Brief Reports

Identifying Clinical Competencies that Support Rehabilitation and Empowerment in Individuals with Severe Mental Illness

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Abstract

Individuals with severe mental illness often do not receive appropriate treatment or rehabilitation. One approach to improving their care begins by identifying competencies that clinicians should possess. This project developed a set of core clinical competencies that pertain to community-based care and support the goals of empowerment and rehabilitation. Development of the competency set began with review of existing literature and competency statements, and focus groups and interviews with clients, family members, clinicians, managers, experts, and advocates. Representatives from each of these groups participated in a national panel and used a structured process to identify 37 final competencies. Panel members agreed that these competencies are very important in determining outcomes and often are not present in current clinicians. This project demonstrates that it is possible to develop a core competency set that can be strongly supported by diverse groups of stakeholders. These competencies may be useful in clinician training, recruitment, and credentialing efforts.

There is increasing support for making rehabilitation services available to individuals with severe and persistent mental illness (SPMI)[1] and for empowering clients and their families to take a more active role in treatment and rehabilitation.[2] However, there are substantial problems with the quality of care currently provided to people with SPMI and a need for approaches that improve treatment quality.[3] For instance, studies of individuals with schizophrenia in usual treatment settings have

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found that appropriate treatments are often not provided,[4,5] the treatments that are provided may have limited effectiveness,[6] and outcomes appear to be much worse than in state-of-the-art treatment programs.[7] While there are many different approaches to quality improvement,[8] few strategies have been proven to improve the treatment of individuals with SPMI. One promising approach focuses on developing important competencies in clinicians.[9] Competent clinicians possess specific attitudes, knowledge, and skills that allow them to provide high-quality care that improves client outcomes.[10] While numerous organizations have written statements regarding valuable clinical competencies, the usefulness of these statements has been limited because they often have focused on select treatment domains while failing to include critically important interventions. For instance, in schizophrenia new rehabilitation interventions show great promise,[11] and these interventions may require appropriate antipsychotic medication to be effective.[12] However, many existing competency statements have minimized both vocational rehabilitation technologies and medication management. There is a need for competency sets that encompass divergent treatment modalities while focusing on domains that result in the greatest improvement in client outcomes.

Competencies define how clinicians are expected to assess, treat, and interact with clients as they provide care. As such, competencies have the potential to improve outcomes by guiding the training and supervision of clinicians, informing the design of programs and clinician networks, and shaping clinician recruitment, credentialing, and profiling efforts. However, competencies differ in important ways from practice guidelines and treatment recommendations (documents that have received greater attention). For one, competencies are likely to be more comprehensive than guidelines, since they encompass interpersonal interaction and attitudinal characteristics. Competencies also have a practical perspective and consist of expectations that are reasonable in community settings and that can be agreed on by healthcare organizations, clinicians, and clients. They place more emphasis on preferences and performance expectations of diverse groups of stakeholders and less emphasis on scientific data, except in key technical competency areas. Competencies reflect the need for performance in typical community settings and the diversity that exists among clinicians. This may be particularly important in the care of individuals with SPMI, which can be provided by social workers, physicians, psychiatric and vocational rehabilitation workers, drug and alcohol counselors, nurses, psychologists, and a variety of personnel with little or no professional training.

While competency documents differ from practice guidelines, practice guidelines provide information regarding effective treatments that is critical to the development of competency sets. For instance, the Schizophrenia Patient Outcomes Research Team developed a set of treatment recommendations that focus on the role of medication treatment, family involvement in care, and assertive community treatment.[13] Guidelines for the treatment of specific disorders, such as bipolar disorder, major depression, and schizophrenia, have been developed by the American Psychiatric Association, the Veterans Health Administration, the state of Texas, managed care companies, and numerous healthcare organizations.[14-24] Certain disciplines have also developed guidelines regarding the provision of culturally appropriate care,[25] rehabilitation and psychosocial services,[26-31] and the role of clinicians in treatment organizations.[32-34] Curricula have been developed for training clinicians to be rehabilitation specialists.[35] In addition, the Center for Mental Health Services recently supported the development of a number of relevant competency statements under the "Mental Health Managed Care and Workforce Training Project." Panels developed competency statements for treatment of adults with SPMI, co-occurring substance abuse disorders, and variety of ethnic groups, including African Americans, Hispanic Americans, Asian Americans, and Native Americans.[10, 36]

