

# **Serving the Underserved: Preparing Psychologists for Effective Practice in the Public Sector**

Plenary 3: Speakers 1 & 2

## **MHSA grant projects: California Psychology Internship Council**

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and

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### **GARCIA-SHELTON**

This Plenary offers a summary of the three MHSA grant projects and, as Dr. Schaefer said, this is the first round of the Mental Health Services Act grants that went to psychology. It's really quite historic. All three schools that received MHSA grants will talk about what they've done. The primary intent of these funds was to increase the number of California psychologists committed to working with people of the California Public Mental Health system and to increase the quality of training for psychologists dedicated to work in the public mental health system.

CAPIC received \$2,639,427 spread out over five years. Funding during the last two years is very small, no stipends will be given out, and those last two years are follow up years for tracking all of the people that we gave stipends to until they complete their payback year. CAPIC stipend recipients are awarded the stipend during the year they are doing their internship, but actually receive the funds the August following their internship. The payback year, and those of you who have received the grants know exactly what this is, is the year after receipt of the stipend and after receipt of the doctorate degree, when a stipend recipient works in an agency that receives public mental health funds. It is the postdoctoral year.

So far CAPIC has given out 69 stipends and we will give out another 31 FTE stipends this current year. If the stipends go to students who are doing half time internships, we give them half a stipend; a fulltime intern receives a full stipend, \$ 20,750. On our website is the protocol we use for making decisions about who is awarded a stipend. There are four raters, two of the four have themselves or their family received services in the public mental health system. The other two raters are our internship or doctoral program faculty.

If you have received a stipend from any of our MHSA psychology programs and you're in this room, please stand up. Thank you. It is to you that this program is dedicated, You are

the ones with the commitment and you are the ones who are going to move into the future. The rest of us are going to help you learn how to better serve the underserved.

We must also evaluate the capabilities of the stipend recipient, and the usefulness of their doctoral program training in preparing them to serve the underserved. CAPIC does this by sending out an evaluation to stipend recipient supervisors, both at the internship level and the post doc. We also ask interns to evaluate themselves in a number of areas. That's all I'll say about our evaluation project because Dr. Wayne Parker is our evaluator and he's going to speak right after me and tell you a whole lot more about that.

Another aspect of the CAPIC grant is that we designed curriculum to develop the knowledge and skills needed to work with the underserved. CAPIC developed 15 online teaching modules, they are free standing modules developed by eight faculty members and they will soon go live. Let me give you the titles of the 15 modules: Advocacy and Public Policy in Professional Psychology; Cognitive Behavioral Interventions in the Treatment of Substance Abuse; Evidenced Based Practice in Public Mental Health Settings; Health & Mental Health: Assuring Needed Care to All; Navigating Through the DMH System and Paperwork; Pharmacology for Clinicians: A CAPIC Workshop; Poverty, SES, Health, and Health Care: Epidemiology and the Needs of Public Mental Health Clients; Recovery and Recovery Oriented Care; Trauma and Substance Abuse: Considerations in Assessment and Treatment; Severe Mental Disorders: Treatment and Systems of Care; Substance Abuse and Working with Families: Special Consideration for Treatment; Supervision in Professional Psychology; Supportive Employment as an Evidence Based Practice for the Severely and Chronically Mentally Ill; Understanding Mental Health Needs and Treatments for the Homeless Mentally Ill; and Working Effectively with Culturally Diverse Populations in the Public Mental Health System.

Let me tell you what these modules look like, and how they're designed, because we hope you will use them. Each module stands alone--it comes with goals and objectives and a brief summary of the module. There are a series of required readings if you want to take it for CE credit or if you want to use it as a teaching module in your doctoral program or in your internship program.

Next there is a 50 minute streaming video of a lecture given by the person who developed the module. A power point slide presentation used for the lecture is also available as part of the module. Next there are a series of six study questions based on the material presented in the module, the readings, the lecture, all aspects. The study questions are designed so that people read the questions and give a thoughtful answer that is limited to 200 words. It is my opinion that writing a good answer with a few words is far more difficult than writing three pages. Brevity requires focus on the key issues. So, we're expecting to get a concise response which then that is posted to that modules website without names to identify who submitted it. This allows everyone taking that module to learn from others who have already completed it. We are not monitoring these discussion questions. They are our attempt to create something of a learning community, something like the discussions that you might have in a class, or discussions you might have in the coffee room with your colleagues.

Finally there is a multiple choice examination. We have a test bank of 24 questions for each module and the initial test is eight of those questions randomly chosen. The learner takes it and they get an immediate response. A person taking the module for CE credit must take and pass the exam by getting 75% of the questions correct, as must the student required to take the test for a class or for an internship learning experience. All learners who fail the exam can redo any or all of the learning experiences until they succeed in passing the test.

Dr. Parker will now present responses to our evaluation questionnaire.

## PARKER

A web based stipend recipient questionnaire was given out last year. Basically what we were interested in finding out was given a list of educational goals, skills and abilities for doctoral level psychologists, what did students in the program see as the ones most important for working in public mental health and how well did their programs prepare them for that work. Also we looked at some of the feedback on practicum and internship experiences, and information on what had been particularly challenging or particularly enriching in the work you've been doing while you've been getting your stipend.

This slide tells us that the first thing we looked at was perceived importance and coverage of knowledge areas. There are 18 knowledge areas that we asked about, two pages of knowledge areas. And the rating is 3.96 out of 4, on the importance of gaining this knowledge to be successful working in public mental health.

And then the arrows are how well did your program prepare you in that area-- up means the feedback was that there was a high level of adequate training, the sideways arrow was it was okay but no home run, and the down arrow was that you weren't well trained at all in this area. What you find is that in the three things that people said were most important to work in public mental health were the impact of diversity issues, racial, ethnic, age, class, etcetera; client confidentiality and ethical and legal issues; and treatment issues. They also said that their programs prepared them very well in those areas for their work.

