinical social workers, though some aspects of demographic data such as gender,

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age, and education level indicate that North American sampling also resulted in some lack of uniformity as the licensure equivalents are not the some in the United States and Canada (Edwards *et al.,* 2006). However much of the findings reflected those of previous research and the geographic sample diversity shed light on areas of potential growth in training on psychopharmacology in both countries.

The sample was also limited in several other ways. As previously mentioned licensure requirements differ between countries, therefore this factor was not considered in correlational analyses. Furthermore, the sample was not significantly ethnically/racially diverse as 85.7% of participants identified as White and 14.2% of participants identified as Asian indicating that the sample is not representative of the national sample of social workers in either the United States or Canada. Future studies should aim to seek out a more representative sample in both countries in order for results to be representative of the clinical social work workforce.

The current study, while informed by the work of Bentley *et al.* (2005), was as a pilot study with survey tool created by the researcher and as such was flawed in several ways. Foremost, perceived competency self-ratings are the participants' views of the own skills level. This is not an objective measurement and thus is subject to respondent bias and significant variation based on the respondent's perception. This was effective for the current study as the aim was to explore the relationship between perceived competency and the activities and information sources that participants thought could have contributed to their skill and knowledge development; however future research may gather a more accurate representation of activity efficacy for competency development if standardized competency measurements are used.

Furthermore, clarity of instructions for questions 17 and 18 on the survey (See Appendix B) regarding current and past work settings could have been more detailed as several participants

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answered these questions in reverse. The survey length and ease of completion were also issues.

Participants were asked to select all of the learning activities they engaged in for each domain

which resulted in lower selection rates in the later domains as this exercise was time consuming.

In future research clarification of instructions, limitation of repetitive questions, and potential use

of an objective skill measurement tool to measure competency, knowledge, and skill level could

be beneficial.

Given the limited sample size, perceived self-ratings of competence, and use of a

correlational design, direct causality and direction of causality could not be determined. Factors

such as "number of settings worked" and "years worked in the field with medicated patients" are

highly related and their influence on activity selection is likely to be significant. To account for

this, future research should use regression analysis to explore overlapping factors such as these

and to more accurately determine the relationship between activity selection and overall

competency rating.

Conclusions

Literature about the role of social work with psychopharmacology has been steadily

increasing for the last 40 years. A number of studies have pointed out a gap in training at the

MSW level for social workers regarding psychopharmacology and ways in which to effectively

engage in appropriate roles with medicated clients. Given this training gap, few studies have

explored how clinical social workers have actually gone about gaining the knowledge and skill to

work with this population. The current study contributes to the literature in that it is one of the

few that has examined what knowledge sources and activities professional clinical social workers

in the field have engaged in to learn about work with medicated clients and examined these

activities in conjunction with perceived self-ratings of competency in this area to explore the potential efficacy of these activities.

A primary aim of the study was to develop and pilot a methodology for examining self-ratings of practice competency and knowledge pathway selection among clinical social workers practicing with clients who are prescribed psychotropic medications. In this regard, the study was innovative and successful. The methodology that was piloted was based on a thorough review of the relevant literature, and informed by the work of Bentley *et al.* (2006). This study confirmed previous research that a training gap exists for social workers at the MSW level and at the continuing education level. The current study also expanded on previous research and found that several groups of activities such as the "consultation" group and the "self-directed" group were selected frequently by participants who self-rated their competency as "advanced" in all domains; thus speaking to the efficacy of these activity groups for skill development.

This is an area that should be researched further because work with medicated clients has become a practice reality for clinical social workers. Agencies employing clinical social workers who work with medicated clients and MSW programs alike may wish to seek to conduct their own research in this area to assess the skill and knowledge level of students and employees who are working with this population. Expansion of curriculum offered on psychopharmacology and close supervision for students during MSW internships by trained clinical social work supervisors and psychiatrists is highly recommended based on the findings from this study. Thus far, all analysis from the participants' responses has indicated that social workers with specific knowledge of medications from personal research and experiential knowledge had higher competency ratings.