While these documents provide valuable information, many have not spanned the diverse components of care for persons with SPMI, ranging from medication management to rehabilitation and empowerment. Medication management is a necessary treatment component for most persons with SPMI.[13] Rehabilitation is supported by a variety of studies,[37] and specific vocational rehabilitation approaches have recently demonstrated strong effects on outcomes.[11,38] While there is less consensus regarding the definition or role of empowerment, this concept has been a priority for consumer organizations, and there is research to support this concept. For instance, it has been known for years that

activating the role of patients in care can improve outcomes for a variety of chronic medical disorders.[39] In mental health, there has been evidence supporting the value of educating families, other caregivers, and clients to take a more active role in the treatment process.[40,41] Recently, a concept of client empowerment has emerged that includes shaping ones own goals, taking an active role in treatment decisions, developing a sense of self-efficacy, having a social support system independent of professionals, and having influence over the organization of care.[2,42,43]

The goals of this project were to develop a useful competency set that could be strongly supported by a diverse group of stakeholders and to develop estimates of how often these important competencies are found in clinicians treating persons with SPMI today. The clinical focus was defined as community-based care of individuals with disabling disorders such as bipolar disorder or schizophrenia. Given increasing policy interest in the domains of rehabilitation and empowerment, a decision was made to define these as important client outcomes. Since one goal was to develop a competency set that would be useful in quality improvement efforts, competencies needed to be prioritized. While it should be possible to improve competencies by educating and profiling clinicians, it will not be practical to simultaneously improve all important competency domains. Competencies were, therefore, prioritized using information regarding the relative importance of competencies with regard to client outcomes. Estimates were also obtained regarding the frequency with which current providers possess important competencies so that competency improvement efforts can be focused on areas of greatest need.

Method

The competency set was developed using literature review, focus groups, key informant interviews, and a national consensus panel. The literature review was designed to include both published journal articles and books and unpublished documents. It began with searches of the published literature and reviews of the Internet sites of national mental health professional and advocacy organizations. One of the authors (AY) then spoke by phone with (1) individuals who had published on mental health competencies, (2) individuals who had unpublished work that was known to the authors, and (3) leaders of large mental health organizations who may have been exposed to competency documents. These individuals were asked for literature they were aware of on the subject (published and unpublished) and for the names of other individuals who might be knowledgeable in this area. This process went through multiple iterations. It led to the review of articles cited in the beginning of this article plus other key references regarding clinical competencies.[44-49]

Next, 10 focus groups were held in Colorado and New Mexico during early 1998. There were 3 groups of mental health clients with a total of 31 participants, 3 groups of direct care clinicians with a total of 29 participants, 3 groups of managers of mental health agencies and programs with a total of 27 participants, and 1 group of family members of clients with 14 participants. Each group lasted between one and two hours. At the groups, a facilitator used a written script to guide the discussion, and a second individual transcribed the participants' comments. All groups addressed the domains of good clinical care, rehabilitation, and cultural factors. Clients' goals regarding hope, empowerment, improved functioning, and quality of life framed each discussion, and participants were asked to express the process by which these could be achieved. However, the focus of the groups differed, depending on the participant composition. Clinician and manager groups discussed the knowledge and skills needed to provide high-quality care. Client and family member groups discussed characteristics that clinicians need to possess to provide care that achieves desired outcomes.