Other things that they are prepared well for were about DSM 4 evaluations. So-so preparation, and by the way these are all in order from most important to least important, that was adequate but not great preparation, in terms of trauma, client assessment, co-occurring disorders, therapeutic use of self and effective lifestyle. The only things that were real strike outs in student feedback in terms of how well their program prepared them to work in these areas was common non-psychoactive medications and their impacts, and agency systems and resources.

When you look at the order of what is perceived important in a doctoral program in order to work in public mental health, as a family therapist who does psychological testing in my private practice I myself am kind of at the bottom of the heap in terms of what was seen as

important in public mental health. But one of the things that this says is that the doctoral programs appear not to be missing a great deal. There are some things that could be done better, but the number of misses between what is important to know and how well your programs are preparing you, aren't too bad.

By the way this isn't something we can do a lot of data mining on, this is more of a quick environmental scan because of the number of responses. We requested responses from 32 people, we got 27 responses. With 27 people there's only so much you can do in terms of data mining.

After we looked at knowledge areas we looked at what were perceived as important skills that new clinical psychologists needed. Not surprisingly communication skills was number one, assessment, development of treatment plans, revising treatment plans, writing, formal psychological testing, case management, and use of informational technology.

The only one of these important skills that folks said that their doctoral programs did a poor job preparing them for was case management, not too surprisingly. This has to do with the kind of role that most students see that they are being trained for when they're in their doctoral program and what they encounter when they hit the real world.

We also looked at the area of perceived importance of abilities and again in terms of the level of abilities there wasn't a lot of variation from the top to the bottom. They were all pretty much in the same ball park. Nothing showed up that the programs appeared to be doing a poor job at. It is encouraging that, like on the other slides, the things that people saw as most important were the things they also rated their doctoral programs as doing the best job on.

This slide shows more abilities from the list we asked about. Again, nothing was listed as a strong weakness in their doctoral programs.

There was discussion earlier today about the need for the field, and for individual psychologists, to be more assertive. One of the things that was sort of in the middle of the pack in terms of perceived importance of abilities was assertiveness. Perhaps from the discussion earlier today that might move up a little bit on the priorities.

In terms of the helpfulness of didactic and research experiences, this is markedly weaker than everything else that came before it--and that is statistics, measurement and research design classes. The statistics, research, and measurement classes were seen as an isolated island that had little application to the real world, and to what you do on an ongoing basis. This is an interesting finding, since we talk often about evidence based practices. The way in which you interpret evidence based practice is by being able to knowledgeably read the literature, so there is somewhat of a disconnect there. But basically, what the students were saying is that what they learned in research classes was not particularly helpful in what they were doing in their day to day work.

In terms of helpfulness of practicum and internship experiences there wasn't a lot of variability from the top to the bottom. Hands on direct practice, mentoring, supervision,

experience prior to beginning the doctoral program, with shadowing and observing being the least helpful, but none of them are dramatically different. In terms of practicum experiences the people brought to the programs, there was a huge variation in number of hours. The range was from 500 to over 3000 hours, median or mean was about 1650 hours. A lot of people had more than one practicum and 45% had at least some hours in county mental health, 60% had at least some hours in county contracted mental health, and about half had some hours in other settings such as university counseling, hospital, school based mental health, and community mental health.

Looking at what folks found most satisfying in working in public mental health, the impact on clients, particularly the underserved, the diversity of the clients that they served, cross disciplinary collaboration in both assessment and treatment, and being more linked into the community showed up as highest. But when we asked what were the things that were most challenging about working in public mental health, crushing paperwork requirements was far and away number one.

When we talk about change and how to create change, it appears that one of the things that folks working in public mental health would love is a vehicle for simplifying reporting, simplifying paperwork, and coming up with systems that are more functional. Second is low pay, third is limited agency resources in both time and money, and last of the big four was the challenges and frustrations in working with substance abusing clients. That one surprised me. I know substance abusing clients can be challenging, but the flavor of some of the comments suggested almost that substance abuse is another discipline and that is not what I signed on for. That was somewhat surprising to me, given the nature of public mental health.

We asked students what you wished you were trained in that you haven't had training in, what training would you like to have either as an additional course, or some kind of specialized training. One thing that came through loud and clear was community resources. A lot of people said I'm supposed to be embedded in the community, I'm supposed to be linking clients to community resources, and I don't know the community resources well enough to do a competent job. And so more training in terms of social service systems, social service programs, and what is available to clients is something the students said they really need a lot more than they are getting.

Second is the whole structure of the community mental health system--they don't know it and have to learn it as they're doing it. Third is a lot of people said they don't have a clue not only how to do case management but exactly what case management is, and that the reality of the mixture of clinical work and case management work leaves students feeling that they need help here.

The last, and least frequent, of the top four was how to navigate agency and office politics. A fair number of people said I know how to work with my clients, but I don't know how to work with administration or with other employees. It's not like I imagined. There are rules that I don't understand, and that I need to understand, in order to survive.

We asked folks if because of the specialized knowledge and training that you've gotten, have you been given any special opportunities, and about a third had. The things that were given as examples were being given opportunities to teach, to present to their colleagues or at conferences, and a fair number of people said they were given the responsibility for helping to develop new programs for clients whose needs weren't being met. Almost all of the people who said that they were given the opportunity to develop new programs did so either in early childhood mental health or parenting programs.

When you talk about some things that need to be changed in the doctoral program curriculum, hopefully this information will give you some kind of frame of reference in terms of the systematic feedback that the students are giving about what's working and doesn't need to be fixed, and where they need more help.