Expansion of training programs and hands-on skill building opportunities with clients is recommended for agencies employing clinical social workers that wish to offer skill and knowledge development in this area. This study, though it did not show strict causality, did indicate that participants with higher self-rated competency valued and frequently accessed knowledge sources and activities in a manner that demonstrated their interest and dedication towards ongoing skill development. Data indicates that competency is not only acquired through personal research, but also through supervision, feedback from peers, hands-on learning with clients, and collaboration with psychiatrists. In conclusion, though coursework is not readily offered, clinical social workers have found heuristic means to develop competent ways for working with medicated clients by accessing myriad knowledge sources and activities through their post-masters employment experience. As such, it would seem clinical social workers have been practicing conscientiously through their own ad hoc attempts to learn, but could benefit from more systemic pathways of training.

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Appendix A

SMITH COLLEGE

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950   F (413) 585-7994

March 15, 2013

Katherine Preston

Dear Katie,

Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Acting Chair, Human Subjects Review Committee

CC: Florence Loh, Research Advisor

TREATING MEDICATED CLIENTS: THE CSW ROLE

Voluntary Nature of Participation

Participation in this study is entirely voluntary. You may choose not to open the survey linked to the recruitment email. You may choose not to agree to the Informed Consent, may skip any question you wish, may choose to exit the survey at any time, and may choose not to submit the finished survey. Should you choose to submit the survey and associated Informed Consent, your data cannot be removed from the study as the data is anonymous and it would not be possible to find your completed survey.

Thank you for your time and interest in this study.

Researcher's Contact:
Katherine Preston

kpreston@smith.edu

Human Subject's Committee
Chair, HSR Committee
Smith College School for Social Work
Lilly Hall, Northampton, MA
(413) 584-2700

*7. YOUR SELECTION OF "I AGREE" INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

○ I AGREE

○ I DO NOT AGREE

Thank you for your interest in this study.

Your answers indicate that you do not meet the eligibility criteria needed for participation in this study. Thank you very much for your time and interest in this research.

START SURVEY

Please answer each question. Some questions are multiple choice. Some require that you enter a numeric response. Please try not to skip any questions.

PERSONAL CHARACTERISTICS

TREATING MEDICATED CLIENTS: THE CSW ROLE

8. What is your age?

Years [   ]

9. What is your gender?

○ Female

○ Male

○ Other

10. What is your racial/ethnic background?

☐ American Indian/Alaska Native

☐ Asian

☐ Black/African American

☐ Hispanic or Latino

☐ Native Hawaiian/ Other Pacific Islander

☐ White

PROFESSIONAL TRAINING AND LIESCENSING

11. Please indicate your highest level of education as a social worker.

○ MSW

○ PhD/DSW

Other (please specify)

[   ]

12. What year was your MSW granted?

YYYY [   ]

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TREATING MEDICATED CLIENTS: THE CSW ROLE

13. Please indicate your highest level of licensure.

○ LCSW

○ LICSW

YEARS WORKING

14. Total number of years employed as a clinical social worker.
Please do not include internship training in your response.

Round to nearest whole year [   ]

15. Looking back over your total career, how many years have you worked with CHILDREN AND/OR ADOLESCENTS who are/were prescribed psychotropic medication(s)? Include time in your current position. TIP: If you worked part-time during some years, count each of those years as a whole year.

If you have not worked with medicated CHILDREN AND/OR ADOLESCENTS, write "0" in the answer field.

Number of years (CHILD / ADOLESCENT) [   ]

16. Looking back over your total career, how many years have you worked with ADULTS who are/were prescribed psychotropic medication(s)? Include time in your current position. TIP: If you worked part-time during some years, count each of those years as a whole year.

If you have not worked with medicated ADULTS, write "0" in the answer field.

Number of years (ADULTS) [   ]

YOUR CURRENT WORK SETTING

TREATING MEDICATED CLIENTS: THE CSW ROLE

17. Please indicate all of the setting(s) in which you CURRENTLY work with medicated patients. "Medicated patients" refers to children/adolescents or adults who are prescribed psychotropic medications, including medications for ADHD. Remember, you are describing your CURRENT work setting(s).

