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Behavioral Health Practice Competencies Among Graduate Social Work Students: A Program Evaluation

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BEHAVIORAL HEALTH PRACTICE COMPETENCIES AMONG GRADUATE SOCIAL WORK STUDENTS: A PROGRAM EVALUATION

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ABSTRACT

The Health Services and Resource Administration (HRSA) of the Department of Health and Human Services (DHHS) has recognized a need for mental health and substance abuse services for children, adolescents, and transitional youth who are at-risk for developing behavioral health disorders. In response to this need, the Obama administration delegated funds to multiple universities for the purpose of expanding the social work labor force. Louisiana State University is among those that received a block grant, allowing some of the students in the School of Social Work to participate in a Behavioral Health Workforce Education Training (BHWET) Program. This quasi-experimental study explored whether students' participation in the BHWET program increased their competencies in five important areas of social work: values, ethics, and theoretical perspectives; assessment; intervention; at-risk youth services, programs, and policies; and leadership. Comparisons of surveys indicated that students who participated in the BHWET program were significantly more competent than their peers who did not participate in the BHWET program in all of the five areas analyzed. We discuss the limitations of this study as well as implications for future social work practice and research.

INTRODUCTION

According to the National Association of Social Work (NASW) Code of Ethics, competence is one of the 6 core values of ethical social work practice on which the mission of social work is based (NASW, 2017). The ethical principle derived from this core value states that, "Social workers practice within their areas of competence and develop and enhance their professional expertise" (NASW, 2017). The Code of Ethics emphasizes the importance of social workers continuously striving to increase knowledge and skills to be applied in practice, as well as to contribute to the social work knowledge base (NASW, 2017). The ethical standards listed below are included in the Code of Ethics in regard to the competence of social workers and their practice.

> (a) Social workers should provide services and represent themselves as competent only within the boundaries of their education, training, license, certification, consultation received, supervised experience, or other relevant professional experience.
> (b) Social workers should provide services in substantive areas or use intervention techniques or approaches that are new to them only after engaging in appropriate study, training, consultation, and supervision from people who are competent in those interventions or techniques.
> (c) When generally recognized standards do not exist with respect to an emerging area of practice, social workers should exercise careful judgment and take responsible steps (including appropriate education, research, training, consultation, and supervision) to ensure the competence of their work and to protect clients from harm.

Five attributes of social work competence include values, ethics, and theoretical perspectives; assessment; intervention; at-risk youth services, programs, and policies; and leadership. The first attribute is relevant because values drive social work practice (Corney, 2004), and assessment is important because social workers need to be able to conduct bio-

psychosocial assessments to evaluate sociocultural, relational, and personal factors that allow for precise diagnoses, appropriate referrals, effective treatment, and client well being (Woods, Priest, & Denton, 2015). The third attribute, competence in s, is used to accomplish the important task of ensuring that all people have access to necessary resources and opportunities, as well as improved social conditions (NASW, 2017). Being competent in the fourth attribute, at-risk youth services, programs, and policies, allows the social worker awareness of gaps in services, and the ability to promote equity in access to care (Ingrao, 2015). The fifth attribute, leadership, is necessary in order to fulfill the ethical standard of helping the public shape policy by enabling their informed participation (NASW, 2017).

When analyzing the importance of competence in social work practice, questions regarding the consequences of incompetent practice arise. Many malpractice lawsuits filled against social workers are results of incompetent practice—claims that can be expensive and that can threaten the profession's integrity (Reamer, 1995). Therefore, it is critical that rising social workers are competent in the areas previously described in order to keep clients safe and to provide them with the best treatment possible, to prevent themselves from making career-threatening mistakes, and to uphold the integrity of the social work profession.

In this thesis, the terms *competence* and *competency* are used interchangeably. The purpose of this study is to understand whether participation in Louisiana State University's (LSU's) Behavioral Health Workforce Education Training (BHWET) program (the independent variable) resulted in a difference in Masters in Social Work (MSW) students' (the study population) self-perceived degrees of competence in five areas of social work practice (the dependent variable).

LITERATURE REVIEW

Conceptualization of Practice Competencies

Competency can be defined as understanding one's limits in expertise, and knowing of what to do when one has reached those limits (Bashook, 2005). According to the Council on Social Work Education website, "Competencies are measureable practice behaviors that are comprised of knowledge, values, and skills" (CSWE, 2008). For the purpose of this proposal, social work behavioral health competency will be defined using the CSWE definition.

There are five primary attributes that will be used to characterize behavioral health competence among the focus population group: at-risk youth. These include values, ethics, and theoretical perspectives; assessment; intervention; at-risk youth services, programs, and policies; and leadership.

Values, Ethics, and Theoretical Perspectives.

This attribute is important because, by definition, values drive professional youth-work practice, and social work educators are committed to raising students' awareness of their own values and biases (Corney, 2004). Social workers' being aware of how their work might be influenced by their backgrounds is of great importance (Prinsloo, 2014). Professionals in this field value the ability to advocate on behalf of at-risk youth through empowerment and promotion of self-determination by including them in the process of taking social action (Corney, 2004). In addition to working hand-in-hand with clients, social workers should also work together with professionals in other disciplines. Professionals' success and the effectiveness of their care provided to clients depend heavily upon the strength of their relationships with social workers at their agencies (Poole et al., 2013).

Assessment.

Social workers must be competent in assessing for necessary changes so that they can help to improve their clients' lives. In order to communicate effectively during assessments, the structured approach should be strengths-based, encompassing empathetic interviewing skills that include careful listening, understanding, and effective responding (Beck, 2005). Social workers should be able to conduct bio-psychosocial assessments to evaluate sociocultural, relational, and personal factors that allow for precise diagnoses, appropriate referrals, effective treatment, and client well being (Woods, Priest, & Denton, 2015).

Intervention.

Parents of troubled youth often feel increased stress, which is linked to the child's symptoms (Bode et al., 2016). Therefore, social workers are expected to assist parents in reducing their stress levels to allow for effective treatment of the child (Bode et al., 2016). Motivating change in clients through intervention requires rapport building and the establishment of trust (Center for Financial Social Work, 2015). Interventions that are successful in assisting youth to cope with stress and to become resilient are grounded in a theoretical view of development—a view that should be utilized by social workers (Smith & Carlson, 1997).