Semistructured key informant interviews were held with 39 expert clinicians, managers, clients, family members, advocates, and academic experts from across the United States. Respondents were selected based on having a national or regional reputation as a leader in their field. An effort was made to ensure that respondents represented the diversity of stakeholders found in the mental health treatment process. The respondent selection process made particular use of information developed

during the literature review. Interviews were usually conducted by telephone. Each key informant was asked to discuss the clinical competencies that they believe most improve client outcomes. Depending on the informant's area of expertise, they were also asked to focus on one of three domains: social, cultural and ethnic competencies; rehabilitation competencies; or medical and psychiatric competencies.

A national panel of 11 individuals was identified that included prominent mental health clients and family members, clinicians, academic experts, administrators, and representatives of managed care companies and advocacy organizations. Participants were selected based on demonstrated knowledge regarding competencies, and an effort was again made to ensure diversity within the group. Each panel member was mailed a preconference survey that included two questions regarding each draft competency. The first question was, "How important is this competency in determining treatment outcomes for people with severe mental illness?" Responses were made on a 9-point Likert scale, with anchors that included *extremely important* (1), *very important* (3), *quite important* (5), *somewhat important* (7), and *not very important* (9). Competencies were discarded if fewer than 75% of respondents rated the competency's outcome effect as 1, 2, or 3. The second question was, "How often is this competency found among current providers in publicly funded organizations?" Responses were made on a 9-point scale, with anchors that included *all of the time* (1), *most of the time* (3), *some of the time* (5), *rarely* (7), and *never* (9).

The national panel met for a one-day conference in August 1998 to reach consensus on the final competency set. The approach used was based, in part, on the RAND/UCLA "appropriateness method," which has been described in detail in a variety of previous research reports.[50,51] The method had the goal of refining the competency set while increasing support among the panel for the final product. At the conference, the research evidence supporting each draft competency was reviewed, the preconference ratings were summarized, and the competency's effect on client outcomes was discussed. The panel had an opportunity to reword each competency, to split or combine competencies, and to discard competencies. They were encouraged to discuss and negotiate areas of disagreement in an effort to increase support for the final competencies. After discussion, the panel members confidentially rated the effect of each competency on client outcomes and the prevalence of each competency in current clinicians using the same responses found in the preconference survey.

Results

A detailed taxonomy was developed that consisted of statements made by participants during the focus groups and key informant interviews. All statements were compiled, and statements that were identical or very similar to other statements were dropped. There were about 350 distinct statements. These statements were then reviewed to identify categories that were consistent conceptually with findings from the literature review. This led to a taxonomy that grouped statements into seven domains: clinician-client relationship, individual and ongoing assessment, rehabilitation and empowerment, treatment, family and support systems, social and cultural factors, and resources and coordination of care.

Next, the taxonomy was summarized to develop a smaller set of draft competencies. This process began by dropping statements that were not in the form of a competency and that could not be reworded to express a clinician competency. The remaining items were reviewed by two of the authors (AY and JS) to develop a smaller number of competency domains. Many statements shared similar themes, and these were summarized by 1 competency that was consistent with concepts from the literature review or the clinical experience of the authors. Summary competency statements were drafted, and these statements were reviewed by each member of the project team. This led to a draft document containing 48 competencies.

The draft competencies were submitted to the members of the national panel for rating before the conference. Of these 48 competencies, 35 were rated by panel members as having a very important

or stronger effect on outcomes and were brought to the conference. Some competencies were reworded before the conference based on feedback from panel members.

At the conference, the panel dropped two proposed competencies and added four new competencies. All competencies were reworded by the panel before being endorsed. The final competency set is found in Table 1. The panel endorsed a wide range of competencies, including those pertaining to, for instance, medical treatment, rehabilitation, social support, and community reintegration.