After you select a setting and population, please indicate the number of years you have worked there. If your work setting is not listed, please write in your setting.

	POPULATION	YEAR(S) IN THIS POSITION
Outpatient mental health clinic		
Private Practice		
Home-based		
Community-based (not overnight)		
School-based		
Residential overnight (includes CBAT/IRT)		
Inpatient psychiatric		
Medical		
Emergency Room		
Other		

If you selected "OTHER" above, please specify setting

YOUR PAST WORK SETTING

TREATING MEDICATED CLIENTS: THE CSW ROLE

18. Please indicate all of the setting(s) in which you PREVIOUSLY WORKED with medicated patients. After you select a setting and population, please indicate the number of years you worked there. If your work setting is not listed, please write in your setting. NOTE: Please do not include your current work setting(s),

	POPULATION	YEAR(S) WORKED IN THIS SETTING
Outpatient mental health clinic		
Private Practice		
Home-based		
Community-based (not overnight)		
School-based		
Residential, overnight (includes CBAT/IRT)		
Inpatient psychiatric		
Medical		
Emergency Room		
Other		

If you selected "OTHER," please specify setting:

19. Do you utilize a specific theoretical orientation in your work?

◯ Yes

◯ No

If Yes, please specify:

ACADEMIC PREPARATION: BSW

TREATING MEDICATED CLIENTS: THE CSW ROLE

20. If you studied in a BSW program, did your BSW program offer courses on psychotropic medication?

○ Yes

○ No

○ Not Applicable

BSW COURSES

21. Were the courses:

☐ Required

☐ Elective

☐ Offered as Colloquia

Other (please specify)

[ ]

22. Did you take any courses on psychotropic medications?

○ Yes

○ No

23. How many courses did you take?

Number of courses [ ]

ACADEMIC PREPARATION: MSW

24. Did your MSW program offer courses on psychotropic medication?

○ Yes

○ No

TREATING MEDICATED CLIENTS: THE CSW ROLE

MSW COURSES

25. Were the courses:

☐ Required

☐ Elective

☐ Offered as Colloquia

Other (please specify)

[   ]

26. Did you take any courses on psychotropic medications?

○ Yes

○ No

27. How many courses did you take?

Number of courses [   ]

ACADEMIC PREPARATION: Clinical Internships

28. During your CLINICAL INTERNSHIPS, did you work with clients who were being treated with psychotropic medication?

○ Yes

○ No

TREATING MEDICATED CLIENTS: THE CSW ROLE

29. During your CLINICAL INTERNSHIP, did you receive supervision about your role or specific skills for working with medicated patients?

○ Yes
○ No

SELF-ASSESSMENT

The literature suggests that working with behavioral health clients who are prescribed psychotropic medications requires a specialized set of skills and roles. For purposes of this research, we call these "Practice Competencies." These skills fall into five skill set groups: 1) consultant, 2) counselor, 3) monitor, 4) advocate, and 5) educator. In the next section, you are asked to consider and rate your current skill development in each of these five areas. There is no right or wrong answer: every journey is personal.

30. CONSULTANT: The consultant role involves diagnostic assessment, establishing treatment goals, discussing referral for medication consultation (including exploring the patient's perspectives about how medication may or may not be helpful or desirable), and collaboration with the treating psychiatrist or prescriber.

I would rate my current skills in this area as:

○ None   ○ Emerging   ○ Basic   ○ Intermediate   ○ Advanced

31. COUNSELOR: The counselor role involves such skills as being able to validate the client's perspectives about and experience with their medications. Discussing medication issues and potential barriers to progress. Assisting the client with developing skills by engaging with the client in problem solving.