The Code of Ethics provides a description of how to end client services. Members of the National Association of Social Workers (NASW, 2017) delegate assembly emphasize that social workers are to assist clients in finding other services if they are still in need upon termination. Social workers must recognize when specialized knowledge outside of their realm is needed, or when intervention with clients is not progressing effectively (NASW, 2017). If either of these circumstances arises, then it is the social worker's responsibility to then refer the client to other

services (NASW, 2017). Interventions can be used to ensure that all people have access to necessary resources and opportunities, as well as improved social conditions (NASW, 2017).

At-Risk Youth Services, Programs, and Policies.

The Code of Ethics (2017) acknowledges social workers' responsibility to be culturally competent and to understand social diversity so that they can be sensitive to the differences among individuals. Professional social workers are aware of gaps in services, and they are concerned with promoting equity in access to care (Ingrao, 2015). Social service professionals are advised to encourage youth to participate in designing programs and policies, to ensure that they are geared toward their needs (U.S. Department of Health and Human Services, 2018). Researchers suggest that educating students on program evaluation skills and budget management be considered a high priority (Bournemouth University, 2013; Gervin, Davis, Jones, Counts-Spriggs, & Farris, 2010). Social work education can promote program evaluation, and the results of evaluations can be used to improve social work practice (Gervin et al., 2010).

Leadership.

The leadership role of social work is gaining momentum, making it imperative that students learn how to move into such positions (Rutgers Online, n.d.). Once leadership roles are achieved, social workers should inspire their colleagues by making personal connections (Rutgers Online, n.d.). In addition to motivating their coworkers, social workers should also empower members of their communities. Research suggests that social workers engage in self-reflection so that they can encourage decision-making and engagement among community members (Barnard, 2012). The Code of Ethics (2017) states that social workers should help the public shape policy by enabling their informed participation.

Research conducted to assess the competence of social work students is revealed through the use of The Field Practicum Placement Assessment Instrument (FPPAI). This measure is based on the 2008 Education Policy and Accreditation Standards (EPAS) of the CSWE (Christenson et al., 2015). The core competencies analyzed in the FPPAI study reflect the characteristics of competency attributes described in this literature review. The 10 competencies measured include (1) professional social work skills and supervision; (2) professional communication; (3) social work values and ethical practice; (4) critical thinking; (5) diversity; (6) human rights, social and economic justice and policy practice, (7) research; (8) human behavior and social environment; (9) generalist practice; and (10) social work practice with individuals, families, groups, organization, and communities (Christenson et al., 2015).

The practice behaviors that correspond to the FPPAI competencies are similar to the characteristics of attributes of the study at hand. The practice behaviors relevant to the first attribute include assessing and managing personal values, gaining self-awareness, as well as utilizing social justice perspectives and person-in-environment theories to advance the well being of clients (CSWE, 2008). Using empathy and other interview skills to involve clients in the assessment of their strengths and limitations is a CSWE (2008) practice behavior that reflects the assessment attribute of this study. The concepts that reflect competency in intervention are paralleled by CSWE (2008) practice behavior of acting as a mediator and advocating for clients' access to services. CSWE (2008) recognized the importance of integrating research-based knowledge into social work practice and in advocating for policies that will help clients, which are concepts that fall under the attribute of at-risk youth services, programs, and policies. Finally, the practice behaviors that reflect the concepts of the leadership attribute involve

advocating for clients by collaborating with colleagues and others to develop agreed upon objectives and interventions (CSWE, 2008).

According to the results of the FPPAI study, students received an average ranking of about 7 (with 0 representing the lowest level of competence and 10 representing the highest) in all areas other than (6) human rights, social and economic justice and policy practice and (10) social work practice with individuals, families, groups, organizations, and communities (Christenson et al., 2015). A competence score of 7 indicates that students surpass competence in all practice behaviors (Christenson et al., 2015). Students received an average score of 5.16 on the sixth competency, indicating that they are competent enough to practice all behaviors well (Christenson et al., 2015). Students received an average score of 6.64 on the tenth competency (Christenson et al., 2015), suggesting that they surpass competency in some of the practice behaviors, and that they are competent enough in others.

This research suggests that students' understanding and practice of critical competencies is beyond decent, but that there remains room for improvement in all areas. The effectiveness of future social work practice with at-risk youth in behavioral health settings—the target population of this study—depends on whether we know, and to what degree, current students are learning these valued competencies. Understanding whether SSW students are attaining the necessary skills to practice professional social work could potentially inform social work instructors for their future teachings. As stated in the Code of Ethics (NASW, 2017), the primary responsibility of social workers is to clients' wellbeing. This objective cannot be achieved without the knowledge of SSW students' understanding of social work competencies.

Conceptualization of the HRSA BHWET Initiative

The Health Resources and Services Administration (HRSA) Bureau of Health Professionals (BHPr) of the Department of Health and Human Services, and the Substance Abuse and Mental Health Services Administration (SAMHSA) called for a proposal to serve children, adolescents, and transitional youth to expand the mental health and substance abuse workforce between 2014 and 2017 (DHHS, 2014). This proposal is known as the Behavioral Health Workforce Education and Training (BHWET) grant initiative (DHHS, 2014), with substance abuse and mental health together referred to as *behavioral health* (DHHS, 2014). The following review covers the purpose of the BHWET program, eligibility to receive the BHWET grant, how the initiative was funded, reporting of progress, and the selection process.

Initiative purpose.

The *Now is the Time* initiative launched by the White House in 2013 has increased funding for early intervention efforts to engage people in mental health wellness and recovery programs (SAMHSA, 2014). The BHWET program is included in this initiative, as it was designed to train approximately 5,000 professionals in the treatment of the at-risk population of children, adolescents, and transitional youth (SAMHSA, 2014). A main goal of the BHWET initiative is to increase employment in rural and medically underserved areas, as well as in integrated health facilities (Kepley & Streeter, 2018), and to emphasize prevention, clinical intervention, and treatment (DHHS, 2014). Research conducted on the mental health of people in impoverished communities suggests that youth in these areas are much more likely to experience short-and long-term anxiety compared to those who do not live in poverty (Jordan, 2013).