As shown in Table 2, all final competencies were rated as having a strong effect on client outcomes. Average panel rating for the effect of each competency on outcomes ranged from an *extremely important* effect for medication treatment ($M = 1.0$, $SD = 0.0$) to a *very important* effect for hospitals and commitment ($M = 2.3$, $SD = 1.2$). The competencies rated as having the strongest effects on outcomes were medication treatment, diagnosis, rehabilitation, functional assessment, clinician optimism, and client self-advocacy skills. The mean of all outcome effect means was 1.6.

There was more variation in the extent to which panel members believed that clinicians typically possess the competencies. Average panel ratings of the prevalence of each competency in clinicians ranged from *some of the time* for minimizing stigma ($M = 4.3$, $SD = 1.6$) to *rarely* for medical evaluation ($M = 6.6$, $SD = 1.1$). The competencies rated as being least prevalent in clinicians were medical evaluation, cultural specificity, holistic approach, and treatment of concurrent conditions. The mean of all competency prevalence means was 5.4.

Discussion

Using literature review, focus groups, key informant interviews, and a national consensus conference, this project identified and briefly described 37 clinical competencies that pertain to the care of individuals with SPMI. While organizations and experts have identified a large number of competencies that may be useful in providing care to this population, this project demonstrates that it is possible to develop a set of core competencies that are strongly supported by a diverse group of stakeholders. These competencies were developed using a process that made use of extensive information from clients, families, and clinicians and considered a wide array of treatment modalities. At the same time, the focus was on competencies that are believed to be very important in determining client outcomes and that specifically support rehabilitation and empowerment. As would be expected from the methods that were used, each of the final competencies was rated by the panel as having a very important effect on client outcomes. Important competencies were found in each of the competency domains. While many competencies were rated as important, those rated as having the strongest effect on outcomes were diagnostic assessment, medication treatment, and rehabilitation. This is consistent with a large body of research literature that supports the efficacy of diagnosis-based treatment, medication treatment, and rehabilitation.[17]

While the panel concurred that the competencies in the final set are very important, they also believed that these competencies are often not present in clinicians currently caring for the SPMI. Within competencies that were rated as having the strongest effect of outcomes, it was estimated that current clinicians are particularly unlikely to possess skills regarding client self-advocacy, rehabilitation, and functional assessment. While this might suggest these as leading targets for competency improvement efforts, it should be noted that none of the competencies were rated as being present *most of the time* in current clinicians, and only 9 of the 37 were rated as being present at least *some of the time*. It is quite striking that the panel defined a set of critical competencies while estimating that these usually are not present in current clinicians. This could represent a biased or cynical view from experts and advocates and an underestimate of the competency of current clinicians. However, the panel members have extensive experience with mental health service provision in many different mental health systems, and we are not aware of research evidence that refutes their estimates. If the panel's estimates are accurate, this suggests that competencies should be improved in all of the domains identified by this project.

Table 1
Set of Core Clinical Competencies for Providing Care to Individuals with Severe Mental Illness

Competency	Definition
Clinician-client relationship	
1. Respect	Have a positive demeanor. Be empathetic and calm. Be able to respect the desires of the individuals receiving services and their reference group or culture.
2. Communication	Have the skills necessary to adapt verbal and written communication to the language style of the individual receiving services and their family.
3. Minimizing stigma	Know the importance of reducing prejudice and discrimination toward the individual with mental illness. Be able to confront personal prejudices, teach individuals to manage discrimination, and advocate for reducing discrimination in the community.
4. Being accessible	Understand the importance of providing clients and caregivers with access to care 24 hours a day, 7 days a week, including returning phone calls promptly and offering drop-in and emergency services.
5. Confidentiality	Know techniques for maintaining the client's wishes regarding confidentiality while encouraging inclusion of support system members. Be able to educate the client regarding confidentiality and develop strategies for resolving problems related to confidentiality.
Initial and ongoing assessment	
1. Diagnosis	Be able to use a structured interview to develop differential and working diagnoses on all axes of DSM-IV. Be experienced in evaluating the cultural context and all possible diagnoses before arriving at the working diagnosis. Demonstrate an ability to diagnose co-occurring mental health and substance abuse disorders. Be knowledgeable about the need to support all diagnoses with documentation.
2. Functional assessment	Be able to complete a functional assessment, including identification of client preferences regarding education, work, and leisure. Know the importance of assessing clients' feelings of hope about the future and their ability to lead a productive life. Be able to identify sources of motivation, resources, strengths, interests, capabilities, major problems, and deficits.
3. Medical evaluation	Be able to complete a thorough medical evaluation to determine the nature of the client's current medical, dental, auditory, and visual needs and the extent to which a medical disorder is causing or contributing to the psychiatric symptoms.
4. Critical stresses	Be able to identify critical stresses that negatively affect the client's mental status and coping strategies and supports that have been successful in the past and can be successful in the future. Have demonstrated ability to develop relapse prevention strategies, including advance directives.

