ASSESSING THE TRAINING AND STAFF DEVELOPMENT NEEDS OF MENTAL HEALTH/MENTAL RETARDATION PROFESSIONALS: A MULTI-METHOD FRAMEWORK

by

Dennis Robert Cogswell

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APPROVED:

Harold W. Stubblefield, Chairman

Dennis E. Hinkle

Steven R. Parson

Howard O. Protinsky

Michael B. Brown

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Blacksburg, Virginia

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CHAPTER 1

Introduction

The purpose of this exploratory study was (a) to design a framework that can be used by any of the 40 Community Service Boards (CSB) across the state of Virginia to assess the training and staff development needs of community mental health/mental retardation professionals and (2) to field test the framework in a CSB in the State of Virginia.

Background of the Problem

In the 1960's, a nation-wide community-based mental health system was started by the Kennedy administration that has grown into an extensive network of community-based programs. These programs are administered by Community Services Boards, also known as Chapter 10 Boards, and serve a relatively small geographic area in comparison to the related set of institutions run by state government which tend to serve a specific region of a state. These centers have been in operation now for approximately twenty years and primarily depend upon local, state and federal monies plus user fees for financial support of their programs.

In Virginia, this system is regulated by the Virginia Department of Mental Health and Mental Retardation. For some time, like its counterpart in other states, this system has been under intense public scrutiny in relation to issues of accountability, accessability of services and quality of

services. One key area of focus has been on the training and staff development needs of those professionals who provide mental health and mental retardation services. It has been assumed that one way to ensure the quality delivery of service is to equate high quality service with well-trained and proficient professionals. Nationwide, the typical CSB employes a large number of professionals from a wide variety of professional backgrounds, disciplines and philosophies, but most frequently from (a) psychiatry, (b) psychology, (c) social work, (d) nursing, and (e) administration or business (Chatlin, 1981). For these helping professionals, their highest held degree provided them with credentials to enter their profession. The professions differentiate between entry level professional practice and proficiency in professional practice and recognize that additional training and education will be necessary for a professional to become fully competent and to remain so (Dublin, 1972; Houle, 1980; Rosenfield, 1981). To meet their training and staff development needs, most professionals involve themselves in a variety of educational activities that range from the reading of journals to attending of workshops, seminars and classes in areas related to their professional practice or specialty in which they hope to become proficient.

The stated need for training and staff development is often linked to the following outcomes: (a) to maintain competency; (b) to prepare for credentialing examinations;

(c) to provide for initial licensure or certification; (d) to provide education in new practice areas; (e) to enhance job security and advancement; (f) to supply information in other areas relevant to practice and (g) to serve as a forum for professional exchange (Bevis, 1974; Queeway and Mantz, 1979). Of all these outcomes, the two that have the highest priority are to maintain competency of skills due to the half-life principle of professional education and to respond to the increased public call for accountability.

The Half-life Concept

The need to keep abreast in a professional field is related to the concept of half-life, a term popularized by continuing education. This concept deals with the issues of proficiency and obsolescence. Obsolescence has been defined as "the measurement at some point in time of the difference between the knowledge and skills possessed by the practicing professional who may have completed his formal education a number of years previously and those possessed by a recent graduate of a modern curriculum" (Lindsay, Morrison & Kelley, 1974, p.5). For the practicing professional, half-life means that the knowledge and skills gained during formal education is good only for a set period of time and then re-tooling is necessary.(Lindsay, Morrison & Kelley, 1974; Faherty, 1979).

The Issue of Accountability

In the 1950's and the 1960's the professions and those that provided the funding for professional services shared a "good neighbor" and "try hard" philosophy. Consumers of services and funders alike relied on the reputation and natural intents of professionals to deliver a high quality of service. Philanthropy and the interest in helping others to create a better world were thought to be enough to ensure that professional services were adequate and competent. However, the 1970's saw a change in attitude on the part of the consuming public. The general public became educated about professional practices and demanded that practicing professionals be accountable for their actions and that they deliver high quality human services. Consumers of human services challenged the long-held belief within the professions that professionals would have self-awareness and would police themselves, as stated by the medical philosophy "physician: heal thyself". The vast increase in the number of malpractice suits against professionals and the growth of consumer organization and their demands for protectionism were new pressures brought to bear on the professions during this time period (Austin, 1972).

One of the main questions asked by both the professionals themselves and the consumers of services was: "How are non-professionals supposed to measure continued competence; how can consumers be sure that they are receiving

the highest quality services available?" One frequently given response, by the professions themselves and those asking the question, was that the quality of services is directly related to the training and staff development of the service providers themselves.

Training and Staff Development in Community Mental Health

Most human service agencies philosophically agree on the desirability and need for life-long learning for their staff members; however, few have well established policies and procedures to meet the continuing education needs of their practitioners. Such is the case in Virginia within the institutions, organizations and agencies that make up the public mental health agencies. Training and staff development programs have been carried out for many years. However, rather than taking a planned approach of any degree to this task, most CSBs have taken a hit-or-miss approach to meeting the educational needs of their practitioners. For example, practitioners frequently attend a wide variety of workshops on diverse subject areas without acquiring a comprehensive understanding of any one specific knowledge area. Popular topics predominate with persons attending training sessions because everyone else in the agency is interested in a specific subject area. A crisis suddenly may stimulate a need for knowledge on a certain topic. The result is that training is always remedial rather than preventive and reactive rather

than proactive. Workshop sessions are frequently chosen more on the basis of location of the sessions ("I've never been to California") rather than an identified need for the training. In large agencies, the trickle-up approach often predominates with staff members passing their new knowledge up the ladder through many levels of managers with gross information distortion and loss of uniform implementation (Pecora, 1982).

Performance Evaluation, Job Analysis and Needs Assessment

A long standing practice within CSBs is the employee annual evaluation or appraisal of performance process. Throughout most of the twenty year history of the CSB movement this task has been handled by the employee's immediate supervisor who has written an evaluation in the format of a narrative. These evaluations have differed from supervisor to supervisor in style, content and method. In many centers, these evaluations have had little direct relationship to personnel decisions such as promotion, or the granting of raises. Furthermore, although the State of Virginia has a formal system of personnel classification, each CSB has tended to develop its own set of job descriptions and titles; the net effect has been a broadly designed and implemented system. In recent years, a majority of the CSBs have begun to use a Job Analysis system which involves a systematic process of identifing the discrete

tasks which comprise whole jobs, the codification of the relative importance of each task from an organizational perspective, the identification of the degree of difficulty associated with each task (Buffum, 1984, p.1).

To date, this process has been implemented to varying degrees throughout the forty CSBs and it is estimated that only a few centers in the state have well developed job or task analysis systems. This system, although inadequately established, lends itself to the assessment of training and staff development needs because it is one of the few processes that exists in all CSBs that directly offers statements about professional performance that can then be translated to assessments of learning needs of all professional staff members. A performance evaluation should attempt to assess the factors that are related to job performance. One of these factors can be the training that is necessary and needed for a mental health professional to function at a proficient level.

State Training Office: Roles and Responsibilities

The Office of Prevention, Information and Training of the Virginia Department of Mental Health and Retardation is the department responsible for training and staff development. This office is mandated to coordinate the training and staff development of all staff that work in the 18 facilities and for the 40 Community Services Boards. In

October 1982, a report entitled "Systemwide Training and Development: Current Status and Recommendations for the Future" was prepared for the Commissioner of Mental Health by a private consultation agency(Riesett, 1982). The report cited the main problems in training and staff development, suggested that training be raised to a higher level within the agency, and provide a more comprehensive human resource development(HRD) function. The report concluded:

1. There is a lack of training policy and standards agency-wide.

2. There is an absence of training leadership. The office of training is too isolated from the other departments in the central office. It lacks authority and influence both in the central office and in the field.

3. State mandated training is resented. It is seen as more of a hassle than a help. It often stresses methodology instead of content.

4. Training decisions are being made by non training wise persons.

5. Training is too low a priority at the senior management level. The first budget cuts are always in training. Development of an agency-wide training plan is seen as important to increasing the commitment and sensitivity to training issues (p.2).

After the Riesett report was released, the Commissioner of Mental Health and Mental Retardation directed the Central Training Office to implement a new training and staff development plan. One of the basic questions that this office has attempted to answer is "what are the training and staff development needs of professionals within the Virginia Mental Health System?" Secondary questions have focused on ways of assessing needs and on developing a model of needs assessment that can be linked to overall training and staff development.

Training and Needs Assessment

It is not an easy matter to gather data and design training programs based upon the data collected. Large, multi-program human service agencies frequently experience a variety of problems and issues when need assessment procedures are being developed. Knowing the type of needs to assess and the approach to use in assessing each type is a complex decision that must be made at the beginning of any needs assessment process. For example, Kaufman has suggested that there are six types of needs assessment, each based upon a different approach. One may seek to assess the goals and policies of an organization (Alpha level), the training needs of professional staff in relation to assumed or set goals (Beta level) or four other types of needs and approaches (Kaufman, 1977). Once the nature of the needs has been decided upon, then the focus becomes the assessment of the

details of the discrepancy that exists. Clarifying and classifying the variables under review must occur. Furthermore, it must be noted as to whether the assessor is making an assessment on the basis of his/her own needs or his/her perceptions of others needs. Following this decision making process, the assessor is faced with deciding between a massive array of methods to employ in actually assessing the needs. Among the most commonly used techniques are standardized tests, surveys, criterion-referenced tests, observations, use of key informants, public forums, use of social indicators, use of social service statistics, interviews, Delphi techniques, (nominal group techniques, force-field analysis, critical incidents and analysis of primary and secondary data. Each method has its own strengths and weaknesses and can best be employed in relation to specific populations and assessment environments.

Most needs assessors also want to rank or rate the needs that are identified. Ranking is the easier process as it primarily involves comparing one need with another and then placing the needs in some sort of an order. However, the person doing the ranking must have some criteria to utilize in making the ranking. Should the ranking occur in relation to the size of the need, the importance of the need, or the possibility of meeting the need? Rating involves comparison of a need to a standard. Many questions arise here. What type of standards should be utilized, normative or criterion-

referenced? And finally, how this can be accomplished with a professional staff that comes from diverse professional backgrounds, have a tremendous variety in the amount of higher education received, and are not linked together in an system that utilizes common job descriptions, titles, or annual evaluation procedures ?

Statement of the Problem

The problem this research approached was that there does not exist a suitable multi-method needs assessment framework that can be used by Training Directors within CSBs to assess the training and staff development needs of community mental health professionals. A five step plan based on a Tylerian approach (Knowles, 1970) to training and staff development has been developed by the Office of Prevention, Information and Training in response to the Riesett report. This approach starts with learning needs, translates them into educational objectives, develops materials to use, outlines content, develops instructional procedures, and then carries out the learning experiences. However, the five step plan does not include any specific prescriptive framework for the actual assessment of needs of the practitioners to be trained, nor have the professionals within each CSB who will have the responsibility to assess the training and staff development needs had training in the use of needs assessment methodology. No decision has been reached about the type of

data to be collected, the methods to employ in collecting the data, ways of summarizing the data, means of using the data in establishing goals and objectives for the training that is to follow, who will make the decisions about the assessment of needs, or the extent of involvement of key persons who are to be involved in this process. A cost effective, utilitarian needs assessment process is needed before any other planning process can be implemented. Furthermore, research on the assessment of training and staff development needs of community mental health/mental retardation professionals has typically involved one assessment method with the researchers concluding that multi-method frameworks are more desirable. No research has occurred that utilizes a multi-method framework with this population.

This study sought to answer the following research questions:

(1) What are the criteria that should govern the establishment of a multi-method framework for assessing training and staff development needs of mental health professionals employed by community service boards in Virginia?

(2) What is a feasible multi-method framework for assessing training and staff development needs of mental health professionals employed by community service boards in Virginia?

(3) What should be the attitudes and roles of the staff members of the State Office of Prevention, Information, and Training in relation to those persons employed by a local CSB with training and staff development responsibilities, and those professionals from the local CSB that are serving on the Regional Advisory Committee of the State Office in relation to needs assessment?

(4) What data needs to be collected at what times in order to accurately access and plan for the training and staff development needs of community mental health practitioners?