One of SAMHSA's (2018) core missions is to improve access to behavioral health services for children, youth, and their families. Transitional youth, who are some of the least likely to regularly participate in treatment, are a main focus in this effort because they are at high risk for developing mental illness, abusing substances, and completing suicide (DHHS, 2014). Suicide is the third leading cause of death in this population (SAMHSA, 2018). Mental disorders have the greatest disability impact on this program's target population, even when compared to the impact of chronic health conditions (SAMHSA, 2018). Children, adolescents, and transitional-age youth are in need of the services offered by the BHWET grant program.

Organizational Eligibility, Funding Opportunities, and Selection.

The grant initiative aims to fund behavioral health training for students receiving a master's degree in social work, psychology, professional counseling, psychiatric-mental health nursing, and marriage and family therapy, as well as those receiving a PhD in psychology (DHHS, 2014). Therefore, eligible applicants included approximately 60-130 accredited schools and programs of these disciplines located in the United States, District of Columbia, Guam, the Commonwealth of Puerto Rico, the Northern Mariana Islands, American Samoa, the U.S. Virgin Islands, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau that required field placement in behavioral health settings as part of their curriculum (DHHS, 2014).

Research suggests that training in rural populations increases the likelihood of students pursuing careers in those areas post-graduation (Wendling, Phillips, Short, Fahey, & Mavis, 2016). Therefore, it is expected that, by providing placements with at-risk populations in at-risk locations, the behavioral health workforce will expand and create greater access to services

among the BHWET target population (Kepley & Streeter, 2018). Schools that received the grant were required to assist students in being placed in such field settings (DHHS, 2014). Applicants were required to have the capacity to train and supervise students in working with the target population, as well as to have been connected with public and behavioral health systems in their communities (DHHS, 2014).

The total annual available funding provided by the Department of Health and Human Services was approximately $26,700,000, with each awardee receiving approximately $480,000 per year (DHHS, 2014). Funds were to be used to provide one-year stipends to students, to recruit those interested in working in a behavioral health setting, to implement interprofessional training, to offer internships focused on the target population in integrated settings, and to evaluate the initiative and share findings (DHHS, 2014).

Recipients were to submit a two-part annual progress report to ensure that their goals were being met (DHHS, 2014). The first part provided information on the accomplishments of program-specific goals, while the second part provided data showing progress and impact of the project as a whole (DHHS, 2014). Semi-annual performance reports were completed because HRSA is required to collect data under the Government Performance and Reporting Modernization Act of 2010, and BHPr is required to provide longitudinal data under the Patient Protection and Affordable Care Act (DHHS, 2014). A final report was conducted to present the accomplishments, barriers and resolutions, impacts, thoughts of continuing or replicating the project, publications produced, and goal changes during the three-year process.

The Division of Independent Review within HRSA consists of a committee of experts in fields related to the initiative under review and manages objective evaluations (DHHS, 2014).

After the review of applications, the committee presents advice to those responsible for final selections of award recipients (DHHS, 2014). Louisiana State University's School of Social Work (LSU SSW) Program received a grant from this national BHWET initiative.

LSU School of Social Work (SSW) BHWET Program

All information regarding LSU's SSW BHWET program was taken directly from conversations and unofficial documents from the LSU SSW BHWET Director, Dr. Scott Wilks.

LSU SSW Goals and Objectives.

Louisiana's at-risk youth have extensive behavioral health care needs. In order for these needs to be met, Louisiana experienced an increase in the number of skilled, professional social workers who are competent in the areas previously discussed and who are available to the population described in the following section. According to Dr. Wilks, the primary goal of the BHWET program was to increase Louisiana's social work labor force. A number of objectives were established in the BHWET program to address this goal, including the recruitment of advanced year students who were committed to careers in integrated behavioral health settings. Each BHWET student was required to involve themselves in certain settings, as well as to complete a course with the substance of content in this area. Additionally, BHWET students attended at least two training seminars focused on the behavioral health of this population (see below). Another objective for meeting this goal was to establish behavioral health partnerships with current and new organizations regarding SSW internships, as well as to expand its at-risk youth behavioral health curriculum content.

For the purpose of this thesis, one specific LSU SSW BHWET objective was addressed: the enhancement of self-perceived practice competencies in behavioral health settings among

BHWET students. As previously discussed, these 5 areas of practice competencies are values, ethics and theoretical perspectives; assessment; intervention; at-risk youth services, programs, and policies; and leadership. Before addressing the methodology of this assessment, a brief discussion of LSU SSW BHWET target population is assessed.

Target Population.

Children, adolescents, and transitional-age youth in Louisiana have behavioral health indicators that are ranked among the most severe of all states. These indicators include HIV/AIDS, domestic violence, poverty, and substance use. Therefore, the LSU BHWET program's target population included those who were developing and those who had already developed behavioral health disorders who were classified as children, adolescents, or transitional-age youth. In the last 16 years, Baton Rouge has experienced an increase in the number of violent and property crimes. LSU's SSW BHWET program placed an emphasis on East Baton Rouge (EBR) Parish as the target location, as well as other Louisiana parishes near this area that are in great need of integrated behavioral health care for the target population (CDC, 2013, 2014, & 2018; NCCP, 2018; BR Crime Rate Report, 2019; & HHS, n.d.). Please note that the target population for this thesis is BHWET students in the SSW masters program.

RESEARCH QUESTIONS

Because there was no expectation of the data moving in any direction regarding the practice competencies of the BHWET students (since this is the first review of the BHWET data) research questions were addressed in lieu of hypotheses (Michaelson, 2019). Half of these questions were within-group comparisons of BHWET students' competencies before and after participation in the program, and of non-BHWET students' competencies at the same times as the BHWET students. These questions included:

- RQ1: Did the students' competencies of values, ethics, and theoretical perspectives improve?
- RQ2: Did the students' competencies in assessment improve?
- RQ3: Did the students' competencies in intervention improve?
- RQ4: Did the students' competencies of at-risk youth services, programs, and policies improve?
- RQ5: Did the students' competencies in leadership improve?