I would rate my current skills in this area as:

○ None   ○ Emerging   ○ Basic   ○ Intermediate   ○ Advanced

TREATING MEDICATED CLIENTS: THE CSW ROLE

32. MONITOR: The monitor role includes such skills as the clinical social workers' ability to "observe and help the client observe" both the positive and negative effects their prescribed medication has on their "psychical, psychological and social" health. Assisting the client to monitor their responses to the medication, including monitoring side effects, symptom presentation, and adherence to the prescribed schedules.

I would rate my current skills in this area as:

○ None   ○ Emerging   ○ Basic   ○ Intermediate   ○ Advanced

33.

ADVOCATE: The advocate role includes such skills as the ability of the clinical social worker to explore with patients their feelings about taking medication as well as to support discussions about the right to access, receive, change, and/or refuse medication. This includes having a "working knowledge" of mental illnesses, psychotropic medications, laws and regulations about medications, and patient rights.

I would rate my current skills in this area as:

○ None   ○ Emerging   ○ Basic   ○ Intermediate   ○ Advanced

34. EDUCATOR: The educator role includes such skills as the ability to provide basic information about relevant medication issues, with the goal of enhancing the patient's and family's knowledge about the roles medication may play in their treatment. To provide basic information regarding the effects and side effects they may encounter and engage in training with clients and families about how to effectively communicate with their prescriber regarding their medication issues and needs.

I would rate my current skills in this area as:

○ None   ○ Emerging   ○ Basic   ○ Intermediate   ○ Advanced

KNOWLEDGE SOURCES

TREATING MEDICATED CLIENTS: THE CSW ROLE

There are many pathways to developing the knowledge and skills that inform clinical social work practice with medicated patients. Skills may be learned "on the job" through exposure to many different types of clinical and training opportunities, through professional development activities, or through activities designed individually. Each journey is unique.

The next five questions ask you to identify which particular activities helped you to develop skills in each of the five competency areas: consultant, counselor, monitor, advocate, and educator. If you don't see an activity on the list, please add your own.

35. CONSULTANT: The consultant role involves diagnostic assessment, establishing treatment goals, discussing referral for medication consultation (including exploring the patient's perspectives about how medication may or may not be helpful or desirable), and collaboration with the treating psychiatrist or prescriber.

Please select those activities or influences that you feel helped you develop skills as a consultant.

- [ ] In-service training at work
- [ ] Outside workshops/training
- [ ] Skill-building workshops
- [ ] Continuing ed courses
- [ ] Consultation with psychiatrist at work
- [ ] Consultation with psychiatrist outside of work
- [ ] Conversations with peers at work
- [ ] Conversations with peers outside of work
- [ ] Supervision at work
- [ ] Supervision outside of work
- [ ] Modeling provided by colleagues
- [ ] Observations of colleagues

- [ ] Observations of psychiatrists
- [ ] Role play
- [ ] Interactions with clients
- [ ] Family conferences / feedback
- [ ] Patient conferences / feedback
- [ ] Case conferences
- [ ] Daily rounds
- [ ] Interdisciplinary team meetings
- [ ] Grand Rounds
- [ ] Participation in research projects
- [ ] Participating in a medication psycho-ed program for families
- [ ] Participating in a medication psycho-ed program for patients

- [ ] MSW program courses/curriculum
- [ ] BSW program courses/curriculum
- [ ] MSW program internship(s)
- [ ] BSW program internships(s)
- [ ] Personal study
- [ ] Medical texts (for example the PDR or DSM)
- [ ] Relevant literature and articles on a particular illness
- [ ] Relevant literature and articles on a particular medication
- [ ] Reviewing evidence-based treatment guidelines
- [ ] Using the internet to research medications

Other (please list)

TREATING MEDICATED CLIENTS: THE CSW ROLE

36. COUNSELOR: The counselor role involves such skills as being able to validate the client's perspectives about and experience with their medications. Discussing medication issues and potential barriers to progress. Assisting the client with developing skills by engaging with the client in problem solving.

