Measuring Workforce Elements

To the Editor:

I am a nursing educator at a hospital in Rhode Island and am responsible for training nursing assistants in the medical portion of the hospital to transition into the mental health area. I have read the article titled “Building a Better Mental Health Workforce: 8 Core Elements” by Kevin Ann Huckshorn, RN, MSN, ICADC (March 2007, Vol. 45, No. 3, pp. 24-34) and found it insightful. The competencies that were mentioned will be difficult to measure. If there is any formulated competency checklist on these skills, I would find it most helpful to view. I share your vision of moving toward a more competent workforce and thereby enhancing quality patient care.

Donna Lamoureux, RN
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Response:

Thank you for writing and commenting on this article. Workforce development is something that I have been directly involved in since the beginning of my nursing career. It seems that we are always playing catch up in addressing the real, although somewhat understandable, lag between school learning and actual work environment demands. Although, I will mention that this gap has seemed to grow larger during the past 10 to 15 years in terms of the current mental health workforce’s knowledge and competency needs and the academic preparation of newly licensed and unlicensed professionals entering these work environments. In any case, I join you in wanting to work toward helping to develop a more competent workforce. I believe, at this point, that the responsibility to develop this workforce rests primarily on our facilities and agencies because academic settings are very slow to change, and many of the members of our workforce come from high school preparation only and rely on our preservice and inservice educational offerings to be trained.

I am, and others in the field are, currently developing a training curriculum that will be available to all (in the public domain) when it is finished. This training curriculum will be directed toward staff members who work in adult inpatient and community settings who hold a high school diploma or GED up to a bachelor’s degree. This curriculum will also be directed to include nurses with 1 and 2 years of academic preparation—those whom we identify by LPN and ADN degrees or licenses.

As such, the competency checklist that you have inquired about is not yet completed and will not be done until early fall. However, I will add that I believe that these competencies will be relatively easy to ascertain once the curriculum is completed. For instance, knowing the signs and symptoms of mental illness will be able to be determined from staff record charting, annual reviews that ask random questions, and the content of client interviews regarding what they have learned about their illness. Competencies in the use of medications will be judged by medication group interactions, the use of...
medication education materials, and consumer discharge interviews. Trauma and coercion informed competencies will be able to be measured by observed staff interactions, involvement in seclusion and restraint events, and, indirectly, the number of injuries experienced by staff and service users. Judging therapeutic alliances will be more difficult, but one way to do so is to conduct a twice-yearly survey of consumers in care, asking for short vignettes about what staff have been particularly helpful in embedding hope for their getting better.

Becoming familiar with evidence-based practices, for the most part, will be expected for staff to better understand current language, not to provide these treatments. This can be measured by post-training examinations as all of what we are looking for is knowledge; most direct care staff will not be expected to implement these practices. Partnering with people in formal roles will be best judged by asking consumers working as staff to identify how staff have demonstrated the ability to include these peer staff as colleagues. Regarding multicultural competency, I would first look at the cultural diversity in staff as compared with the service user demographics, especially in terms of language proficiency. In terms of ethics, we will attempt to ensure that training includes basic ethical standards and that the quality improvement plan includes benchmarks in two to three key areas, such as informed consent, the right to choice, and real service user involvement in treatment planning.

Measuring competency is not an easy road, and the answers are complicated, as you probably know. However, if we are going to transform our workforce, we need to determine our goals and work toward this end. I do not think we will ever be perfect in doing this work, but the random sampling of these competency markers in the staff and the people we serve will go a long way in helping us evaluate whether we are going in the right direction. I hope this is helpful to you. Please write me at the end of the summer when we will be piloting this curriculum and its competencies. I would very much like your input on this. My work e-mail is kevin.huckshorn@nasmhpd.org.

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To the Editor:

I wanted to congratulate you for publishing a very timely issue covering topics that are at the top of the nation’s thoughts. I have already shared with faculty and students data from the articles on stalking (“Nature and Prevalence of Stalking Among New Zealand Mental Health Clinicians,” by Frances A. Hughes, RN, DNurs, ONZM; Katey Thom, MA; and Robyn Dixon, PhD, April 2007, Vol. 45, No. 4, pp. 32-39) and mental health issues of college students (“Striving to Help College Students with Mental Health Issues,” by Linda Cook, DNSc, RN, BC, April 2007, Vol. 45, No. 4, pp. 40-44).

These topics are of vital importance. Perhaps now mental health services for students will be strengthened. We should all hope that stalking laws will be enacted in all states. The tragic events at Virginia Technical Institute will haunt Americans for a long time.

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