The next five questions were between-group comparisons involving competencies of BHWET students compared to those of non-BHWET students. They included:

- RQ6: Do the scores that indicate non-BHWET students' competencies of values, ethics, and theoretical perspectives significantly differ from those of BHWET students?
- RQ7: Do the scores that indicate non-BHWTET students' competencies in assessment differ significantly from those of BHWET students?
- RQ8: Do the scores that indicate non-BHWET students' competencies in intervention significantly differ from those of BHWT students?

- RQ9: Do the scores that indicate non-BHWET students' competencies of at-risk youth services, programs, and policies significantly differ from those of BHWET students?
- RQ10: Do the scores that indicate non-BHWET students' competencies in leadership significantly differ from those of BHWET students?

The following section includes a description of the design, sampling, measures, and analysis used to explore these questions.

METHODOLOGY

Design and Sampling

A quasi-experimental design was used to address these questions. A quasi-experimental design is one that consists of two groups—an intervention group and a comparison group—into which participants are not randomly assigned (Trochim, 2006). In other words, no chance procedures were used to place participants into one of the two groups, which would have ensured equal chance of any participant being assigned to either group (Cherry, 2018). An application and interview process was used to determine who participated in the BHWET program—a process that did not allow for random assignment. A within-group comparison was used to determine the progress that BHWET students made upon completion of the BHWET program. In a within-group design, every participant is exposed to the treatment (Cherry, 2018), which, in this case, is the passage of time.

Simultaneously, a between-groups comparison was used to determine whether the progress in competency made by BHWET students exceeded the progress made by the comparison group of non-BHWET students. A between-groups design is one in which participants in a comparison group (who did not receive treatment) are compared to those in an intervention group (who did receive treatment) (Explorable, 2018). For each of the three cohorts of LSU advanced year SSW students that graduated in 2016, 2017, and 2018, pretest data collection took place during the first week of the advanced academic school year and posttest data collection took place during the final week of the advanced academic school year. The comparison group consists of LSU MSW students who graduated in those years and did not participate in the BHWET program. Participation in this study was voluntary and approved by

the LSU Institutional Review Board (IRB). A consent process was used to inform potential participants about the study, and this process is explained in the following section.

Measures

Dr. Wilks distributed a consent form to all SSW students who participated in the BHWET study before it began. It informed students of the name of the study, the location in which it took place, the name of the investigator, and the purpose, as well as which and how many students were eligible to participate. Other information provided included procedures, risks and benefits of participating, the right to refuse at any time, and ensured privacy. A four-digit numerical code was used for non-identifying purposes. A survey was used to measure competency in the five areas previously described—an instrument called the Revised Social Work Competency Scale, which will be referred to as RSWCS for the purposes of this discussion. This instrument is derived from the Hartford Partnership Program in Aging Education (HPPAE) survey, and amended to change the focus population to at-risk youth. It can be found on the Council on Social Work Education website (CSWE, 2019).

Demographic questions regarding gender, ethnicity, age, BHWET recipient status, as well as yes or no questions as to whether participants considered themselves part of an underrepresented minority and/or having come from a disadvantaged background. However, the question about identification in a minority group was only included in surveys of the 2016-17 and 2017-18 advanced year cohorts. There are five standardized subscales with Likert response formats for each of the competency areas described above, with each scale consisting of 10 items. Self-reported scores range from 0 to 4, with 0 representing “Not skilled at all” and 4 representing “Expert skill.”

The items in the first subscale (which measure perceived competency of values, ethics, and theoretical perspectives in relation to the target population) regard addressing personal biases, promoting dignity and the right to self-determination, applying ethical principles when making decisions, respecting diversity, addressing values and beliefs, relating theoretical perspectives to practice, identifying issues relating to transitions, and participating in effective interdisciplinary work. The items in the second subscale (which measure perceived competency in assessment of the target population) regard using empathy and sensitive interviewing skills, conducting a comprehensive assessment, assessing mental and behavioral health status, assessing social functioning and support, assessing caregiver needs, administering and interpreting assessment and diagnostic tools, developing service plans, and reevaluating and adjusting plans continually.

The items in the third subscale (which measure perceived competency in intervention with the target population) regard establishing rapport and maintaining relationships, enhancing coping skill capacities and mental health, utilizing group interventions, mediating situations with angry clients, assisting caregivers in maintaining their health, linking clients to resources, advocating on the behalf of clients, and adhering to laws and public policies. The items in the fourth subscale (which measure perceived competency of at-risk youth services, policies, and programs) regard providing outreach, adapting organizational policies to facilitate work with diverse clients, developing strategies to address barriers, including clients in community organization, developing program budgets, evaluating practice and programs, applying findings, organizing with the public to assist in meeting needs, identifying the availability of resources, and addressing negative impacts of social and health care policies.

The items in the fifth subscale (which measure perceived competency in leadership with the target population) regard assessing "self-in-relation", creating a mission, analyzing policies from a global rights perspective, planning strategically to reach objectives, using a strengths perspective, building collaborations to reduce gaps in services, managing stakeholder processes to optimize services, communicating to the public through multiple medias, and promoting the use of research.

Data Analysis

Because Dr. Wilks and his research team collected data, the data analysis described here is secondary information. Dr. Wilks granted permission for BHWET data to be used for this thesis. Descriptive statistics were used for demographic data to determine the frequency and valid percentages of non-parametric variables, and to determine the means and standard deviations of parametric variables. In order to answer the first five within-group research questions regarding BHWET students' competencies before and after participation in the program, we used independent samples *t*-test statistical analyses. This test was used because its purpose is to compare the mean differences between two groups of data (Complete Dissertation, 2019). In this case, we compared the BWHET students' perceived competencies before completing the program and after completing the program, and we compared non-BHWET students' perceived competencies at the same intervals. The statistics reported in the following section for these within group designs are *t*-tests and *p*-values, with the significance level set at .05.