(5) What is the worth/utility of the needs assessment data collected by the framework and the multi-method framework employed in this study?

Objectives of the Study

The broad goal of this research was to develop and field test a framework that could be used in CSBs across Virginia to assess the training and staff development needs of mental health professionals employed by or under contract to a community services board. The main objectives of this research were:

(1) To list criteria that relate to the establishment of a needs assessment framework that can be used to assess the training and staff development needs of community mental health professionals.

(2) To develop a multi-method framework that can be used to assess the training and staff development needs of community mental health professionals.

(3) To field test the framework developed with the professional staff of the Rockbridge community mental health center in Lexington, Virginia.

(4) To list the training and staff development needs of the professional staff of a community mental health center in the state of Virginia using the framework developed.

(5) To evaluate the utility of the multi-method needs assessment framework in assessing the training and staff development needs of community mental health professionals.

Definition of Terms

These terms were used within this study on the basis of the following operational definitions:

Staff Development: any process or educational program designed to improve the knowledge and skill base of a mental health/mental retardation professional that then will lead to improved job performance.

Training: a special type of continuing education specifically related to educational needs of professional staff that are related to their professional roles.

Community Services Board (CSB): the agency responsible for the administration of community-based mental health services within a specified geographic area. This agency

consists of a board of directors and a professional staff. The services offered may be directly offered by the professional staff or contracted out to other community agency. The term CSB in this study refered to the professional staff component of the CSB.

Significance of the Study

This research addressed the problem of developing a multi-method needs assessment framework that can be used by Training Directors within local CSBs to identify training and staff development needs. The Office of Prevention, Information and Training of the Virginia Department of Mental Health and Mental Health had asked each CSB to supply them with a listing of the training and staff development needs of their center's professional staff but had not developed a framework to use state-wide. Without appropriate data in relation to the training and staff development needs of mental health professionals, the five step programing model being implemented will not be able to be used adequately. Furthermore, related research on needs assessment frameworks for use with a variety of human service professional populations have often recommended that multi-methods frameworks be tested (Doelker and Lynett, 1982; Gates, 1982; Odor, 1982; Pecora, 1982). This research provided a multi-method needs assessment framework that can be employed by CSB. It also contributed to the knowledge

about the use of multi-method needs assessment models in assessing the training and staff development needs of community mental health professionals.

Organization of the Study

The dissertation is organized into five chapters. Chapter One is an introductory chapter that provides background information on the problem, a statement of the problem, objectives of the research, delimitations and assumptions of the research, definitions of terms and a statement of the significance of the research. Chapter Two contains a review of the related literature in relation to the stated problem. Chapter Three reports the procedures used in the study: population involved, design and instrumentation, data collection and analysis procedures. Chapter Four includes the non-evaluative reporting of the data collected during the study. Chapter Five contains the summary of the findings, and the evaluation of the framework and the products produced by the framework. It ends with conclusions reached as a result of the research and recommendations for future research. The Appendix to the Dissertation contains many different forms and related items used in the carrying out of the research.

CHAPTER TWO

Review of Literature

This chapter will review the professional literature on needs assessment methods and related concepts that have high utility for the development of training and staff development needs of community mental health professionals. Literature in these areas were identified and reviewed: (1) the concept of needs, (2) needs assessment methods, (3) criteria related to the selection of needs assessment frameworks, (4) adult education principles related to needs assessment and (5) research on training and staff development in community mental health.

Concept of Need

The concept of need is relevant to almost all aspects of human functioning. When human functioning is viewed in relation to a learning or educational context, the works of Maslow (1954), Knowles (1970) and Kidd (1975) are basic. Maslow theorized that human being have a set of five basic needs that could be viewed in a hierarchy. These are: physiological, safety, love, esteem, and self-actualization needs. Knowles suggested that human needs included those of physical needs, growth needs, the need for security, the need

for new experience, the need for affection and the need for recognition. Kidd looked specifically at adult learner needs and wants and classified them into items that related to health, family and friendship, sociocivic-relations, consumer aspects of life, occupational, recreation and religion and philosophy.

In the adult education literature, distinctions are made between different types of need. Frequently used categories include felt needs, ascribed or normative needs and real needs. Felt needs are those that are self-defined by the individual as being important. They are often equated with or described by the individual as being a "want". An ascribed or normative need is one that is perceived by others; those which experts or significant others define as being important. A real need is one that is active or is a demand, regardless of who does or does not perceive it (Atwood & Ellis, 1971; Mazmanian, 1977b; Scissions, 1982).

Knowles (1970) (1973) defined an educational need as something a person ought to learn for his/her own good, for the good of an organization, or for the good of society. It is as a gap between an individual's present level of competencies and a higher or desired level, as viewed by another person, professional organization or society itself. The gap is often called a discrepancy, which is the most common way that professionals view educational need (Trimby, 1979; Pratt, 1980). Nadler (1981) has suggested a

typology of educational needs: (1) education: individual-related learning experiences, (2) training: job-related learning experiences and (3) staff development: organizational related learning experiences.

Need Assessment Frameworks and Methods

Needs are identified by a process commonly known as needs assessment. Two of the most widely quoted theorists on needs assessment are Kaufman and English (1975). They define needs assessment as a formal process for determining gaps between present and desired outcomes. Needs assessment is typically done at the beginning of a program planning process and often times is called "front-end analysis". The actual assessment method is related to an overall data collection framework which in almost all instances is specific to the assessment environment.

Need Assessment Frameworks

Barbulesco (in Moore, 1980) has suggested that most need assessment frameworks include six common elements. They are: (a) a statement of purpose; (b) an identification of the audience for the results; (c) a definition of the general problem area; (d) a delineation of data sources; (e) a description of techniques for data collection and analysis; and (f) an outline of how the results will be reported.

Pennington (1980a) identified six different clusters or models of needs assessments. They are: (a) self-fulfillment models, (b) individual appraisal models, (c) system discrepancy models, (d) diagnostic or medical models, (e) analytical models and (f) democratic models.

A self-fulfillment model focuses on the interests of a known segment of a population. These models generally lack precision of measurement, have strong trainer and institutional bias built into the assessment process and really is more of a marketing approach than a data collection method.

The individual appraisal model involves the individual himself/herself in assessing his/her own learning needs. Issues pertaining to this model include the built-in bias of self-assessment, potential lack of vision and the dependence upon individual initiative.

System discrepancy models tend to focus on groups of learners. Needs, expressed as gaps or deficiencies between what is and what should be, are identified. The main concern with this model is the tendency to develop needs that represent the needs of the majority of those being assessed but that may not identify the special needs of persons who are quite different from the typical representative of that population.

Diagnostic or medical assessment models view needs as being the absence of something and utilize an expert as the

assessor. Learners are only passively involved in the assessment process. Assessor bias is a factor here.

The analytical model of assessment involves a systematic data collection and analysis process in order to assess needs. In addition to the issue of assessor bias, this model depends upon trained assessors who may not always be available and who lessen the possibility of learner ownership of the needs because of the passive involvement of the learner.

The democratic model involves learners in collaborative ways of assessing needs. The concern about this approach focuses around the tendency of this model to identify normative needs and omit specific identification of needs of fringe members. In addition, this process generally takes a long time to complete and needs may be outdated by the time upon which they are finally agreed.

Data Collection Methods

Most need assessment frameworks utilize one or more of these methods: standardized tests, surveys, criterion-referenced tests, observations, use of key informants, public forums, use of social indicators, use of social service statistics, interviews, Delphi techniques, critical incidents, and analysis of primary and secondary data.(Kimmel,1977; Mazmanian (1977). These methods are frequently compared in an effort to find the "best needs

assessment method". Most evaluators conclude that the use of a specific method is situational and should be decided on a case by case basis.

For this study, three different assessment methods were chosen. The first method was the qualitative data analysis of professional performance evaluations. The performance evaluation assessment method was chosen because of the growing use of performance evaluations within CSB's in Virginia. Performance appraisal consists of an attempt to judge objectively an employees behavior in relation to one or more performance standards. The intent of this method was to identify those factors that are necessary for the improvement of job performance; in this case, those that could be changed by training or staff development. Frequently, this method does have a number of difficulties associated with it:

1. Standards for measuring performance may not be clear.

2. Existing standards may be too subjective to be easily quantified or otherwise used in measuring performance.

3. Personality conflict or positive bias may distort the appraisal.

4. Performance appraisal places heavy demands upon a supervisor's or committee's time.

5. A relatively high level of supervisor/staff communication is necessary in order for employees to receive

and profit from the appraisal (Kearney, 1978; Leonard, 1974 in Pecora, 1982, p. 41-42).

The second method selected for use in this study was the use of a key informant group to identify training and staff development needs. Key informants are persons whose professional or organizational roles suggest that they are in a position to know of staff member's interests and needs that relate to training and staff development. The method assumes that these persons are knowledgeable and willing to provide information related to learning needs. In a group setting, the actual suggestion of needs and the prioritizing of needs can be influenced by issues of power, position, frequency of speaking out and other variables that would bias the nomination and rankings. Therefore, the key informant method is frequently linked to a nominal group method. The nominal group technique is useful for group situations where individual judgements must be secured and then combined to get a consensus. The method itself was developed by Andre L. Delbecq and Andrew H. Van de Ven in 1968 and has been widely used in many assessment and planning situations. The basic steps to a nominal group process are:

1. Silent generation of ideas in writing.

2. Round-robin feedback from group members to record each idea in a terse phrase on a flip chart.

3. Discussion of each recorded idea for clarification and evaluation.

4. Individual voting on priority ideas with the group decision being mathematically derived through rank-ordering or rating (Delbecq, Van de Ven, & Gustafson, 1975, p.8).

Three methodological difficulties may exist when this technique is used (Delbecq, p.112-113):

1. The selection of target groups for problem exploration.

2. The specification of the question to be used in nominal group meetings for gathering data from target groups.

3. The transformation of this raw data into standardized measurement instruments.

The third method selected was the utilization of a questionnaire to survey respondents about a list of knowledge/ability areas that are generic to community mental health professional practice. The knowledge/ability areas chosen for this study came from the categories of clinical, prevention and consultation and administration competencies. The main strength of this method is that it provides a quantitative way of assessing needs. Respondents can assess their knowledge/abilities in relation to other variables on a five-point Likert scale. The main problem with this approach is that there is no clear linkage between specific job tasks of the professionals and the corresponding competencies that are listed on the questionnaire. Survey items tend to be more global in nature when specific assessment may be needed.

Finally, surveys may assess interests or wants of workers rather than knowledge or information that is directly needed to help them carry out their professional roles (Pecora, 1982).

Adult Learning Theories and Needs Assessment

Need assessments are the first step in most adult education program planning models (e.g Bergevin, Morris and Smith's Procedure, Knowles' Andragogical Process of Program Development and Knox's Program Development Model). These educators have suggested that the data collection method utilized must involve the learner as much as is possible in assessing his/her own needs and that program developers should avoid telling learners what they need to learn. Knowles (1970) points out that asking a person to state his preferences involves them in the planning process and helps them take the ownership of the entire learning process far beyond needs assessment.

The research that has been done on ways of assessing the needs of various human service populations tends to agree (King, 1977; Ford, 1980; Kirkpatrick, 1981; Silverman, 1981; Gates, 1982). These researchers all concluded that the data collection process must be a collaboration between those persons with training responsibilities and the practicing professionals whose needs are being assessed. For example, Kirkpatrick (1981) surveyed the perceptions and preferences

of mental health personnel in terms of guidelines for staff development planners within community mental health centers to follow. Some of his conclusions were:

> The need to accurately assess learner needs and not administrator perceptions was a predominant theme in the literature. . . Experts in the field of adult learning have stressed the importance of adult learners being involved in all stages of their learning, from needs assessment to evaluation. Learner involvement, identification and support should be a key objective of staff development. The respondents in the study agreed overwhelmingly with these sentiments (p.38-40).