- [ ] In-service training at work
- [ ] Outside workshops/training
- [ ] Skill-building workshops
- [ ] Continuing ed courses
- [ ] Consultation with psychiatrist at work
- [ ] Consultation with psychiatrist outside of work
- [ ] Conversations with peers at work
- [ ] Conversations with peers outside of work
- [ ] Supervision at work
- [ ] Supervision outside of work
- [ ] Modeling provided by colleagues
- [ ] Observations of colleagues

- [ ] Observations of psychiatrists
- [ ] Role play
- [ ] Interactions with clients
- [ ] Family conferences / feedback
- [ ] Patient conferences / feedback
- [ ] Case conferences
- [ ] Daily rounds
- [ ] Interdisciplinary team meetings
- [ ] Grand Rounds
- [ ] Participation in research projects
- [ ] Participating in a medication psycho-ed program for families
- [ ] Participating in a medication psycho-ed program for patients

- [ ] MSW program courses/curriculum
- [ ] BSW program courses/curriculum
- [ ] MSW program internship(s)
- [ ] BSW program internship(s)
- [ ] Personal study
- [ ] Medical texts (for example the PDR or DSM)
- [ ] Relevant literature and articles on a particular illness
- [ ] Relevant literature and articles on a particular medication
- [ ] Reviewing evidence-based treatment guidelines
- [ ] Using the internet to research medications

Other (please list)

_____

TREATING MEDICATED CLIENTS: THE CSW ROLE

37. MONITOR: The monitor role includes such skills as the clinical social workers' ability to "observe and help the client observe" both the positive and negative effects their prescribed medication has on their "psychical, psychological and social" health. Assisting the client to monitor their responses to the medication, including monitoring side effects, symptom presentation, and adherence to the prescribed schedules.

- [ ] In-service training at work
- [ ] Outside workshops/training
- [ ] Skill-building workshops
- [ ] Continuing ed courses
- [ ] Consultation with psychiatrist at work
- [ ] Consultation with psychiatrist outside of work
- [ ] Conversations with peers at work
- [ ] Conversations with peers outside of work
- [ ] Supervision at work
- [ ] Supervision outside of work
- [ ] Modeling provided by colleagues
- [ ] Observations of colleagues

- [ ] Observations of psychiatrists
- [ ] Role play
- [ ] Interactions with clients
- [ ] Family conferences / feedback
- [ ] Patient conferences / feedback
- [ ] Case conferences
- [ ] Daily rounds
- [ ] Interdisciplinary team meetings
- [ ] Grand Rounds
- [ ] Participation in research projects
- [ ] Participating in a medication psycho-ed program for families
- [ ] Participating in a medication psycho-ed program for patients

- [ ] MSW program courses/curriculum
- [ ] BSW program courses/curriculum
- [ ] MSW program internship(s)
- [ ] BSW program internships(s)
- [ ] Personal study
- [ ] Medical texts (for example the PDR or DSM)
- [ ] Relevant literature and articles on a particular illness
- [ ] Relevant literature and articles on a particular medication
- [ ] Reviewing evidence-based treatment guidelines
- [ ] Using the internet to research medications

Other (please list)

_____

TREATING MEDICATED CLIENTS: THE CSW ROLE

38. ADVOCATE: The advocate role includes such skills as the ability of the clinical social worker to explore with patients their feelings about taking medication and to support discussions about the right to access, receive, change, and/or refuse medication. This includes having a "working knowledge" of mental illnesses, psychotropic medications, laws and regulations about medications, and patient rights.

☐ In-service training at work	☐ Observations of psychiatrists	☐ MSW program courses/curriculum
☐ Outside workshops/training	☐ Role play	☐ BSW program courses/curriculum
☐ Skill-building workshops	☐ Interactions with clients	☐ MSW program internship(s)
☐ Continuing ed courses	☐ Family conferences / feedback	☐ BSW program internships(s)
☐ Consultation with psychiatrist at work	☐ Patient conferences / feedback	☐ Personal study
☐ Consultation with psychiatrist outside of work	☐ Case conferences	☐ Medical texts (for example the PDR or DSM)
☐ Conversations with peers at work	☐ Daily rounds	☐ Relevant literature and articles on a particular illness
☐ Conversations with peers outside of work	☐ Interdisciplinary team meetings	☐ Relevant literature and articles on a particular medication
☐ Supervision at work	☐ Grand Rounds	☐ Reviewing evidence-based treatment guidelines
☐ Supervision outside of work	☐ Participation in research projects	☐ Using the internet to research medications
☐ Modeling provided by colleagues	☐ Participating in a medication psycho-ed program for families	
☐ Observations of colleagues	☐ Participating in a medication psycho-ed program for patients	