The remaining five research questions were also analyzed using independent samples *t*-tests. These questions involved comparisons between BHWET and non-BHWET students'

perceived competencies before and after the intervention group treatment. Independent samples *t*-tests were used because the purpose of this test is to determine whether differences between the independent variable and the dependent variable are a result of the influence of the independent variable (Complete Dissertation, 2019). The statistics reported in the results section for the between groups comparisons are also *t*-tests and *p*-values, where the level of significance is set at .05.

RESULTS

Descriptive Statistics

Sample Characteristics.

The sample of 3 cohorts consisted of 252 SSW advanced year students between the years 2015 and 2018. Most of the participants were female (85.7%), Caucasian/White (71.8%), and non-BHWET stipend recipients (61.1%). Most self-identified as not having come from a disadvantaged background (78.5%), nor to have been part of an underrepresented minority group (67.4%). The other ethnicities of participants were African American (21.8%) and Hispanic/Latino (3.6%). The average age of participants was approximately 28 years.

In the intervention group of those who participated in the BHWET program, most were female (90.8%), Caucasian/White (69.4%), and, on average, almost 27 years old. Most participants self-identified as being part of an underrepresented minority (68.7%), and most reported not having come from a disadvantaged background (76.1%). The breakdown of other participants' ethnicities was 26.5% African American/Black, 1.0% Hispanic/Latino, and 3.1% multiracial. In the comparison group, most of the participants were female (82.5%), Caucasian/White (73.4%), and, on average, approximately 28 years old. Most self-reported not belonging to an underrepresented minority (66.2%), and only 19.1% reported having come from a disadvantaged background. Other ethnicities of participants in this group included African American/Black (18.8%), Hispanic/Latino (5.2%), multiracial (1.9%), and Asian (0.6%). For full details on descriptive statistics of sample characteristics, please see Table 1 below.

Table 1. *Descriptive statistics of the sample*

Variable	Overall Sample	Intervention	Comparison
BHWET participation			
Gender			
Female	n=216 (85.7%)	n=89 (90.8%)	n=127 (82.5%)
Male	n=35 (13.9%)	n=8 (8.2%)	n=27 (17.5%)
Other	n=1 (0.4%)	n=1 (1.0%)	
Ethnicity			
Caucasian/White	n=181 (71.8%)	n=68 (69.4%)	n=113 (73.4%)
AA/Black	n=55 (21.8%)	n=26 (26.5%)	n=29 (18.8%)
Hispanic/Latino	n=9 (3.6%)	n=1 (1.0%)	n=8 (5.2%)
Multiracial	n=6 (2.4%)	n=3 (3.1%)	n=3 (1.9%)
Asian	n=1 (0.4%)		n=1 (0.6%)
Underrepresented minority			
No	n=91 (67.4%)	n=46 (68.7%)	n=45 (66.2%)
Yes	n=44 (32.6%)	n=21 (31.3%)	n=23 (33.8%)
Disadvantaged background			
No	n=106 (78.5%)	n=51 (76.1%)	n=55 (80.9%)
Yes	n=29 (21.5%)	n=16 (23.9%)	n=13 (19.1%)
Age	M=27.7 (SD=8.06)	M=26.7 (SD=6.39)	M=28.3 (SD=8.93)

Abbreviation Meanings:

n = Frequency
% = Valid Percent
M = Mean
SD = Standard Deviation
AA = African American

Within-Group Results.

The descriptive statistics from the RSWCS for the within-group intervention group (BHWET students) are shown below in Table 2. The differences between RSWCS pretest and posttest scores are depicted, as well as *t*-test scores and their significance. The differences in scores from pretest to posttest for this group are all statistically significant ($p < .01$).

Table 2. *Within-Group Results: Intervention Group (BHWET students) per RSWCS Subscale*

Subscale	Pre M (SD)	Post M (SD)	M Diff	*t* (Sig)
Values, ethics, theory	19.3 (5.50)	28.82 (5.04)	-9.52	-14.095 ($p < .01$)
Assessment	14.8 (5.68)	25.1 (5.26)	-10.3	-14.109 ($p < .01$)
Intervention	15.9 (6.34)	27.1 (6.13)	-11.2	-14.256 ($p < .01$)
Services, programs, policies	13.2 (7.74)	26.1 (8.12)	-12.9	-12.636 ($p < .01$)
Leadership	12.6 (7.40)	26.0 (8.54)	-13.4	-13.412 ($p < .01$)

Abbreviation Meanings:

Pre = Pretest
Post = Posttest
Diff = Difference

The descriptive statistics from the RSWCS subscales for the comparison group (non-BHWET students) is shown below in Table 3. This table is formatted exactly like Table 2, depicting change in scores from pretest to posttest and the significance of those differences. These scores are all show longitudinal significant difference ($p < .01$) as well.

Table 3. *Within-Group Results: Comparison Group (Non-BHWET students) per RSCWS Subscale*

Subscale	Pre M (SD)	Post M (SD)	M Diff	*t* (Sig)
Values, ethics, theory	20.2 (5.64)	25.8 (7.84)	-5.6	-4.664 ($p < .01$)
Assessment	16.6 (7.28)	23.3 (7.11)	-6.7	-5.562 ($p < .01$)
Intervention	17.8 (7.92)	24.5 (8.04)	-6.7	-5.398 ($p < .01$)
Services, programs, policies	15.5 (8.96)	23.0 (10.62)	-7.5	-3.947 ($p < .01$)
Leadership	14.3 (9.00)	23.6 (10.79)	-9.3	-4.378 ($p < .01$)

Between-Group Results.

Table 4 shows the differences in mean scores on the RSWCS subscales between the intervention group and the comparison group. Comparison group scores are higher than those

of the intervention group on every subscale, but none of the differences are statistically significant ($p > .05$). On all outcomes, the groups are statistically identical.

Table 4. *Between-Group Results: Pretest*

Subscale	Inter M	Comp M	M Diff	*t* (sig)
Values, ethics, theory	19.0	19.4	-0.4	-.458* ($p > .05$)
Assessment	14.7	15.6	-0.9	1.001 ($p > .05$)
Intervention	15.8	16.2	-0.4	.411 ($p > .05$)
Services, programs, policies	13.2	13.7	-0.5	.439* ($p > .05$)
Leadership	12.5	13.4	-0.9	.726 ($p > .05$)

*Equal variances assumed based on Levene's Test

Abbreviation Meanings:

Inter = Intervention group

Comp = Comparison group

Results from the posttests show that those in the intervention group scored significantly higher in all competency areas than those in the comparison group. For full details, please see Table 5 below.