The literature on training and staff development in human service organizations recognizes the differences between pedagogy and andragogy. For some trainers, there is a tendency to function from a pedagogical set of assumptions. This comes from the learning experiences of the trainers throughout their own professional training and is related to the concept that training and staff development is an educational function designed to supplement earlier learning. It must be noted that professionals have been trained in a university-based training program that results in the granting of a degree that is accepted as an entry level credential for beginning professional practice in mental health. The learning environments of professional training

programs are pedagogical in their philosophy and structure with curriculum choices made largely by teachers and oriented towards subject matter rather than specific problems. Wood & Thompson(1980) suggest that McGregory's Theory X is the philosophy that should guide pre-professional training. Having been educated by a system that is based on Theory X or pedagogical assumptions, most professionals tend to repeat what has been modeled for them. As a result, many persons who have training and staff development responsibilities have frequently perceived professionals as (a) disliking inservice training and tending to avoid involvement in professional growth; (b) needing to be persuaded, rewarded, punished, controlled and forced in order to get them to work towards the goals of the organization and to participate in inservice education; and (c) prefering to be directed and wishing to avoid responsibility for their own learning needs (Wood and Thompson, 1980).

However, once a trainer has studied in the field of adult education, he has been exposed to andragogical principles and can utilize a different set of assumptions upon which to base their practice. There are three principles of andragogy that can be utilized with needs assessment frameworks. The first is that learners should be involved in the assessment process as much as possible. Professionals tend to resist learning situations which they believe are an attack upon their competence or that they feel are imposed

upon them.

The second principle is that motivation to learn is directly related to the assessment of needs as needs assessments are carried out primarily to allow for the identified discrepancies or gaps to be removed through continued learning on the part of the professional. Thus, unless the professional is motivated to learn in relation to the identified needs, the needs assessment process is a "straw dog" and a waste of effort.

The last principle is that training and staff development programs need to be organized around actual problems and performance issues rather than subject matter topics. Adult learners learn best when the learning experience is based on an assessment of needs that is directly related to the way the professional perceives job related activities and learning needs (Wood and Thompson, 1980; Knowles, 1971).

Criteria for Evaluating Assessment Methods

Many professionals who assume the role of need assessor select a specific needs assessment method because it is attractive or seems to be the most convenient or least expensive to employ. Kaufman (1977, p. 60) suggests that assessors answer three basic questions before they decide upon a needs assessment framework: (a) What is a need? (b) What is a need assessment? and (c) When should a needs

assessment be made, and if it is, which model should be used? The answers to these questions should then lead the researcher to one of six types or levels of needs assessment, depending upon the basic goals of the assessment process. He advocates a systems approach that employs a six level typology: Alpha (1.0), Beta (2.0), Gamma (3.0), Delta (4.0), Epsilon (5.0), and Zeta (6.0). Each assessment differentially starts at one level of a system's needs according to the existing organizational's goals, objectives, structures, available data and/or existing restrictions placed upon the needs assessment efforts and plans for use of the assessment. The levels are differentiated according to the following characteristics:

ALPHA: Assumes few or no "givens" concerning starting conditions and ground rules for operation or resolution;

BETA: Assumes the validity and utility of the goals and objectives of the sponsoring or target agency. Attends to finding the gaps between current organizational outputs and required or desired outputs only.

GAMMA: Starts by determining discrepancies concerning methods-means for problem resolution.

DELTA: Gap analysis relative to implementation of selected methods-means.

EPSILON: Gap analysis relative to the existing objectives derived, not to any referent outside of the implementing agency.

ZETA: A gap analysis for the entire process, based on the entire process as given and only discrepancies relative to the system are determined (Kaufman and English, 1979, p. 61).

Rossett's (1982) typology for deciding which methods of need assessment to employ differentiates between methods for finding needs and methods for selecting needs. His typology seeks to assist the assessor in understanding the performance problem related to a proposed needs assessment. There are five general purposes for assessments and five types of questions (Rossett calls these items). The types are: (1) Problem Finding, (2) Problem Selecting, (3) Knowledge/Skill Providing, (4) Finding Feelings and (5) Cause Finding. Problem Finding types seek the nature of problems, whether there is a discrepancy, what it is, and what its exact nature is. Problem Selecting types lead assessors to select and prioritize needs from among several needs or facets of one need. The Knowledge/Skill Proving type seeks to show what the learners know about themselves in relation the the problem being assessed. These questions assume some degree of learned subject matter and attempt to test the amount of that degree. The Finding Feelings type seeks to assess the emotions and attitudes of the learners about the problems. The Cause Finding type seeks to find out what and who is contributing to the problem at hand.

Several authors have developed criteria that may be employed in selecting a needs assessment framework. Newstrom and Lilyquist (1979) offer five very general criteria: (a) employee involvement, (b) management involvement, (c) time required, (d) cost and (e) the relevance/quantifiability of data gathered.

Barbulesco (1980, p.79-80) offers eleven criteria to use as a checklist for evaluating a plan for a major needs assessment study. Her criteria are:

1. Is the needs assessment designed to identify critical educational needs and make useful recommendations to planners and decision makers?

2. Does the needs assessment relate to a long-range comprehensive plan?

3. Is the procedure simple and easily administered?

4. Is the cost for implementing the needs assessment reasonable?

5. Are opportunities provided for various groups and individuals to become involved in the needs assessment process?

6. Are data-gathering instruments appropriate and comprehensive?

7. Is it clear what kinds of data are being sought?

8. Does the needs assessment model provide for validity and reliability of the instrument?

9. Does the procedure provide a method or criterion by which identified needs can be ranked?

10. Has the procedure taken into account needs assessed in similar settings as well as previous needs studies conducted in the same setting?

11. Does the procedure provide for some positive initial action to address needs identified in the study?

Steadham (1980) takes the same approach and offers a list of thirteen selection criteria. They focus around issues of resources, roles, responsibilities, problems related to assessment, use of the data, data collection preferences, types of needs, degree of reliability and validity needed, and expertise of those involved (learners and assessors) with the methods being considered.

These typologies and criteria are useful in that they involve the researcher through an analytical planning process in deciding what assessment method(s) to employ. They focus on the reasons why the assessment is being done, the resources available for the assessment and the use the data will be put to after the assessment is complete.

Mental Health Training and Staff Development

During the last twenty years there has been a variety of research completed about the learning needs of practicing mental health professionals. The initial research efforts were primarily product oriented; that is, they sought

primarily to assess the needs of those professionals in their population rather than develop a process to do needs assessment. In the early 1970's, the Illinois Mental Health Institutes and the Abraham Lincoln School of Public Health were awarded a three year federal grant to improve the quality of mental health services in the Chicago metropolitan area through training efforts. This research was primarily product oriented, and dealt mostly with the needs identified and the subsequent training to be offered in relation to the needs researched (Silverman, 1980, 1981, 1982).

The Council on Social Work Education (CSWE) carried out a project in 1973-1977 that developed, tested and evaluated models for continuing education for community mental health practitioners in five different parts of the country (Miller,1980). The project, entitled the "CSWE Continuing Education Project in Community Mental Health" was founded on these assumptions: (a) There is a need for increasing the competency of personnel in community mental health programs; (b) Continuing education is an indispensable resource for service delivery systems- an agency's effectiveness and accountability relates directly to the knowledge and skill of its personnel; and (c) Schools of social work have a responsibility to participate in the updating of personnel by making their resources and knowledge accessible to the various practice fields (Miller, 1980).

These models of continuing education practice were based in Alabama, Illinois, Pennsylvania, Utah, and Virginia. A variety of needs assessment methods were employed in the different projects. The Alabama project utilized a questionnaire to survey the directors and supervisors of the mental health centers in the project and another questionnaire that was administered to participants at a meeting of the Association of Mental Health Center Directors. A series of workshops was then planned and feedback from the first series of workshops through a midpoint evaluation was used to revise the curriculum of the workshop.

In Illinois, five high priority learning groups were selected and brought together for a day-long needs assessment workshop. Participants developed job profiles and then discussed and listed their diverse learning needs.

In Philadelphia, a planning committee of those persons participating in the project as trainers was formed. They met with staff in community mental health centers to ascertain how they perceived their learning needs and interests. The data collected was organized into a composite list of training areas that was prioritized by the center staff and used for curriculum development.

The Utah project focused primarily on the needs of a target population in Salt Lake City, not the learning needs of mental health professionals.

The Virginia project focused on training both board and staff members in relation to increasing communication among the CSBs. In this case, the needs of the learners participating were pre-established by CSWE and the Virginia Department of Mental Health and Mental Retardation prior to the beginning of the project. Training goals and objectives were established by the trainers based upon their professional judgements of the needs that existed in relation to the identified problem.

An early focus on the process of assessing needs of mental health professionals was begun by the Southern Regional Educational Board in the late 1970's. It created a task force to define the process of needs assessment and outline a conceptual framework to define or identify institutional needs. The Board suggested that data be collected from three sources: (1) external sources such as direct legislative mandates, specific consumer pressure, accreditation requirements or union demands; (2) internal sources such as in house political pressures, changes in goals or purposes, changes in staff numbers or composition, changes in employee expectations, and perceived problem areas by supervisory and administrative staff; and (3) professional literature reports on the development of new service delivery techniques and the perceptions of continuing educators themselves. Data gathered from these sources are analyzed, synthesized, and divided into needs that are related to one

set of data or combinations of sets of data. These then may be rank ordered (Regional Education Board,Needs,1978).

During the last seven years, several individuals have carried out research on the process of assessing the learning needs of mental health professionals. Luke (1977) described a competency based training program for outpatient mental health clinicians that established competencies based on demographic data, outcome and satisfaction data from clients and referring agencies and program management data from within the agency. Training programs related to those competencies were then designed and offered to the staff.

Rosenfield (1981) decided that the concept of a profession implies that a professional should assume responsibility for his/her own continuing education. He reviewed several models that had been developed to assist professionals in examining, planning and evaluating their continuing professional development needs.

Geib and McMeen (1983) developed a three track model of staff development in community mental health. The tracks related to (a) individually negotiated career development goals which included activities such as individual study, research and publication and attendance at professionally sponsored activities such as workshops and seminars; (b) inservice training activities that are directly work/task related, programatic and of direct benefit to the agency of employment and the provision of its services; and (c)

continuing education that emphasizes professional development in an organized instructional program under responsible sponsorship and qualified instruction.

One concern of researchers has been how to identify the knowledge and skills needed by mental health professionals in their professional practice. Teare(1979) reviewed manpower planning frameworks within the social work profession and then described research conducted on job activities in public welfare agencies. He used a structured self-report questionnaire called the Job Analysis Survey(JAS). His conclusion was that the JAS was a useful preliminary tool for investigating the nature of work in an agency.

Sluyter (1980) looked at the competencies needed to practice in Michigan's Community Mental Health system by developing an Inventory of Job Functions (IJF) to use in assessing non-client and client service related functions. He reported that there were few significant differences among the various professional groups involved in his study (doctoral psychologist, nondoctoral psychologist, counselor, social worker, bachelor level paraprofessional, and non-degree paraprofessional) in self reported job functions or between the self reported job functions of the professionals and bachelor level paraprofessionals.

Wanamaker (1981) researched behavioral skills related to counselor performance in community agencies. She established seven major categories of competencies: (a) helping skills/abilities. (b) evaluative skills/abilities, (c) knowledge/understanding of human service delivery system, (d) ability to understand self, (e) abilities/skills in clerical/administrative and program development, (f) educating, training and consulting knowledge/skills and (g) research skills/abilities. From these categories, she developed a 122 item questionnaire and field tested it on 15 practicing community agency counselors asking them to indicate their ratings of perceived importance of each of the items on a five point scale. Her research suggested that a counselor's work setting can significantly affect how s(he) perceives the importance of each competency, and that other demographic variables reflected the weight placed on each competency.

Corley (1981) sought to develop a list of perceived professional and technical knowledge, and ability statements needed by mental health professionals for adequate job performance in community agency settings. He took knowledge, skill and ability statements from the relevant professional literature and sent them to 300 counselors who were working in federally funded community mental health centers. A modified Delphi technique was employed and through three rounds of questionnaires, a list of high priority, second

highest priority and low priority competencies was developed. Corley concluded that in addition to identifying listing knowledge and ability areas related to community mental health practice, the list has implications for credentialing procedures, articulation of a practice standard, and professional development and study.

Chatlin (1981) researched areas in which Community Mental Health Center(CMHC) administrators perceived the need for continuing education. He developed a list of knowledge, skill and administrative training activities and included those in a survey instrument that was administered to 618 CMHC administrators in each of the 10 National Institute of Mental Health regions. His study provided data about many of the demographic characteristics of the administrators and demonstrated that core competencies for CMHC administration could be identified.