Other (please list)

☐

TREATING MEDICATED CLIENTS: THE CSW ROLE

39. EDUCATOR: The educator role includes such skills as the ability to provide basic information about relevant medication issues, with the goal of enhancing the patient's and family's knowledge about the roles medication may play in their treatment. To provide basic information regarding the effects and side effects they may encounter, and engage in training with clients and families about how to effectively communicate with their prescriber regarding their medication issues and needs.

☐ In-service training at work	☐ Observations of psychiatrists	☐ MSW program courses/curriculum
☐ Outside workshops/training	☐ Role play	☐ BSW program courses/curriculum
☐ Skill-building workshops	☐ Interactions with clients	☐ MSW program internship(s)
☐ Continuing ed courses	☐ Family conferences / feedback	☐ BSW program internships(s)
☐ Consultation with psychiatrist at work	☐ Patient conferences / feedback	☐ Personal study
☐ Consultation with psychiatrist outside of work	☐ Case conferences	☐ Medical texts (for example the PDR or DSM)
☐ Conversations with peers at work	☐ Daily rounds	☐ Relevant literature and articles on a particular illness
☐ Conversations with peers outside of work	☐ Interdisciplinary team meetings	☐ Relevant literature and articles on a particular medication
☐ Supervision at work	☐ Grand Rounds	☐ Reviewing evidence-based treatment guidelines
☐ Supervision outside of work	☐ Participation in research projects	☐ Using the internet to research medications
☐ Modeling provided by colleagues	☐ Participating in a medication psycho-ed program for families	
☐ Observations of colleagues	☐ Participating in a medication psycho-ed program for patients	

Other (please list)

☐

REFLECTION

TREATING MEDICATED CLIENTS: THE CSW ROLE

40. Please briefly reflect on and describe the three most influential knowledge sources you have accessed that have enhanced your knowledge, skills, and competency in working with patients who have been prescribed psychotropic medications.

41. Do you feel there is a need for increased learning opportunities for professional development of practice competencies with psychotropic-medicated clients?

○ Yes

○ No

42. Please check to be sure that you have answered every question and then select "SUBMIT."

○ SUBMIT

THANK YOU

Dear Participant,

Thank you for completing this survey and for your participation in the study. Please do not hesitate to contact this researcher with any questions or concerns using the contact information below

Also listed below are resources you may choose to print or save which include relevant literature, links to NASW ethics and standards, and a link to the NASW continuing education webpage where you may look for training opportunities in your area on psychotropic medication and working with clients prescribed them

Thank you.

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TREATING MEDICATED CLIENTS: THE CSW ROLE

Resources for Clinical Social Workers' Work With Clients Prescribed Psychotropic Medications.

Literature Resources on Practice:

Bentley, K.J., & Walsh, J. (2006). The social worker and psychotropic medication: Toward
effective collaboration with mental health clients, families, and providers (3rd ed.).
Belmont, CA: Brooks/Cole

Bentley, K.J. (2003). Psychiatric medication issues for social workers, counselors, and
psychologists. Binghamton, NY: The Haworth Press, Inc.

Guidelines for Practice by NASW:

1) National Association of Social Workers. (2008). NASW Code of Ethics
Accessed at: http://www.socialworkers.org/pubs/code/code.asp

2) National Association of Social Workers. (2005). NASW Standards for Clinical Social Workers in Social Work Practice.
Accessed at: http://www.naswdc.org/practice/default.asp

Continuing Education Opportunities:

NASW Continuing Education Homepage: http://www.naswdc.org/ce/default.asp