Table 5. *Between-Group Results: Posttest*

Subscale	Inter M	Comp M	M Diff	*t* (sig)
Values, ethics, theory	28.8	25.0	3.8	-3.955 ($p < .01$)
Assessment	25.1	22.4	2.7	-2.849 ($p < .01$)
Intervention	27.1	23.4	3.7	-2.861 ($p < .01$)
Services, programs, policies	26.2	22.0	4.2	-2.750 ($p < .01$)
Leadership	26.1	22.4	3.7	-2.407 ($p < .05$)

DISCUSSION

This paper encompasses an exploration of two groups of LSU SSW students in regard to their competencies in social work practice. One of these groups included those who participated in the BHWET program, and the other included those who did not. Government officials acknowledged a need for a greater number of competent social workers to serve the population of children, adolescents, and transitional youth because they are at higher risk of developing mental illness, and this population's mental health in Louisiana is ranked among the most severe in the US. The focus of this study is to compare the self-reported competency scores in the five core areas of those who participated in the BHWET program (involving specific training with the at-risk population) and of those who did not.

Explanation of Results

The students in both groups improved their scores in every competency area upon completion of the academic year. However, the BHWET students' improvements were much greater than those of the non-BHWET students. It is possible that by completing their advanced year in the social work program, non-BHWET students strengthened their competencies. Another finding indicates that the two groups had slightly differing scores the first time that they took the test, with non-BHWET students scoring less than one point higher in every area. However, when compared to the non-BHWET students' group scores, BHWET students scored much higher in every competency area on the last test.

Limitations and Future Research

Because LSU SSW professors selected BHWET participants after an application and interview process, random assignment was not warranted. Therefore, the participants in the

two groups may have been different in ways that were not controlled for, and that may have ultimately affected the results of the study. It is possible that those chosen to participate in the BHWET program were selected because they presented in ways that led professors to believe that they were more capable of developing competencies in the core social work practice areas for the at-risk population, compared to their peers who were not selected. Perhaps professors were "creaming"— unintentionally selecting those who were most likely to excel in understanding social work competencies and who may have reached that understanding without participation in the BHWET program, while denying applicants whose needs were greater and who had less chance of exceling without the program (Gilbert & Terrell, 2013). Randomly assigning participants into the two groups of BHWET students and non-BHWET could eliminate this limitation in future studies. Another limitation is that the results are based on self-reported data, which allows for the possibility of response bias. One way of ameliorating this limitation might be to use a more objective, observation-based measure instead of one that requires self-reports.

Implications to Social Work

Many professionals have called for thorough program evaluation studies for years, and they have recognized that development of the social work profession depends on such critical research that can be used to influence practice (Thyer, 2001). The profession started as a group of people who merely wanted to help others, and it has evolved into a curious group inquiring about whether their work has made a difference in the lives of their clients, and how and why that difference occurred (Holosko, 2010). Asking these questions promotes good practice. Einat Peled (2010) sees "good" as a goal of social research (p. 22). According to his definition of good,

good research aims to produce knowledge that communities can use to contribute to social change and to the well being of its members (Peled, 2010). The study at hand is an example of good research in that it can be used to understand whether an intervention made a difference, and to influence practice based on that understanding. Professors at the LSU SSW and government officials who awarded them with the BHWET grant can use this information to understand whether the initiative to create a better mental and behavioral health workforce for at-risk children, adolescents, and transitional youth made a difference in the effectiveness of helping that population.

HRSA has provided hundreds of millions of dollars for programs like this one, and this study is a critical piece of evidence that shows that their money was put to good use. HRSA can use this study to make an informed decision as to whether they should continue allocating funds to this program. Although this research is not experimental and therefore cannot be used to infer causal relationships, we can say with confidence that the program may have played a part in the higher competencies among BHWET students as compared to non-BHWET students.

Conclusion

The focus of this study was to determine whether participation in a BHWET program implemented at LSU SSW made a difference in students' self-perceived competencies in five core social work areas (values, ethics, and theoretical perspectives, assessment, intervention, at-risk youth services, programs, and policies, and leadership) in work with at-risk children, adolescents, and transitional-age youth. A fairly rigorous quasi-experimental design was used to attempt to understand the perceived competencies among advanced-year MSW students. The study at hand is critical because it shows that it is likely that the BHWET program did in fact

improve the competencies of those who participated—an accomplishment that is expected to create a more effective workforce of Louisiana social work practitioners who specialize in work with at-risk children, adolescents, and transitional-age youth. This program evaluation is up-to-date in the evolution of the social work profession because it is a production of "empirical knowledge that can inform social work practice," (Holosko, 2010, p. 672).

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APPENDIX A. IRB APPROVAL

Consent Form

Study Title: *Evaluation of At-Risk Youth Competencies*

Performance Site: LSU School of Social Work (LSU SSW)

Investigator: Scott E. Wilks; swilks@lsu.edu; 225-578-5875

Purpose: To assess the effectiveness of the LSU SSW BHWET Stipend Program

Participant Inclusion: MSW advanced year students

Number of participants: Approx. 60; number varies annually based on size of each MSW cohort

Procedures: Please complete the following questionnaire. The questionnaire solicits data on demographics, at-risk youth practice competencies, and understanding of issues regarding at-risk youth. Participation is not tied to any course assignment or grade. All data will be reported aggregately.

Benefits: Data from this study are needed to provide evidence on the effectiveness of the LSU SSW BHWET Stipend Program.

Risks: No known.

Right to Refuse: Participation is voluntary. You may choose not to participate or to withdraw from the study at any time without penalty or loss of any benefit to which you might otherwise be entitled.

Privacy: No identifying information will be included in any public reports, unless disclosure is required by law.

Consent: *This study has been discussed with me and all my questions have been answered. I may direct additional questions regarding study specifics to the investigators. If I have questions about subjects' rights or other concerns, I can contact Dennis Landin, Institutional Review Board, (225) 578-8692, irb@lsu.edu, www.lsu.edu/irb. I agree to participate in the study described above and acknowledge the investigator's obligation to provide me with a signed copy of this consent form.*

Please keep a copy of this completed form for your records.