Raber (1982) sought to identify the competencies for doing consultation and education (C&E) within community mental health centers. Twelve identified C & E functions were listed and then a panel of 16 experts and 264 practitioners developed an extensive list of competencies in the areas of conceptual knowledge and personal characteristics/values/attitudes in relation to these functions. A modified Delphi approach was utilized that resulted in the identification of a group of "top ten" competencies for each of the 12 functions. Raber's overall

conclusion was that there was a great deal of agreement in existence between experts and practitioners as to the competencies that it takes to do consultation and education in community mental health practice.

Many researchers have focused on the ways of assessing a learning need. The concept of hindrance played a major part in the research of Betz and Bremseth (1980). They researched the training needs of Senior Citizen Center Directors, professional staff of Area Offices on Aging and State Office professional staff and Nutrition Project Directors in relation to administration knowledge and ability needs. They used a questionnaire that listed 74 knowledge and ability administrative competencies and then asked the respondents to assess the importance of each ability, the frequency of use of each ability in their professional functioning and the amount of job hindrance because of lack of the knowledge and skill. The hindrance factor was computed by dividing the frequency of use of a knowledge/ability item by the frequency of being unable to do a job because of lack of knowledge or ability (and multiplying by 100).

Because of the qualitative nature of needs assessment data, several researcher have looked at the use of more than one method in assessing learning needs. Doelker and Lynett (1982) developed a model for conducting a staff development needs assessment in a large multi-program public welfare human service agency and then field tested it. They gathered

data through a computerized staff survey, use of key informants and a nominal group of administrators. They concluded that their multi-method framework did provide useful data and that all data collection elements were necessary for a successful needs assessment process.

Although not focused on community mental health practice, Pecora (1982) used information from supervisors and from allied health professionals in combination with a survey of 279 line child welfare workers about their knowledge, skill or interpersonal discrepancies that posed some hindrance to them in job performance. He concluded that there was substantial agreement among the various data sources overall about worker training needs but that significant differences of opinions did exist for some areas.

The literature search revealed only one project with a state-wide focus towards assessing the training needs of community mental health professionals. The West Virginia Department of Health in collaboration with West Virginia University has carried out research on this topic through their collaborative program known as the West Virginia Training Resources Center. They used interviews and surveys to assess the needs of community mental health practitioners within that state and then developed a Training Resource Center based in the Department of Behavioral Medicine and Psychiatry at the Charleston Division of the West Virginia University School of Medicine to continue the assessment

process and offer training and staff development programs (Ellis, Greenwood, Stevenson, and Linton, 1983).

Summary

The professional literature suggested that a multi-method needs assessment process provides more valid and reliable data that does a single method. Corley (1981) and Doelker and Lynett(1982) used multi-method frameworks for assessing the learning needs of their populations and their designs served as general models for this research. The choice of the different methods is left up to the researcher; however, the use of a questionnaire in relation to competencies has been used in various setting with positive results. Studies by Betz and Bremseth(1980), Corley(1981), Pecora(1982), and Raber(1982), offer a comprehensive list of competencies in relation to the three areas chosen for use in this study: (1) clinical, (2) prevention and consultation, and (3) administration training and staff development needs. The Betz and Bremseth questionnaire was adapted for use in the Corley study and is appropriate for this research in that it provides a quantitative way to evaluate a learning need in relation to a competency.

Delbecq and Van de Ven are frequently quoted in the professional literature in relation to the nominal group technique. Their detailed and precise instructions for use of

this technique were used when this technique was applied with the the key informants group.

It is important to involve the key members of a learning system in the needs assessment process as much as is possible. In the case of community mental health centers, this includes those persons who have training and staff development responsibilities, supervisors who have responsibility for quality of service delivery and the professionals themselves whose needs are being assessed. The criteria offered by Barbulesco (1980) and Steadham (1980) for the selection of needs assessment methods were used as guiding criteria for the criteria developed for use in this study.

The multi-method framework designed for use in this study is related to the Kaufman and English(1979) Beta level needs assessment goal in that the CSBs and the State Office of Training, Information and Prevention have clearly defined goals and are trying to find gaps between current organizational outputs and desired outputs in relation to the performance of the professionals in the system. Two of the three methods, the Performance Evaluation Method and the Self-assessment Questionnaire clearly focus on hindrance and performance rather than wants or interests as is the case with many needs assessments. The multi-method framework is most closely related to Pennington's System Discrepancy model (1980a) in that it focuses on groups of learners and seeks to

develop need statements that relate to deficiencies that represent the needs of the majority of the professionals within the system.

CHAPTER THREE

Methods

The content of this chapter explains the research design used in this study, the criteria established to guide the development of the needs assessment framework, the different data collection methods of the multi-method framework, the field testing procedures, data analysis issues, and the evaluation of the multi-method framework's processes and outcomes.

Research Design

The design of this study was an ex post facto utilization focused evaluation research. The research focused on the assessment of needs that are already in existence and on the development of a framework that has direct applicability and high utility for the 40 CSBs in Virginia. A major portion of the research was qualitative in nature because the data sought was detailed in its description, variable in content and format and the responses sought were not easily standardized or systematically evident. The framework contained several data collection procedures including document analysis, solicitation of opinions from professionals representing the various administrative units of the CSB and responses from a survey that pertained to established mental health/mental retardation competencies.

The design featured six specific steps: (a) development of criteria for the framework, (b) development of the framework, (c) validation of the framework, (d) field testing of the framework (e) data analysis issues, and (f) evaluation of the needs assessment process and products.

Development of Criteria for the Framework

The first step in this research process was the development of criteria or normative statements to use in guiding the establishment of a multi-method needs assessment framework that correlates closely with existing conditions within CSBs in Virginia that would influence the assessment of staff development and training needs. The literature review suggested several basic principles to use in developing the criteria. For example, by nature needs assessment data tends to be inferential in that few needs are directly measurable. Typically, the assessor of needs is not the one who possesses the needs. Research on needs assessment processes indicates that the extent of involvement in the needs assessment process of those persons whose needs are being assessed will affect the outcome. It has been concluded that needs assessment processes need to involve as much as possible those persons whose needs are being assessed in order to reduce the observer bias of the individuals assessing the needs (Gates, 1982; King 1977; Kirkpatrick,1981; Ford,1980; Silverman,1981).

Studies on the assessment of learning needs of helping professionals by Sluyter, 1980; Corley, 1981; Odor, 1982; and Pecora, 1982, have recommended that a multi-method process of assessing the needs of their populations would seem to be superior to a single method. These researchers did not suggest any specific combination of methods but recommend that a combination be employed that best relates to the assessment situation.

In addition to the literature review, the goals of the State Office of Prevention, Information and Training pertaining to their 1984 training and staff development plan were used to guide the development of the criteria. These were (a) to improve training coordination between the Central Training Office, Regional Training Committees, Division of Mental Health and Mental Retardation (DMHMR) Facilities and CSBs, (b) to strengthen regional staff development capacities and (c) to provide DMHMR guidelines and direction for development and submission of annual regional staff development plans.

The criteria that were established are:

1. The data to be collected must be related to the assessment of gaps between the current functioning levels of mental health professionals and the required or the desired level of functioning. Furthermore, the needs statements must relate to the main professional responsibilities of community mental health professionals.

2. The data to be collected must facilitate the Regional Staff Development Committee's development of their Five Step Training and Staff Development Plan.

3. Following appropriate training and with the aid of the Operations Manual, the Training Director of a CSB must be able to successfully administer the multi-method needs assessment framework within his/her CSB and then interpret and report the data to the Executive Director of his/her CSB and the Regional Staff Development Committees.

4. The needs assessment framework employed must involve those persons within the system with administrative responsibility for training and staff development and those professionals whose needs are being assessed in the data collection, summarization and analysis process.

5. The multi-method assessment framework must produce need statements that can be compiled and analyzed on a yearly basis for use in the Five Step Planning Process. It must also yield needs statements that can be summarized and compared over an extended time frame of many years.

6. The data collected through the multi-method framework must use terminology and relate to generic areas of practice that correspond to the professional activities of a wide variety of community mental health professionals.

7. The framework developed must be one that can be implemented in relation to the time and the technical

resources available within a CSB or supplied by the Office of Prevention, Information, and Training.

Data Collection Methods and Instrumentation

Several guiding typologies and concepts were chosen from the professional literature for use in developing the specific framework. The Kaufman and English typology lists Beta-type needs assessments as those that seek to identify perceived needs of a total population, analyze them, rank order them and then design programs to meet those needs. This is done in relation to the stated goals of an organization. This type of needs assessment was what was being sought by the Virginia Department of Mental Health and Mental Retardation. The needs assessment framework developed was a multi-method one that involved the use of three separate but related methods: (a) analysis of professional performance evaluations, (b) a key informants group (Training Assessment Committee) that used a nominal group technique to identify and rank needs and (c) a questionnaire that identified needs in relation to the categories of clinical, prevention and consultation and administration training and staff development needs. These categories were chosen as they represent three areas in which almost all community mental health professionals have major responsibilities.

The performance evaluation assessment method was established because of the growing use of performance

evaluations within CSB's in Virginia. Every CSB in Virginia has a process where employee performances are rated in a summary fashion by supervisors and other administrative personnel. These evaluations vary greatly in content, depth, length and style. Most utilize a combination of a rating system and a narrative. The evaluations tend to focus on responsibilities that relate to each employee's professional position and the their performance. An unofficial pilot study performed in September 1984 in an Outpatient Division of an CSB where twenty performance evaluations were reviewed and learning needs identified from them supported the assumption that learning needs could be assessed from performance evaluations.

The key informant method was chosen because a review of the literature on needs assessment indicated that this was a frequently utilized survey method with high utility for the assessment of training and staff development needs in human service fields. As an exploratory research technique, the nominal group technique is essentially a process for generating qualitative data It is a special-purpose technique used to bring a group of individuals to a consensus. In the case of assessing training and staff development needs, this procedure can be used to assess the normative needs of the staff of the CSB. Delbecq and his colleagues's major work on the use of the nominal group technique technique was chosen as the model of this type of

needs assessment.

The strengths of this method are that it allows multi-target groups to participate in defining problem dimensions, ranking items generated and expressing these items in their own jargon. Three methodological difficulties often exist when this technique is used (Delbecq, 1975): (a) the selection of target groups for problem exploration, (b) the specification of the question to be used in nominal group meetings for gathering data from target groups, and (c) the transformation of this raw data into standardized measurement instruments (p.112-113).

These difficulties were managed by the overall design which compared the data generated from one method with that generated by the other two. The question asked was a specific one as it sought needs related to the areas of (1) clinical, (2) prevention and consultation and (3) administration.

The questionnaire method of surveying the staff was chosen because of the ease of the collection of data and its effect in involving all the professional staff members in a self-assessment process. The questionnaire itself was adapted from several previously designed questionnaires. The knowledge and ability variables came from research carried out by Betz and Bremseth(1980), Corley(1981), Chatlin(1981), Raber(1982) and Pecora(1982). These researchers developed a list of competencies needed by helping professionals in specific areas such as management, prevention and

consultation and clinical practice and ways to measure the effect of these competencies on professional performance.

Using a modified Delphi approach with 300 counselors who worked in federally funded community mental health centers, Corley (1981) developed a list of perceived professional and technical knowledge, skill and ability statements needed by mental health professionals for adequate job performance in community agency settings. His list consisted of high priority and second highest priority and low prior competencies.

Chatlin (1981) surveyed 618 CMHC administrators in terms of knowledge, skill and administrative training activities for continuing education and developed a list of core competencies for CMHC administration.

Raber (1982) identified competencies related to the delivery of consultation and education (C & E) services by community mental health centers. Twelve C & E functions were given to a panel of 16 experts and 264 practitioners for use in the development of an extensive list of competencies and personal characteristics/values/attitudes related to C & E. Groups of ten top competencies for each of the 12 functions were then developed.