5. Basic needs	Know how to elicit the client's choices regarding basic needs, such as financial resources, food, shelter, and safety.
6. Cultural factors	Be skilled at including cultural factors in the assessment process. Understand how cultures differ in the experience of stress and the role of family and other natural supports in the treatment process. Be familiar with culture-bound syndromes associated with the client's ethnic group. Be able to identify cultural factors that can be used to support treatment and rehabilitation.
7. Client preferences	Be able to identify and know the importance of respecting the client's choices regarding services. Have skills necessary to elicit the individual's history of satisfaction and dissatisfaction with services, including medications.
8. Risk factors	Be able to identify and mitigate factors that place the client at high risk for suicide, violence, victimization, medical disorders such as HIV, or substance abuse.
9. Client knowledge	Be able to assess the client's understanding of their illness, medications and other treatments, and potential medication side effects.
10. Cognitive assessment	Be able to assess cognitive deficits and develop appropriate rehabilitation and treatment strategies.
Rehabilitation and empowerment	
1. Optimism	Believe in the potential for growth and improvement. Have the skills to help the client restore or sustain hope and a sense of the future.
2. Holistic approach	Be able to view the client as a whole person and to see beyond the illness. Have the skills to elicit the individual's personal experiences and world view.
3. Goals	Be able to help the client identify and organize personal goals in the areas of learning, work, leisure, and living. Know how to support the client's unique pace toward goal achievement.
4. Education	Be able to educate the client about mental illness, medications, and rehabilitation. Be able to communicate the value of rehabilitation and medication treatment to clients.
5. Rehabilitation	Be skilled in using current psychosocial/psychiatric rehabilitation approaches. Be able to teach goal-setting and problem-solving skills and living, social, and illness self-management skills. Be able to help the client gain employment, education, and/or meaningful activity (when desired).
6. Client self-advocacy	Know how to create opportunities for the client to take optimal responsibility for his or her own life. Be able to foster and support self-advocacy.
7. Natural supports	Be able to provide flexible types and intensities of services. Know how to help the client meet changing needs and goals and transition from clinical services to natural supports.

Table 1 Continued

Competency	Definition
Treatment	
1. Medication treatment	Have demonstrated ability to use psychotropic medications to improve outcomes while minimizing side effects. Know how to recognize and educate the client regarding the side effects of common medications. Know current strategies for medication choice and dosage in the context of ethnicity and age. Know the importance of closely monitoring symptoms and side effects.
2. Concurrent conditions	Know how to treat common concurrent conditions, including concurrent mental and substance use disorders.
3. Crisis intervention	Know how to use effective crises intervention approaches such as warm and hot lines, mobile crisis response, respite beds, and alternatives to hospitalization. Be able to evaluate client preferences regarding interventions that have been successful in the past.
4. Hospitals and commitment	Know when and how to admit the client to psychiatric hospitals. Know the laws, policies, and procedures regarding the commitment process. Understand the importance of advance directives.
5. Outreach	Know when to use outreach. Be able to deliver mobile services to homeless individuals and to individuals in community settings and the hospital.
Family and support system	
1. Family involvement	Be skilled at assessing the client's preferences regarding family involvement. Be knowledgeable about methods for involving the family and other support system members as part of the assessment, treatment, and rehabilitation process (subject to the approval of the client).
2. Information from the family	Be aware of the importance of soliciting information from the family and other members of the client's support system as part of the assessment process.
3. Family role	Be knowledgeable about the role of the family in treatment and rehabilitation (in the context of the client's culture). Be skilled at providing ongoing education and problem-solving assistance to family and other support system members. Have the ability to educate the family regarding mental illness, treatment, rehabilitation, empowerment, available resources, and mutual support groups.