Signature: _____ **Date:** _____/_____/_____

APPENDIX B. SURVEY

Social Work with At-Risk Youth Competency Scale

1. Last 4 digits of LSU ID: _____

2. Age: _____

3. Gender (check one):

   Male _____ Female _____ Other _____

4. Ethnicity (check one):

   African Amer./Black _____ Amer. Indian/Alaska Native _____ Asian _____
   Caucasian/White _____ Hispanic/Latino _____ Pacific Islander _____
   Other _____ Multiracial _____

5. Do you consider yourself a member of an underrepresented minority group? (check one)

   Yes _____ No _____

6. Do you consider yourself to come from a disadvantaged background? (check one)

   Yes _____ No _____

The following is a listing of skills important to social workers effectively working with and on behalf of at-risk youth and their families. These competences are to be developed at different levels across the social work learning continuum, from BSW, to MSW at the foundation and advanced levels and in life-long learning post-MSW. The Scale was designed for pre-post evaluations of education and field training.

Please use the scale below to thoughtfully rate your current, social work skills with at-risk youth.

0 = Not skilled at all (No experience with this skill)
1 = Beginning skill (I have to consciously work at this skill)
2 = Moderate skill (This skill is becoming more integrated in my practice)
3 = Advanced skill (Done with confidence and is an integral part of my practice)
4 = Expert skill (I complete this skill with sufficient mastery to teach others)

0	1	2	3	4
Not skilled at all	Beginning skill	Moderate skill	Advanced skill	Expert Skill

I. VALUES, ETHICS, & THEORETICAL PERSPECTIVES	Skill Level (0–4)
7. Assess and address values and biases regarding at-risk youth.	
8. Respect and promote at-risk youths' right to dignity and self-determination.	
9. Apply ethical principles to decisions on behalf of all at-risk youth with special attention to those who have limited decisional capacity.	
10. Respect diversity among at-risk youth and their families (e.g., class, race, ethnicity, gender, and sexual orientation).	
11. Address the cultural, spiritual, and ethnic values and beliefs of at-risk youth and their families.	
12. Relate concepts and theories of development to social work practice (e.g., attachment, stages of development, and the ecological perspective).	
13. Relate social work perspectives and related theories to practice with at-risk youth (e.g., person-in environment, social justice).	
14. Identify issues related to changes and developmental transitions in designing interventions.	
15. Understand the perspective and values of social work in relation to working effectively with other disciplines in interdisciplinary practice with at-risk youth.	

II. ASSESSMENT[1]	Skill Level (0–4)
16. Use empathy and sensitive interviewing skills to engage at-risk youth in identifying their strengths and problems.	
17. Conduct a comprehensive assessment (bio-psychosocial evaluation).	
18. Assess behavioral health and mental health status of at-risk youth (e.g., conduct disorder, depression).	
19. Assess social functioning (e.g., social skills, social activity level) and social support of at-risk youth.	
20. Assess parents' or caregivers' needs and level of stress.	

[1] (Chart Cont'd)

II. ASSESSMENT	Skill Level (0–4)
21. Administer and interpret standardized assessment and diagnostic tools that are appropriate for use with at-risk youth (e.g., depression scale, substance abuse scale).	
22. Develop clear, timely, and appropriate service plans with measurable objectives for at-risk youth.	
23. Reevaluate and adjust service plans for at-risk youth on a continuing basis.	

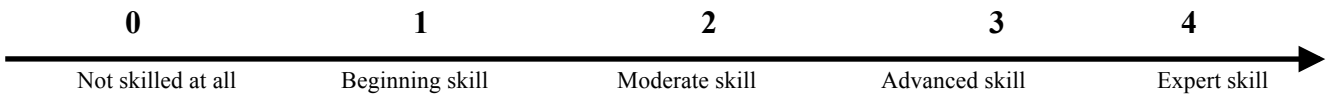
III. INTERVENTION	Skill Level (0–4)
24. Establish rapport and maintain an effective working relationship with at-risk youth and family members.	
25. Enhance the coping capacities and mental health of at-risk youth through a variety of therapy modalities (e.g., supportive, psychodynamic).	
26. Utilize group interventions with at-risk youth and their families (e.g., social skills groups, anger management groups, parenting groups).	
27. Mediate situations with angry or hostile at-risk youth and/or family members.	
28. Assist parents or caregivers to reduce their stress levels and maintain their own mental and physical health.	
29. Provide social work case management to link at-risk youth and their families to resources and services.	
30. Apply skills in termination in work with at-risk youth and their families.	
31. Advocate on behalf of clients with agencies and other professionals to help at-risk youth obtain quality services.	
32. Adhere to laws and public policies related to at-risk youth (e.g., child abuse reporting, legal guardianship, court mandates).	

0	1	2	3	4
Not skilled at all	Beginning skill	Moderate skill	Advanced skill	Expert skill

IV. AT-RISK YOUTH SERVICES, PROGRAMS, & POLICIES[2]	Skill Level (0–4)

[2] (Chart Cont'd)

IV. AT-RISK YOUTH SERVICES, PROGRAMS, & POLICIES	Skill Level (0–4)
33. Provide outreach to at-risk youth and their families to ensure appropriate use of the service continuum.	
34. Adapt organizational policies, procedures, and resources to facilitate the provision of services to diverse at-risk youth and their families.	
35. Identify and develop strategies to address service gaps, fragmentation, discrimination, and barriers that impact at-risk youth.	
36. Include at-risk youth in planning and designing programs.	
37. Develop program budgets that take into account diverse sources of financial support for the at-risk youth population.	
38. Evaluate the effectiveness of practice and programs in achieving intended outcomes for at-risk youth.	
39. Apply evaluation and research findings to improve practice and program outcomes.	
40. Advocate and organize with the service providers, community organizations, policy makers, and the public to meet the needs and issues of the at-risk youth population.	
41. Identify the availability of resources and resource systems for at-risk youth and their families.	
42. Assess and address any negative impacts of social and health care policies on practice with historically disadvantaged populations.	