Pecora (1982) developed and tested multiple methods of assessing worker training needs in child welfare. One of his methods was the use of a questionnaire where 279 line child welfare workers indicated how lack of knowledge, or skill in

various competencies hindered their job performance. This approach was an adaptation of the method that Betz and Bremseth (1980) used when they researched how lack of knowledge or ability in 74 administrative competencies hindered the professional functioning of senior citizen center directors.

The actual list of 150 competencies was established by first drawing up a master list of competencies from the studies cited above, the elimination of any competencies that were redundant, and then arbitrarily establishing a 150 maximum number of competencies that could be listed. This number was established as it was felt that mental health professionals would not respond to a questionnaire that was long and would take more than one hour to complete. Dr. Howard Protinsky, Associate Professor in the Center for Family Therapy at Virginia Tech and an experienced mental health consultant, and Mr. Michael Brown, Director of Consultation and Community Education, New River Valley Mental Health Services, reviewed the initial list of knowledge/ability statements and helped edit the list until the stated 150 competencies were agreed upon. Thus, the competencies came from previous research that established knowledge and ability competencies of helping professionals and was subjectively edited based on utilitarian issues. The response form was adapted from the questionnaire developed by Betz and Bremseth (1980) that assessed the training needs of management level staff of the

Tennessee Commission on Aging, which was in turn an adaptation of a nationally recognized training needs assessment methodology.

Validation of the Framework

Prior to the field testing, the framework was validated for use within the mental health system of the state of Virginia by an ad hoc committee of Training Directors from CSB's chosen for this task by the Office of Prevention, Information and Training. A list of the members of this committee may be found in the Appendix, Item A. This committee was given a copy of the Operations Manual (Appendix, Item B) designed to guide the Training Director throughout the needs assessment process, asked to review the manual and to answer six questions about the framework and use of the manual. These questions were:

1. What additional criteria or modifications of the criteria listed to guide the development of a multi-methods framework can you offer?

2. What difficulties would you anticipate in the use of the proposed framework to assess the training and staff development needs of mental health professionals in a CSB in Virginia?

3. What help would you need in carrying out each of the following needs assessment methods: (a) performance evaluation assessment method, (b) key informant assessment

method, (c) questionnaire assessment method?

4. What improvements would you suggest in the wording of steps one through three in the Operations Manual?

5. How much staff time do you think it would take to fully use and complete a needs assessment using each of these methods: (a) performance evaluation assessment process, (b) key informant/nominal group assessment process, and (c) completion of the questionnaire?

6. What additional or summary comments would you offer about the multi-method assessment framework and the needs assessment research being proposed?

Written responses were received from six members of the seven member validation committee. Their feedback was then used to guide the final editing of the manual and subsequent revision of the assessment processes prior to the actual field testing. A copy of the memo sent to them on 25 January 1985 summarizing their feedback and the changes that were made as a result of it may be found in the Appendix, Item C.

Field Testing the Framework

The Rockbridge Area Community Services Board was selected as the CSB where the the multi-method needs assessment framework would be tested. This CSB serves Rockbridge County, Bath County and the communities of Lexington and Buena Vista, Virginia. Dr. Michael Gilmore, Ph.D., is the Executive Director and Chief Clinical Officer

of that CSB. He selected Mr. Kenneth Lane, Jr., M.Ed., the Coordinator of the Continuing Care Services, to serve as the Training Director for this study and to coordinate the actual needs assessment. The entire assessment was completed within a one month period during January and February 1985. Twenty professional staff members employed by the CSB to provide mental health services and/or mental retardation services participated in the needs assessment. Professional staff were defined as (a) those persons who hold positions within the system that provide mental health services to clients, or (b) those persons who provide administrative services and have a professional degree that would allow them to assume direct service delivery roles if they were employed to provide direct service to clients. Although sampling procedures could have been utilized in relation to the performance evaluation assessment process and the questionnaire, the assessment process involved 100% of the professional staff in order to facilitate later involvement in the actual training and staff development.

Researcher's Role and Processes

The researcher worked as a non-participant observer throughout the entire assessment process with the Training Director administering each of the assessment methods. The researcher sat in on all meetings of the Performance Evaluation Committee and Training Assessment Committee and

observed the processes involved, the questions raised as the specific method was being employed, and the feelings and attitudes of the evaluators as they proceeded through the process and the outputs that were generated. The sessions were tape recorded and summary field notes were written following each session. The notes described the processes observed and contain the researcher's own reactions and feelings. The field notes pertaining to the three assessment methods can be found in the Appendix, Item D.

Field Testing Processes

Step One:Organizing the Assessment Process

Early in January 1985, a meeting was held with the Training Director to establish a timetable where all three assessment methods would be utilized during the latter half of January and the first part of February 1985. This was important as it represented a way of controlling issues of maturation and history that may have effected the validity of the needs assessed. The process began with the Executive Director discussing with the total staff at a staff meeting the reasons for participation in this study and then continuing with a memo indicating that Ken Lane had been appointed Training Director of the project.

At the same time, a meeting was held with the Executive Director and the Training Director to review the steps to the overall assessment, clarify roles and expectations, and plan

for the training that was to be given the Training Director. A copy of the Operations manual was given to the Training Director for his review prior to the actual training.

One week later, a two hour training meeting was held. Five hypothetical performance evaluations written on the forms typically used in the CSB were given to the Training Director and he was asked to review them and assess the training needs they indicated using the procedures outlined in the Operations manual. Next, a pre-test was given the Training Director on the use of the nominal group procedure as outlined in the training manual. Based on the results of the pre-test, consultation was given the Training Director until he could correctly answer all 16 questions on this procedure and all his concerns were discussed. The Self-assessment Questionnaire method was discussed and the plans for use of this method discussed and clarified. A copy of the standard performance evaluation used by the Rockbridge CSB and a copy of the pre-test are contained in the Appendix, Items E & F.

Step Two A: Performance Evaluation Assessment

Prior to the first meeting of this committee, a decision was reached by the Training Director in consultation with the Executive Director to change the structure to a two person committee from the three person committee specified in the Operations Manual. They were concerned about the confidentiality of the performance evaluations. The two

members chosen to review the evaluations and nominate needs were staff members who already had had access to these materials. They were Michael Gilmore, Ph.D, Executive Director, and Kathy Causey, Administrative Assistant.

Other than this change, the process was carried out as outlined in the Operations Manual. Conceptually, this process involved the use of an inductive needs assessment process in relation to the performance evaluations in order to assess training and staff development needs. Conceptually, this process involved the specific observation of an event or process and moves towards description of the general pattern that exists in relation to that being observed.

The actual use of this method was carried out in one three hour session by the two member committee and assisted by the Training Director as a participating facilitator. Only 12 evaluations were available for review because several of the staff members had not been employed long enough by the CSB to have received performance evaluations.

The actual assessment began with the committee members individually reading each evaluation and taking notes on those training and staff development needs that were specifically stated or that they were able to infer from the evaluations. In most cases, the actual words of the evaluator were utilized. Twelve evaluations were reviewed in one hour. The identified needs were listed on newsprint and then clarified. The frequency of each need identified by each

assessor was indicated on newsprint by noting each assessor's nominations with a separate color of magic marker, totaling these frequencies, and dividing by two in order to establish the overall frequency. The inter-rater reliability appeared high as both raters consistently identified the same need statements at the same frequency level. The end result was a list of the top ranked in each of the categories of (a) clinical, (b) prevention and consultation, and (c) administration.

Step Two B: Training Assessment Committee Method

At the same time that the Training Director convened the ad hoc committee utilizing the performance evaluation method, he began the process of having a Training Assessment Committee assess needs through the use of the nominal group technique. Called the Training Assessment Committee, it was a five member committee with the Training Director serving as a non-participant facilitator. Five members were selected to represent the total staff of Rockbridge CSB because the CSB operationally was divided into seven divisions (Adult Outpatient Services, Child/Adolescent Services, Psychiatric/Medical Services, Continuing Care Services, Alcohol/Drug Services, Administrative Support, and Mental Retardation Services). No representatives were nominated by the Psychiatric/Medicine Unit because this unit is staffed by two part-time physicians who did not put a high priority on their participation in this project nor by the Administrative

Support Unit because this unit does not contain any MH/MR professionals whose training and staff development needs were being assessed.

Following the procedures outlined in the operations manual, the Training Director led two group sessions where the nominal group method was employed in order to assess needs.

Step Two C: Questionnaire Assessment Method

The third of the multi-method needs assessment methods was a questionnaire that asked the respondents to rate themselves in two categories in relation to 150 items pertaining to knowledge and skill areas related to community mental health practice. The initial section of the questionnaire asked respondents for the following demographic information: (a) age, (b) sex, (c) race, (d) highest held educational degree, (e) educational major of highest held degree, (f) Division of CSB in which they work, (g) present job title, (h) number of years since last degree was awarded, and (i) number of years employed by the present mental health agency. The body of the questionnaire contained 150 competencies pertaining to the three areas of clinical, prevention and consultation and administration with respondents asked to take each knowledge or skill area and rate it on a five point Likert-type scale in relation to (a) frequency of usage of the knowledge/skill(How often do you deal with situations requiring this ability [Questionnaire: Column A]?); and (b)

frequency of asking for instruction in relation to this knowledge/skill (How often have you had to ask others for instruction before you could accomplish this [Questionnaire: Column B]?).

Data Analysis The data were analyzed to determine (a) percent distribution of each demographic category for the entire CSB, (b) ranking of clinical, prevention and consultation and administration ability clusters by percent of time hindered for the entire CSB, (c) frequency of performance of all ability items for the entire CSB.

The data were analyzed in five steps:

(a) For each item, each respondent's rating was used only if:

1. At least 50 percent of the total respondent group (10+) responded to the ability item.

2. Their rating on the Likert Scale was a 2 or higher (thus, after recoding, they were indicating that they used the knowledge/ability more than once a year).

(b) The responses in Columns A and B were recoded to represent the number of working days per year, i.e., N/A = 0 days; 1 (Seldom) = 0 days; 2 (Quarterly) = 4 days; 3 (Monthly) = 12 days; 4 (Weekly) = 52 days; 5 (Daily) = 260 days.

(c) A ratio of time the person was hindered on the item to the time utilized was obtained by dividing the response to Column B by the response to Column A. More specifically, each competency was scored by computing a Grand Total of days the competency was used by those staff responding to that item with a response of 2 or higher and then divided by the number of respondents who used that item at least quarterly (response of 2 or higher).

(d). The actual ratio of time hindered was computed by adding each staff member's rating of the amount of time that additional knowledge or skill would have been helpful together to receive a Grand Total and then dividing that total by the number of respondents that said that additional skill/knowledge would be helpful on a quarterly or more frequent basis. This total was then divided by the mean score obtained for column A to obtain a "Ratio of Time Hindered" score. This score represents a training and staff development need.

(e) The hindrances were ranked from highest to lowest ratio of time hindered (Betz & Bremseth, 1980, p. 13-15). Only those items where over 50% (10) of the professional staff indicated that the competency was used at least quarterly were included in the rank ordering of the hindrances or learning needs.

These controls were included because only a total of 20 professional staff members were involved in this study and such a small sample size greatly increases the possibility that one response would bias the results unless this control was utilized. The numbers used in the recoding were based upon a total of 260 working days in a year. Vacations, sick days, and other times when a professional would not be using basic competencies vary widely from staff member to staff member. Therefore, the maximum time that could be given to the carrying out of professional responsibilities were chosen as base figures.

It should be noted that a ratio was used instead of a percentage because it is possible for the hindrance factor to exceed 1.0 on a ratio scale or 100% on a percentage scale. This could result because of the ordinal scale used in the questionnaire and the subsequent recoding of the responses into five separate categories pertaining to days that did not have an equal amount of time between categories. That is, if the professional staff used a competency an average of four times a year but would have found additional knowledge/skill helpful 52 times a year, their hindrance ratio would be 13.00 to 1.0 or their percentage hindrance would be 1300%. As we are dealing with time as the actual item being measured, amounts of time over 100% are conceptually impossible, and thus a ratio score is a more logical conceptual score with which to work.

Utilization of the Self-assessment Questionnaire. The Training Director distributed the questionnaire to each staff member and asked them to complete the questionnaire and return it to him within ten days. Ninety percent of the staff returned their questionnaires within the deadline and 100% within six days of the original deadline.