Social and cultural factors	
1. Social and cultural knowledge	Be knowledgeable about how cultural and socioeconomic status affects the client's diagnosis and treatment. Be able to identify financial, cultural, and social resources that can facilitate rehabilitation and treatment.
2. Cultural specificity	Know how to use culturally competent and specific interviewing and intervention skills (e.g., sweat lodges, folk healing, herbal remedies). Be able to meet the specific language needs of the individual receiving services.
Resources and coordination of care	
1. Entitlements	Know which entitlement programs are available and their rules. Be able to work with clients to evaluate the advantages and disadvantages of entitlements. Know how to help clients access entitlements and work incentive programs.
2. Community integration	Believe in the importance of community integration and the use of natural supports.
3. Community resources	Be able to help clients access housing, transportation, self-help organizations, mutual support groups, and peer companion programs. Be able to provide information regarding other treatment and rehabilitation programs and opportunities.
4. Coordination of care	Be skilled at coordinating service planning and provision. Know the importance of having a fixed point of responsibility for implementation of an integrated care plan and of including all service providers, the client, and their support system.
5. Ongoing medical care	Be able to ensure that individuals with mental illness have ongoing medical evaluation and treatment.

Table 2
Panel Members' Ratings for Each Competency

Competency	Estimated Effect on Client Outcomes[a]		Estimated Prevalence in Current Clinicians[b]	
	M	*SD*	*M*	*SD*
Clinician-client relationship				
1. Respect	1.3	0.7	5.0	1.5
2. Communication	1.9	0.8	4.9	0.8
3. Minimizing stigma	1.9	1.1	4.3	1.6
4. Being accessible	1.7	0.9	5.1	1.7
5. Confidentiality	1.9	0.9	5.4	1.8
Initial and ongoing assessment				
1. Diagnosis	1.1	0.3	4.8	0.9
2. Functional assessment	1.2	0.4	5.5	1.6
3. Medical evaluation	1.9	1.4	6.6	1.1
4. Critical stresses	1.3	0.6	5.9	1.6
5. Basic needs	1.4	0.5	4.4	1.6
6. Cultural factors	1.6	1.3	6.0	0.8
7. Client preferences	1.9	0.9	5.5	1.9
8. Risk factors	1.6	0.8	5.1	1.5
9. Client knowledge	1.8	1.0	4.9	1.6
10. Cognitive assessment	1.9	1.6		
Rehabilitation and empowerment				
1. Optimism	1.2	0.4	5.1	1.4
2. Holistic approach	1.5	0.7	6.1	1.5
3. Goals	1.3	0.5	5.6	1.1
4. Education	1.3	0.7	5.4	1.8
5. Rehabilitation	1.1	0.3	5.5	1.5
6. Client self-advocacy	1.2	0.4	5.9	1.8
7. Natural supports	1.9	1.2		
Treatment				
1. Medication treatment	1.0	0.0	4.4	0.9
2. Concurrent conditions	1.3	0.5	6.1	1.0
3. Crisis intervention	1.5	0.7	5.9	1.6
4. Hospitals and commitment	2.3	1.2	4.5	2.1
5. Outreach	1.6	1.3	5.4	1.7
Family and support system				
1. Family involvement	2.1	0.9		
2. Information from the family	2.2	0.9	5.4	1.7
3. Family role	1.7	0.7	6.0	1.6
Social and cultural factors				
1. Social and cultural knowledge	2.1	1.0	5.9	1.0
2. Cultural specificity	1.7	0.8	6.3	0.9
Resources and coordination of care				
1. Entitlements	1.6	0.7	4.4	1.4
2. Community integration	1.4	0.7		
3. Community resources	2.0	1.1	5.3	1.8
4. Coordination of care	1.8	0.6	5.3	1.3
5. Ongoing medical care	1.6	0.8	6.0	1.3