V. LEADERSHIP[3]	Skill Level (0–4)
43. Assess "self-in-relation" in order to motivate yourself and others including trainees, students, and staff toward mutual, meaningful achievement of a goal(s).	
44. Create a shared organizational mission, vision, values and policies responding to ever changing service systems in order to promote optimal, at-risk youth services.	
45. Analyze historical and current local, state, national policies from a global rights perspective in order to identify problems with at-risk youth and effect change.	
46. Plan strategically to reach measurable objectives in program, organizational, or community development for at-risk youth.	

[3] (Chart Cont'd)

V. LEADERSHIP	**Skill Level (0–4)**
47. Administer programs and organizations from a strength's perspective to maximize and sustain human resource and fiscal resources for effectively serving at-risk youth.	
48. Build collaborations across disciplines and the service spectrum to assess access, continuity, and reduce gaps in services to at-risk youth.	
49. Manage individual and multi-stakeholder processes at the community, interagency, and intra-agency levels in order to inspire, leverage power, and resources to optimize services for at-risk youth.	
50. Communicate to public and policy makers through multiple media including reports and legislative statements and/or orally presenting the mission and outcomes of the services of an organization or for diverse client group(s).	
51. Advocate for at-risk youth and their families for building youth friendly community capacity (including the use of technology) and enhance the contribution of at-risk youth.	
52. Promote use of research to evaluate and enhance the effectiveness of social work practice and at-risk youth related services.	

APPENDIX C. TABLES

Table A.1. *Descriptive statistics of the sample*

Variable	Overall Sample	Intervention	Comparison
BHWET participation			
Gender			
Female	n=216 (85.7%)	n=89 (90.8%)	n=127 (82.5%)
Male	n=35 (13.9%)	n=8 (8.2%)	n=27 (17.5%)
Other	n=1 (0.4%)	n=1 (1.0%)	
Ethnicity			
Caucasian/White	n=181 (71.8%)	n=68 (69.4%)	n=113 (73.4%)
AA/Black	n=55 (21.8%)	n=26 (26.5%)	n=29 (18.8%)
Hispanic/Latino	n=9 (3.6%)	n=1 (1.0%)	n=8 (5.2%)
Multiracial	n=6 (2.4%)	n=3 (3.1%)	n=3 (1.9%)
Asian	n=1 (0.4%)		n=1 (0.6%)
Underrepresented minority			
No	n=91 (67.4%)	n=46 (68.7%)	n=45 (66.2%)
Yes	n=44 (32.6%)	n=21 (31.3%)	n=23 (33.8%)
Disadvantaged background			
No	n=106 (78.5%)	n=51 (76.1%)	n=55 (80.9%)
Yes	n=29 (21.5%)	n=16 (23.9%)	n=13 (19.1%)
Age	M=27.7 (SD=8.06)	M=26.7 (SD=6.39)	M=28.3 (SD=8.93)

Table B.2. *Within-Group Results: Intervention Group (BHWET students) per RSWCS Subscale*

Subscale	Pre M (SD)	Post M (SD)	M Diff	*t* (Sig)
Values, ethics, theory	19.3 (5.50)	28.82 (5.04)	-9.52	-14.095 ($p < .01$)
Assessment	14.8 (5.68)	25.1 (5.26)	-10.3	-14.109 ($p < .01$)
Intervention	15.9 (6.34)	27.1 (6.13)	-11.2	-14.256 ($p < .01$)
Services, programs, policies	13.2 (7.74)	26.1 (8.12)	-12.9	-12.636 ($p < .01$)
Leadership	12.6 (7.40)	26.0 (8.54)	-13.4	-13.412 ($p < .01$)

Table C.3. *Within-Group Results: Comparison Group (Non-BHWET students) per RSCWS Subscale*

Subscale	Pre M (SD)	Post M (SD)	M Diff	*t* (Sig)
Values, ethics, theory	20.2 (5.64)	25.8 (7.84)	-5.6	-4.664 (p < .01)
Assessment	16.6 (7.28)	23.3 (7.11)	-6.7	-5.562 (p < .01)
Intervention	17.8 (7.92)	24.5 (8.04)	-6.7	-5.398 (p < .01)
Services, programs, policies	15.5 (8.96)	23.0 (10.62)	-7.5	-3.947 (p < .01)
Leadership	14.3 (9.00)	23.6 (10.79)	-9.3	-4.378 (p < .01)

Table D.4. *Between-Group Results: Pretest*

Subscale	Inter M	Comp M	M Diff	*t* (sig)
Values, ethics, theory	19.0	19.4	-0.4	-.458* (p > .05)
Assessment	14.7	15.6	-0.9	1.001 (p > .05)
Intervention	15.8	16.2	-0.4	.411 (p > .05)
Services, programs, policies	13.2	13.7	-0.5	.439* (p > .05)
Leadership	12.5	13.4	-0.9	.726 (p > .05)

Table 5. *Between-Group Results: Posttest*

Subscale	Inter M	Comp M	M Diff	*t* (sig)
Values, ethics, theory	28.8	25.0	3.8	-3.955 (p < .01)
Assessment	25.1	22.4	2.7	-2.849 (p < .01)
Intervention	27.1	23.4	3.7	-2.861 (p < .01)
Services, programs, policies	26.2	22.0	4.2	-2.750 (p < .01)
Leadership	26.1	22.4	3.7	-2.407 (p < .05)

VITA

Cameron Barney was born in Baton Rouge, Louisiana and received her undergraduate education from Centenary College of Louisiana in Shreveport, where she was awarded the outstanding graduate in psychology in 2017. Cameron has experience working with those in crisis through her voluntary work at the Baton Rouge Crisis Intervention Center, and through her internship as a Victim Assistant Coordinator at the District Attorney's Office. She also has experience in work with adolescents through her employment at the Our Lady of the Lake TAU Adolescent Psychiatric Center, as well as through her internship at Heritage Ranch Christian Children's Home. Cameron anticipates graduation from the LSU School of Social Work in May of 2019, and she anticipates graduation from the LSU Health Science Center's School of Public Health in May of 2020.