Following the return of their questionnaires to the Training Director, the researcher met with the members of the Training Assessment Committee to discuss the amount of time that it took them to fill out the questionnaire, any difficulties experienced in interpreting any instruction or question and any suggestions that they would have about adding questions, deleting questions or the process of surveying staff through use of a questionnaire. No one reported using more than one hour to complete the questionnaire and no serious problems were identified in the use of this method. The specific feedback given is contained in the field notes pertaining to this method which may be found in the Appendix, Item D.

Step Three: Summary Report

Following the completion of the three needs assessment methods, a report was written summarizing the needs assessed in relation to the areas of clinical, prevention and consultation and administration training and staff development needs. The first section of the report contains summarized needs assessment statements generated by each of

the three methods listed under the method used to generate the data. The data from these reports are contained in the tables listed in Chapter Four. The explanations of each of the needs that was written by the Training Director about each of the needs assessed for methods one and two are contained in the Appendix, Item G.

The second section of the report, written by the researcher, summarized the findings of each of the methods, compared the findings of the different methods and included a summarizing analysis of the needs identified through the employment of the multi-method framework. A review of the list of needs in each of the three categories generated by each of the methods showed that although various needs were identified by more than one method, there was no corresponding comparison between the ranks of the needs as established by each of the methods. Therefore, the rank order of a need as identified method was not a major factor in determining the importance or strength of a specific need.

The prioritizing of needs generated by the multi-method framework was done on the basis of how many methods identified the same need (allowing for variations in wording). Those needs that were identified by all three methods were evaluated to be the primary training and staff development in each of the three categories. Those that were identified by any two of the three methods were evaluated as the secondary training and staff development needs. Those

that were identified by only one method were evaluated as having the lowest priority training and staff development needs. This produced a final ranking of the needs identified by the multi-method framework.

The final report was also sent to the Office of Prevention, Information and Training of the Virginia Department of Mental Health and Mental Retardation.

Methodological Issues

Other than the pilot test cited previously, there have been no previous testing of the use of qualitative data analysis of performance evaluations to assess training and staff development needs of this population. This method was heavily dependent on the ability of the committee members to accurately review performance evaluations and then state learning needs that relate to the performance issues. Committee members were instructed to search for needs that were observable in a wide variety of situations and that were repeatedly mentioned in the same language format in the evaluations. The question "What are the clinical, prevention and consultation and administration training and staff development needs of the professional staff of this CSB?" was one that could elicit a wide variety of responses. The terms "clinical", "prevention and consultation", and "administration" were ones that the assessors accepted being regularly used in looking at groupings of tasks related to

professional practice in community mental health. They demonstrated that they had considerable organizing ability in relation to discussion and need generation throughout the multi-method assessment process.

Data Analysis Issues

The goal of the study was to provide a perspective on the training and staff development needs of community mental health professionals within the context of their professional practice and to evaluate the ability of the multi-methods framework to generate accurate and reliable data within the resources typically allocated to this project by a CSB. By its very nature, exploratory research does not provide those controls that allow the researcher to speak to external and internal validity threats to any great extent. The qualitative analysis design did focus on keeping methods and data in context (Patton, p. 332). The analysis of the data included a look at the processes involved in collecting the data as well as the data itself. The major goal was to provide information that can be related to the research questions developed.

The reliability and validity of each of the needs assessment methods by themselves is unknown. The nature of the research did not allow for a test-retest or alternate form of the assessment process to be utilized. The knowledge/ability competencies utilized in the questionnaire came from previous research designed to develop competencies

related to the roles of community mental health professionals. Thus, through indirect means, content and face validity was established. These two types of validity were also established through the validation process where a panel of experts reviewed the multi-method needs assessment process and the Operations Manual and offered feedback that was then used in revising the multi-method framework.

The performance evaluation process was based upon the assumption that supervisors ratings of professional performance are accurate and on the further assumption that the ad hoc committee members can by induction infer training needs from the performance evaluations. Because of the exploratory nature of the study, no formal procedures were established to measure validity or reliability of this method. A type of criterion validity (concurrent validity) was assessed by examining the level of agreement among the three assessment methods.

The three main kinds of sampling errors that can arise in qualitative research designs are (a) distortion in the situations from which data is collected, (b) distortions introduced by time periods during which the observations took place(history and maturation issues) and (c) distortion in the findings because of the selectivity in the people who were sampled (Patton, 1980, p.332). These threats to internal validity were managed by employing all three needs assessment methods within the same time period (approximately one

month), using a multi-method assessment framework to gather data that was then triangulated and compared and the collection of data from all the professionals employed by or under contract to a CSB.

Evaluation of the Needs Assessment Process and Products

The data produced by the framework were carefully reviewed by validating and verifying the findings. The first process employed was the reconciling of the data from the different methods by the process of triangulation. This process was utilized to evaluate the consistency of different data collection methods. The intent was not to find that the data corresponds 100% in terms of need identification and prioritization from method to method but to assess what agreement or disagreement exists and what explanations might be offered for either.

Summary statements were made about the processes employed in field testing the framework, the needs identified and the relationships or linkages between the two. These statements described linkages, patterns, themes, needs identified or any other variable that helped analyze the relationship between the methods and the outcomes.

The final section of the evaluation section contains a summary of the essential findings, conclusions, reasons for acceptance or rejection of the findings and suggestions for future research. The research questions posed were used as a guiding foci of this analysis.

CHAPTER IV

Results

A multi-method needs assessment process was employed to generate data on the training and staff development needs of 20 community mental health professionals employed by the Rockbridge CSB. Each of the methods collected data on the same 20 professionals on (a) clinical, (b) prevention and consultation and (c) administration training and staff development needs. In this chapter the demographic characteristics of the professional staff involved in the study, the data collected by each of the three methods, a comparison of the needs identified by the different methods, a listing and explanation of the primary and second ranked needs that were identified by the multi-method assessment and description of the outcomes of the methods as influenced by the three different assessment processes are given.

Demographic Characteristics of Professional Staff

The demographic characteristics of the staff members participating in the field study were obtained from the Self-assessment Questionnaire Method. As there was a 100% response rate to the questionnaire, the demographic information collected is descriptive of the entire population of this study. Table 1 shows that the Rockbridge CSB professionals range in age from 20 to 65 years of age, with 35% of the staff in the range between 36-40 years. The staff

Table 1

Selected Demographic Characteristics

Age

Years	Number of Staff
20-25	1
26-30	4
31-35	3
36-40	7
41-45	3
46-50	1
51-55	0
56-60	0
60-65	1

Sex

Female	12
Male	8

Race

White	20
Other	0

(table continues)

Table 1

Division of CSB Where Employed

Division	Number of Staff
Mental Health	14
Substance Abuse	2
Mental Retardation	2
Combined Appointment	2

Highest Held Educational Degree

Degree	Number of Staff
Associate Degree	1
Bachelor's Degree	5
Master's Degree	7
Doctorate	4
M.D.	1
No College Degree	2

(table continues)

Table 1

Educational Major of Highest Held Degree

Degree	Number of Staff
Psychology	8
Social Work	2
Sociology	2
Nursing	1
Medicine	1
Education	1
Liberal Arts	1
Child Development and Family Relations	1
Counseling	1
Occupational Therapy	1
N/A	1

Number of Years Since Last Degree was Awarded

Years	Number of Staff
1 Year or Less	1
1-2 Years	1
2-5 Years	7
6-10 Years	6
11-20 Years	2
21-30 Years	1
N/A	2

(table continues)

Table 1

Selected Demographic Characteristics

Number of Years Employed By Present Mental Health Agency

Years	Number of Staff
0-1 Years	7
1-2 Years	2
2-5 Years	9
6-10 Years	2

is entirely white with 12 female and eight male staff members. Sixty percent of the staff hold a graduate degree with 25% of the staff possessing an earned doctorate or a M.D. degree. Staff members majored in a wide variety of areas with 40% of the staff majoring in psychology. 35% of the staff have been out of school 2-5 years with 30% having been out of school 6-10 years. None of the staff have been employed by this CSB for over 10 years with 35% having been employed less than a year and 45% employed for 2-5 years.

Performance Evaluation Method

This assessment method was carried out by a committee of two administrators with the Training Director participating with them as a facilitator. They reviewed performance evaluations of professional staff members to determine training needs in each of the three categories.

Clinical Needs

A review of 12 performance evaluations by the performance evaluation committee resulted in the identification of 13 rank ordered clinical needs (see Table 2-A). The two highest ranked needs were identified as (a) emergency, hospital pre-screening, and crisis intervention skills, and (b) training in psycho-social rehabilitation. These two needs were each identified 14 times on the 12 performance evaluations identified. The first need pertains specifically only to staff members assigned to Mental Health

and Alcohol Services, all of whom perform emergency pre-screening examinations and offer crisis intervention services during their 24 hour on-call shifts. The specific skills related to this role include conducting interviews, assessing the mental status of patients, providing suicide prevention counseling, making referrals to other community caregivers, and carrying out crisis intervention problem-solving. Knowledge of hospital admissions criteria and of commitment statutes are also important components of this need.

Training in psycho-social rehabilitation applies specifically to social and task skill training with chronic mentally and/or emotionally disabled adults and disturbed adolescents. Specific skills needed include performing behavioral assessments, goal-setting, and the use of behavioral methodologies in relation to activities of daily living.

The third ranked need was skills training in counseling and treatment modalities. The need statement did not specify the level or types of training called for, although basic counseling skills training is recommended for the Continuing Care staff who tend to lack formal training in this area. This need was identified eight times on the 12 evaluations.

There were two fourth ranked needs. They focused on specific treatment specialties relating to children, adolescent and families. They were identified four times on

Table 2-A

Top Ten Ranked Clinical Needs as

Identified by the Performance Evaluation Method

Rank and Statement of Need	Assessment Frequency
1A. Emergency, hospital pre-screening, and crisis intervention skills.	14
1B. Training in psycho-social rehabilitation skills and techniques.	14
3. Skills training in counseling and treatment modalities.	8
4A. Treatment of children, adolescents and families; parenting and child management techniques.	4
4B. Family therapy.	4
6A. Problem-solving and conflict management skills.	3
6B. Formulation of treatment plans.	3
8A. Diagnosis of child and adolescent disorders.	2
8B. Performance of psychological evaluations.	2
10A. General diagnosis.	1
10B. Performance of intake evaluations.	1
10C. Working with families of substance abusers.	1
10D. Geriatric mental health.	1

the 12 evaluations.

The other eight needs were identified on less than 25% of the evaluations reviewed; they each had a frequency of three or less. They all relate to training in counseling and various current treatment modalities such as (a) problem solving and conflict management, (b) the formulation of treatment plans, (c) diagnosis of child and adolescent disorders, (d) performance of psychological evaluations, (e) general diagnosis, (f) performance of intake evaluations, (g) working with substance abusers, (h) and geriatric mental health. The assessors did not specific the level and types of training needed, although basic counseling skills training was recommended for several selected Continuing Care staff.

Prevention and Consultation Needs.

Only five needs in this category were identified by the performance evaluation method (see Table 2-B). What statements there were on the evaluations reflected a variety of consultation/education needs. The top ranked need identified the need for consultation skills that could can be used with a wide variety of agencies and client populations. Examples given by the assessors in explaining this need include providing consultation on child and adolescent development, classroom management, alcohol and drug abuse prevention, and disposition recommendations to physicians regarding their patients. This need was identified on eight

Table 2-B

Top Five Ranked Prevention and Consultation Needs as Identified by the Performance Evaluation Method

Rank and Statement of Need	Assessment Frequency
1. Community consultation and prevention skills (community agencies, professionals, schools, and hospitals).	8
2. Consultation and training skills to adult home staffs.	2
3A. Liaison skills with state hospital and community agencies.	1
3B. Advocacy for mental health.	1
3C. Public mental health education.	1

of the 12 evaluations.

The second ranked need, identified on two of the performance evaluations, focused on consultation to a very specific population- adult home staffs. The last three ranked needs, identified only one time each, focused on liaison skills with state hospital and community agencies, advocacy for mental health and public mental health education.

Administration Needs.