a. Rated from 1 to 9; lower scores indicate a stronger effect on client outcomes.
b. Rated from 1 to 9; lower scores indicate that the competency is present more often in current practitioners; A-7, C-10, E-1, and G-2 were not rated by the panel.

There are a number of important issues regarding implementation of these competencies. First, a particular client's care is not likely to require all the competencies but may require competencies from multiple domains. A given clinician may not possess competencies from all the domains or may specialize within one or several domains. However, the panel believed that it is crucial to integrate competencies when treating a particular client. Therefore, treatment may often entail collaboration among a team of clinicians who are differentiated according to discipline or work role.[52,53] If a client with SPMI has only one clinician, then that clinician should possess all the necessary competencies. However, if a team is providing care, then the team should possess the necessary competencies. A team may delegate competencies to different members with, for instance, a psychiatrist and rehabilitation worker performing different functions. Also, teams may include technical or trainee clinicians who do not fully possess a required competency, and these individuals should be adequately supervised by a clinician who is fully competent.

Clinical competencies are characteristics of individual clinicians and not of an organization or system.[10] However, it seems likely that treatment organizations and systems can have a substantial effect on treatment quality by, for instance, limiting access to beneficial medications or rehabilitation technologies. These competencies were explicitly developed to be used within the context of comprehensive, quality care that responds to client, family, professional, and legal needs. Care must, for instance, respect the linguistic and cognitive abilities of clients. Professional and ethical standards need to be maintained. Finally, legal issues such as client dangerousness can influence the use of the competencies.

There are a number of important limitations regarding this competency set. First, the competency statements documented here are not thorough definitions but instead provide an overview of domains that are required to effectively care for a population with SPMI. Second, this project relied on the panel members' experiences regarding treatment and did not determine empirically whether the approach used to aggregate competencies is consistent with effective care. For instance, a clinician's competency may differ for mood stabilizers and antipsychotic medications, and it is possible that these should be separate competencies. Third, this competency set was not designed to be completely inclusive. The fact that a competency is not presented does not imply that it is not important or should not be available. Fourth, the competency set will need to be revised as consumer preferences and our understanding of effective treatment changes. Finally, it is quite possible that a different competency development process or a national panel with different members could have led to a different final competency set. Overall, the competency set developed by this project should be viewed with caution until studies can determine whether improving particular competencies leads to improvement in client outcomes.

Implications for Behavioral Health Services

This project developed a set of clinical competencies that representatives of a wide range of stakeholders believe are important in determining outcomes of individuals with SPMI. These competencies suggest that it is necessary to have clinical professionals involved in supervising or directly providing behavioral healthcare and to have specific curricula that can be used to train clinicians. Also, consistent with previous work regarding the quality of care usually provided this population, the stakeholder representatives on this panel estimated that important competencies are often not present in current clinicians. Mental health treatment organizations that plan to evaluate and improve the quality of their care may be able to use these competencies to inform their efforts. For instance, the competencies of clinicians may be improved through education and training programs and by recruiting competent clinicians. Clients can also be directed to clinicians with relevant competencies. While it is critical to evaluate the effect of quality improvement efforts such as these, effective treatments exist, and individuals with SPMI should benefit from having access to competent clinicians.

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