The performance evaluation method identified a variety of training needs in the administration category (see Table 2-C). It should be noted that it was possible for the same need to be identified several times in an evaluation as each evaluation consisted of several separate yet related sections. Thus the frequencies listed for each identified need are relative only to each other and do not directly relate to the total number of evaluations reviewed. Because of the way these frequencies were generated, a review of the ranking of needs by frequency should be done with the realization that there is not equal distance between any of the ranks and that the ranking is an approximation of the overall strength of the need.

The assessment committee, in their review of the needs identified, saw the top ranked need as relating to the improvement of working relationships among the professional

Table 2-C

Top Ten Ranked Administration Needs as Identified by the Performance Evaluation Method

Rank and Statement of Need		Assessment Frequency	
1.	Development of others within personnel.		39
	1A. General personnel relations.	13	
	1B. Effective communication at all levels of personnel.	11	
	1C. Managerial skills (eliciting cooperation).	9	
	1D. Assertiveness training and conflict management.	3	
	1E. Identification and resolution of problems.	2	
	1F. Acquisition of team skills.	1	
2.	Organizational management skills.		12
3.	Supervision and employee evaluation skills.		9
4.	Case management skills.		6
5.	Program planning and development skills.		5
6.	Accounting.		2
7.	Orientation to work setting and job duties.		1

staff or what they entitled "Development of others within personnel". Throughout the 12 evaluations reviewed, 39 different statements were noted that focused on improving the quality of daily interactions among all levels and divisions of personnel. This need was subdivided by the assessors into six specific topics. Three of these topics, noted on nine or more evaluations, included skills related (a) to the ability to give and receive constructive feedback, (b) to making positive requests in intra-staff communication, and (c) to the effective expression of feelings and management of interpersonal conflicts. The other topics overlapped and were related to (a) assertiveness training and conflict management, (b) problem solving and (c) team building skills.

The second ranked need was managerial skills. The assessors saw this area of skill as relating to the formation and maintenance of organizational systems involving communication of information, planning and decision-making, and evaluation.

The third ranked need focused on supervisory skills in general and employee evaluation skills specifically. It was identified six times.

The fourth ranked need was case management skills. This assessors noted that this primarily pertained to the management of client information, the accurate and prompt maintenance of case records, and the management of communication among professionals treating the same client

system. It was noted 6 times.

The fifth ranked need, program planning and development skills, focused on general methods that should be employed in the development of new services to client systems. The sixth ranked need, accounting, focused on basic accounting skills, such as one might receive in a college class. The last identified need, was to have a specific employee become more oriented to his/her work setting and job duties. The frequencies of these respective needs were five, two and one.

Process Issues

The instructions for use of this method included the establishment of a three person committee that was to include the Training Director as a full-participant. However, shortly before the assessment was to begin, a decision was reached by the Executive Director and the Training Director to change the membership from a three person committee to a modified two person committee. This was done because of a concern about the confidentiality of the performance evaluations. The Executive Director and his Assistant were chosen as the two person committee because they had already read all the evaluations because as part of their administrative responsibilities within the center. The Training Director had seen only those evaluations that he had written in his supervisory role. His role was restructured to prohibit him from reviewing specific evaluations but to allow

him to participate in the discussion of the initial need statements, the collapsing of need statements into more generic categories and the final ranking of the needs. Once the assessment was about to begin, the committee discovered that they only had 12 performance evaluations for the total staff instead of the twenty evaluations that were anticipated. This difference was a result of having several new staff members who had not yet had an evaluation performed on them, having two evaluations missing from their personnel files, and having one staff member who just recently had changed positions within the agency and had not been evaluated in the normal evaluation process. The end result was that only 12 performance evaluations were available to be reviewed and training needs assessed.

The actual assessment process followed the instructions given in the Training Manual for this method. No major difficulties arose in their following the assessment process outlined. The Performance Evaluation Committee reviewed twelve evaluations for the initial assessment of needs in one hour and were able to complete the total assessment in one three hour meeting.

Following the completion of the assessment, the committee members discussed the assessment process. They stated that they wished that the supervisors who had written the evaluations had been involved in the rating and discussion process. They did not feel that confidentiality

was as important an issue as had been earlier indicated. Overall, they stated that the process was an interesting and revealing one in identifying training and staff development needs.

Overall, the process went smoothly considering that it had not been employed previously by any of the three committee members. The inter-rater reliability appeared to be high as many of the needs were stated by one of the assessors and then confirmed by the other i.e "I noted that need also, in those exact terms." The fact that the Executive Director of the entire CSB was a committee member did not seem to have an overt restricting effect upon the process. There was active ample discussion of the needs identified and all three members contributed to the assessment. The Training Director assumed from the beginning that operational definitions should be written for each of the categories of clinical, prevention and consultation and administration training and staff development needs and used by each rater. Committee members stated that they felt that it was important that the needs were first written on newsprint as the raters interpreted them from the evaluations and then collapsed into more generic categories. This allowed for a more uniform agreement of the number of times each need was identified.

The Rockbridge CSB Performance Evaluation forms have a place for supervisors to make statements in regard to this statement : "<u>DEVELOPMENT AND TRAINING</u> - (a) indicate

recommendations for future development and training for purposes of preparing the employee for additional responsibilities for the improvement of current job performance; (b) Identify any training or developmental activities the employee has completed since his/her last performance evaluation. Such training was (check one) taken as a result of the supervisor's recommendation ___, or the employee's initiative___". Even with this specific directive, the statements made were very general and varied greatly from supervisor to supervisor in terms of content, terminology and whether the directive was actually carried out.

Training Assessment Committee Method

The Training Assessment Committee (TAC) method was a modified nominal group needs assessment method. Five staff members met twice to nominate needs in each of the three categories.

Clinical Needs

This method resulted in the initial identification of 34 training needs with the top ten needs being prioritized in rank order (see Table 3-A). The highest ranked need was the development of skills related to performing mental status exams. The TAC's explanation of this need included (a) obtaining knowledge of the step-by-step procedures involved

Table 3-A

Top Ten Ranked Clinical Needs as

Identified by the Training Assessment Committee Method

Item	Individual Votes	Total Weighted Votes
1. Skills in mental status exams.	4,4,8 10	26
2. Advanced group psychotherapy techniques (all disabilities).	10,7,5	22
3. Diagnostic skills using DSM III.	10,1,9	20
4. Human sexuality issues.	9,10	19
5. Adolescent group therapy (all disabilities).	1,10,7	18
6. Knowledge of medications and related issues.	3,2,2, 4,4	15
7. Behavioral management techniques (including handling risk of violence).	7,5	12
8. Learning disabilities diagnostic skills.	2,9	11
9. Cognitive therapy techniques.	3,1,6	10
10. Skills in setting up work activity programs (including data collection).	8,2	10

in doing mental status exams and in developing practical skills that could be used in applying that knowledge. The use of role play and audio-visual process recall was recommended by the TAC as ways of helping staff meet this training need. The highest weighted score, 26, was given this need through the nominal group process.

The second top ranked item, advanced group psychotherapy techniques, was operationally defined by the TAC to include (a) the skills of marketing groups to the community, (b) the selection of group members, (c) development of the group into a cohesive unit, (d) working with client termination in an ongoing group, and (e) dealing with the issue of confidentiality that frequently surface among clients who are in group therapy in a small community. Also involved in this need was specialty training for individual staff in group therapy with special population groups such as parents groups, schizophrenics, Vietnam veterans, singles groups, clients who are depressed, clients who are experiencing marital problems, clients who are substance abusers, and adolescents. This need received a weighted score of 22. The fifth item, adolescent group therapy, was seen as a subset of the second ranked need. Its weight was 18.

The third top ranked need, DSM III diagnostic skills, was explained by the TAC as the need for didactic teaching of (a) recognition of various psychiatric disorders according to

DSM III, (b) skill training in making differential diagnosis, and (c) ways to use this knowledge in clinical settings. It received a weighted score of 20.

The fourth ranked need was human sexuality issues. The TAC indicated that this was a generic topic of interest to all the professional staff. Sub-topics of this need included (a) knowledge and treatment of sexual dysfunction, (b) theoretical information on sexual identity, and sexual growth and development, (c) unplanned pregnancy and its prevention, (d) sexual abuse, and (e) sexual communication among partners. "We have no one on staff clinically trained in any of these areas," was one observation made. The weighted score given this need was 19.

The sixth ranked need, medications, was the only subject on this ranking that was unanimously identified as a need by all committee members (although it received no high rankings). The committee elaborated that this need included (a) knowledge of the new psychotropic drugs, especially the side effects of these drugs, (b) the interaction of medications for the polypharmacy user, (c) medications for the elderly population, (d) issues and risks of substance abusers receiving medication (e) the use of street and over-the-counter drugs, (f) clinical implications of medication therapy, and (g) the effects of medications on psychological test performance. The weighted score for this item was 15.

The seventh ranked need was the use of behavioral management techniques in working with difficult clients. The TAC noted that instruction was needed in ways to work with clients that were prone to aggressive and/or violent acting out was needed. This need received a weighted score of 12.

The eighth ranked score, which received a weighted score of 11, focused on skills pertaining to the ability to diagnosis learning disabilities.

The two final needs tied for ninth place with weighed scores of 10 each. The TAC stated that the broad topic of learning about cognitive therapy techniques, such as those originating from Rational Emotive Therapy, Reality Therapy, Transactional Analysis and other modern therapy models was one of these two needs. The other was very generally stated by the TAC as the need for skills in setting up work activity programs. One sub-topic of this need mentioned was related to ways of building data basis for use in various programs.

Prevention and Consultation Needs.

The Training Assessment Committee identified ten separate prevention and consultation needs by this method (see Table 3-B). Two needs tied as the top ranked items. One was the development of a public relations/speakers bureau. The TAC stated that the Rockbridge CSB should develop a team of representative staff members who have been trained in public speaking and public relations. Skills needed by the team

Table 3-B

Top Ten Ranked Prevention and Consultation Needs as Identified by the Training Assessment Committee Method

Item	Individual Votes	Total Weighted Votes
1A. Public relations/speakers bureau.	7,8,6 6	27
1B. Parenting skills workshops.	3,5,7 8,4	27
3A. Emergency Services consultation skills.	9,6,3 7	25
3B. Training paraprofessionals.	10,6,9	25
5A. Consultation with judical systems.	5,10,1, 1,5	22
5B. Effective public speaking.	8,4,10	22
7. "Caspar" training.	7,9,3 2	21
8A. Consultation to teachers re: classroom management.	4,2,10 3	19
8B. Advanced volunteer management training.	6,5,8	19
10. Employee assistance program.	1,9,8	18

would include (a) the ability to effectively deliver speeches and make public presentations, (b) the development and use of brochures and audio-visual aids, (c) the ability to relate to and work with the media and (d) the effective use of mailings and other public relations marketing approaches. This need received a weighted score of 27.

The other top ranked topic was parenting skills workshops. The committee identified the specific components of this need as (a) the organizing and development of parent training groups, (b) learning about different teaching approaches for the teaching of parenting skills, (c) information on the stages of growth for children and adolescents, (d) creative use of group interaction. and (e) programming to meet the special needs of adult children of mentally disabled parents. The weighted score of this need was also a 27.

The third ranked need was emergency services consultation skills. Groups that the TAC identified that might be the recipient of this service included "gatekeepers", family members or other caregivers and service providers who are dealing with persons in psychiatric crises. The skills that the staff need to have expanded were listed as those related to the teaching of police, court service personnel, medical hospital staff, and family members content on how to identify and manage behavioral symptoms of persons in crisis. These individuals typically would include

potentially violent persons, emotionally troubled youth, substance abusers, and acutely psychotic or depressed persons. A related aspect of this skill is the promotion of effective networking and collaboration of resources for persons in crisis. The weighted score of this need was 25.

The fourth ranked need was training paraprofessionals. The TAC listed the components of this need as: (a) marketing and recruitment techniques for involving volunteers, (b) volunteer training and management of volunteers within the Board Services system and (c) training staff aides and the operators of adult homes in training inpatient management. The weighted score here was 25.

Two needs tied for fifth. One was training in effective public speaking. The other was consultation with judicial systems. This focused on the use of basic consultation models in reference to a specific human service delivery system that frequency interfaces with the mental health system. The weighted scores that each of these items received was 22.

The seventh ranked need was "Caspar" training, a specific curriculum on substance use/abuse education aimed at school-age children and adolescents. The focus would be on growth and development issues, value clarification and decision-making. The recipients of the training would be public school teachers. The item received a weighted score of 21.

Two needs tied for the eighth rank. The first was consultation to another specific delivery system: school teachers. The consultation would be on classroom management issues. The other was advanced volunteer management training. The weighted scores for both these needs were 19.

The tenth need identified was employee assistance programs. As clarified by the TAC, this type of mental health programming refers to early identification and intervention of persons with psychiatric or substance abuse disturbance by employers in the community. It includes learning about models of employee assistance programs and the functioning of professional staff within those models. Its weighted score was 18.

Administration Needs.

Table 3-C shows the top ten ranked scores related to the administration category. The top ranked need in this category, grant writing, received a 35, the highest weighted score of the entire assessment. This need was identified by all the assessors in the voting/ranking process. This need was also linked with the sixth-ranked need, location of funding sources (weight of 18). The committee identified the components of this need as (a) the technical skills of needs assessment, (b) the organizing and prioritizing of data, and (c) the political skills of developing and mobilizing constituencies and fostering the support of decision-makers.

Table 3-C

Top Ten Ranked Administration Needs as Identified by the Training Assessment Committee Method

Item	Individual Votes	Total Weighted Votes
1. Writing grants.	9,4,8, 4,10	35
2. Supervision training.	2,10, 10,7	29
3. Program evaluation.	5,6,7 9,1	28
4. Case management.	10,7,3 3	23
5. Staff stress management.	10,6,3	19
6. Funding sources.	8,3,1 6	18
7. Staff evaluation.	4,1,8 4	17
8A. Fee collecting.	7,8	15
8B. Data base construction and application.	6,9	15
8C. Effective charting.	9,6	15
8D. Effective communication.	7,8	15

This training was directed to the management level staff of the CSB.

The second ranked need was the training of supervisors in the various tasks pertaining to clinical and administrative supervision. The weight given this item was 29.

Program evaluation was the third ranked need. The assessors indicated that staff wanted to know more about methods for evaluation of different clinical programs, especially in relation to issues of effectiveness, efficiency and cost-effectiveness. This need received a weighted score of 28.

The fourth ranked need was case management. The assessors noted that this included training in the identification, assessment, referring, monitoring and follow-up process aimed at multi-need clients. In addition to the training and staff development needs identified, the assessors felt that a more advanced case management system, both internally within the Board Services and on an interagency level, would need to be established.

The fifth ranked need was staff stress management. The assessors specifically related this to burnout that most human service professionals eventually face. They wanted information on what burnout is, and what can be done individually and agency-wide to prevent and manage professional and personal stress. The weighted score of this need was 19.

The seventh ranked need was staff evaluation. The assessors did not identify the components of this need. It received a weighted score of 17.

Four needs were eighth ranked. The first focused on the collection of fees from clients, the clinical and administrative issues pertaining to this task. The weighted score for this item was a 15.

Data base construction and application was the second eighth ranked need. The assessors referred to the skills involved in organizing various MIS data pertaining to clients, their demographics, symptoms, and treatment goals so that correlational studies can be done. They believed that the use of such analysis could have implications in the design and implementation of new services, group therapy compositions, staff patterning, and heightened fiscal and services accountability. This too had a weight of 15.

The third need listed was effective charting. The TAC saw this as helping professional staff improve their accuracy and efficiency in the utilization of the data management system of the CSB.

The fourth need was effective communication. The assessors was this as referring primarily to to team building, supervisor-supervisee relationships and overall professional functioning. It too received the weighted score of 15.

Process Issues.

This assessment method was scheduled to be carried out in two meetings. The first meeting of the committee lasted three hours and the second meeting, an hour and a half. In the first meeting, the committee members spent over an hour nominating needs and recording them on newsprint. They then discussed the identified needs, and carried out a "straw vote" on the top ten needs in each category using the nominal group voting method outlined in the Needs Assessment Training Manual.

During the preliminary assessment, several of the group members stated a concern about having to limit themselves to only voting for ten needs in the clinical category. They felt that because there were many more needs initially nominated in that category in comparison to the other two areas, that they should be allowed to select more than 10 clinical needs. The Training Director acknowledged their concerns but asked them to limit themselves to ten needs in each category. The committee members then asked for additional time to discuss the needs listed on newsprint and to clarify, broaden or limit specific statements. They had been given this opportunity earlier, but had not responded to the invitation at that time. The pressure of actually having to chose seemed to prompt committee members to seek clarification, to compromise and to lobby for specific needs.

At this time another concern was raised. One member asked if he had to select ten needs in each category. He felt that his administrative unit only had a few needs, and he did not want to be put in a position where he had to nominate needs that did not pertain to his unit or that pertained to the specialties of others. He stated this concern strongly. After consulting the Training Manual, the Training Director explained that the nominal group procedure asked that each member nominate ten needs. The concerned committee member was asked to follow the instructions and "to trust that it will work out ok." He reluctantly agreed to do so. The committee then discussed their preliminary ranking, and voted on the top ten needs for the final time.

The main purpose of the second meeting was to develop explanatory statements pertaining to each need that could be used to develop learning experiences to meet each identified need. This was done for each of the three categories; the committee spent about 20 minutes per category discussing and clarifying need statements. The committee members did not exhibit the same interest and enthusiasm that was shown in session one. The Training Director had to frequently suggest meanings for need that would then receive general consent from the committee. The Training Director utilized open-ended questions to stimulate discussion, but the committee members did not respond actively to this approach. Consensus was reached about the definitions of all the need statements. The

group was thanked for their input and contribution to the total CSB needs assessment.

The main problem that surfaced in relation to this method was the amount of time the committee spent waiting for members to write down needs that they were going to nominate and then having to wait for each other to complete their preliminary voting. The other issues developed mainly from the lack of familiarity with the nominal group philosophy and procedures. The Training Director and the Researcher discussed these issues after the assessment was complete and the Training Director made several suggestions in order to streamline the process so that less time would be spent together in committee. They primarily involved having the initial nomination of needs made individually in writing and given to the Training Director prior to the first meeting.

Self-assessment Questionnaire Method

A 100% response was received in response to the Self-assessment Questionnaire. Tables 4-A, 4-B, and 4-C contain (a) the rank of the hindered competency, (b) the competency itself, (c) the number of respondents who use the competency, (d) the mean percent of time that competency is utilized by those professional staff members using the competency and (e) the mean ratio of time the staff is hindered on each competency. Median hindrance rates for each of the three categories were computed using only those competencies that

were used by 10 or more professional staff persons.

Clinical Needs

The top ten needs in this area were ranked according to the percent of time the staff was hindered on each competency. Only those competencies that were used by 10 or more staff were included in the ranking. The median hindrance rating for the clinical competencies was .2798.

Table 4-A shows that the top two top ranked competencies were related to the field of mental retardation. The top ranked need, with a hindrance rating of 1.5957, dealt with the need for information pertaining to the benefit systems available to mentally retarded clients. The second ranked need (.9826) dealt with a need to increase the ability to assess developmental delays and distinguish these from mental retardation.

The third (.7629), fourth (.7448), and sixth (.6000) ranked needs all focused on increasing assessment and diagnostic skills. The third ranked need focused on identifying adolescent alcoholics and drug abusers, the fourth ranked need focused on family dynamics assessment, and the sixth ranked need, on the identification of sexual abuse.

The fifth ranked need (.6402) dealt with the ability to make relevant input into psychiatric team meetings on therapy programs and treatment plans.

Table 4-A

Top Ten Ranked Clinical Needs as

Identified by the Self-assessment Questionnaire Method

Rank, Competency, No. of Respondents Using Competency	Percent of Time Competency Utilized	Ratio of Time Staff Hindered
1. Knowledge of the benefit systems available to MR clients: Social Security, Medicaid, Employment. (N=11)	19.72%	1.5957
2. Ability to assess developmental delays and distinguish these from mental retardation. (N=11)	24.05%	.9826
3. Ability to identify adolescent alcoholics or drug abusers. (N=11)	18.85%	.7629
4. Ability to assess family interaction patterns, identifying family strengths, weaknesses, needs and problems as well as their ability to resolve problems. (N=17)	21.54%	.7448
5. Ability to make relevant input into psychiatric team meetings on therapy programs and treatment direction. (N=14)	29.01%	.6402
6. Ability to identify sexual abuse, including incest. (N=15)	6.54%	.6000
7. Ability to foster trust-building relationships and participation between group members. (N=15)	31.48%	.5602
8. Ability to assist group participants to learn effective inter-personal behavior. (N=15)	25.12%	.5551

(table continued)

Table 4-A

Top Ten Ranked Clinical Needs as

Identified by the Self-assessment Questionnaire Method

Rank, Competency, No. of Respondents Using Competency	Percent of Time Competency Utilized	Ratio of Time Staff Hindered
9. Ability to conceptualize a case given developmental data and diagnostic information from various theoretical frameworks. (N=18)	28.03%	.5579
10. Ability to organize and present facts, observations, critical incident information, and assessment results regarding a client in a case conference. (N=17)	18.00%	.5577

hindrance rating. This was closely related to the ninth (.5579) and tenth (.5577) ranked needs which dealt with the ability to conceptualize a case from various theoretical frameworks and the ability to organize and present facts, and assessment information in case conferences.

The other two ranked needs focused on group therapy needs. The seventh (.5602) ranked need was identified as the ability to foster trust-building relationships and participation between group members and the eighth (.5551) ranked need of gaining the ability to assist group participants to learn effective inter-personal behavior.

Prevention and Consultation Needs.

The median hindrance rate for the prevention and consultation needs was computed at 1.1103; the highest ratio by a considerable amount, for any of the three categories. It suggests that the strongest training needs are related to the prevention and consultation area (see Table 4-B).

Within this cluster of needs were a need for knowledge and skills related to four specific areas: (a) knowledge of programing models and theories (top ranked need, hindrance rate of 2.2813; fifth ranked need (1.4603); and ninth ranked need (1.0000), (b) public speaking and working with large groups of people (needs ranked second (1.9423); fourth (1.6122); and sixth (1.1209), (c) needs related to

Table 4-B

Top Ten Ranked Prevention and Consultation as Identified by the Self-assessment Questionnaire Method

Rank, Competency, No. of Respondents Using Competency	Percent of Time Competency Utilized	Ratio of Time Staff Hindered
1. Knowledge of program development theory. (N=13)	6.98%	2.8813
2. Ability to speak in public and facilitate audience participation. (N=14)	5.71%	1.9423
3. Knowledge of community organization concepts. (N=10)	6.92%	1.9130
4. Knowledge of large group dynamics theory. (N=12)	12.69%	1.6122
5. Knowledge of and ability to use different programing models and methods. (N=14)	13.84%	1.4603
6. Ability to communicate effectively to groups at various levels of sophistication. (N=17)	19.46%	1.1209
7. Knowledge of networking theories and methods. (N=15)	14.87%	1.1103
8. Ability to serve as a consultant to various community groups and agencies. (N=14)	10.99%	1.0100
9. Knowledge of family life education concepts.(N=10)	6.15%	1.0000
10. Knowledge of the various roles that consultants can carry out in consulting relationships.(N=15)	20.21%	.9441

consulting and the roles consultants play (needs ranked eighth (1.0100); and tenth (.9441), and (d) knowledge and theories related to community organization and networking (needs ranked third (1.9123); and seventh (1.1103).

Administration Needs

The median hindrance ratio of the needs assessed overall in this category was .5474. The needs identified in this category fell into four different patterns (see Table 4-C). The first (2.3750), fifth (.6013), and tenth (.4523) ranked needs dealt with program evaluation. These competencies hindered focused on overall monitoring and measuring of programs in order to achieve stated objectives. Others, those ranked second (1.4389), seventh (.5676), and ninth (.4852), are related to the structuring of work for efficiency and carrying out administrative problem solving. Working with interns and volunteers was a recognized need, with needs ranked third (1.2000), and sixth (.5833), related to this area. The fourth (.9052) and eighth (.5272) ranked needs were specific in nature and yet related to all of the other needs; they focused on the skill of linkage between organizations and knowledge of management theories and techniques.

Table 4-C

Top Ten Ranked Administration Needs as Identified by the Self-assessment Questionnaire Method

Rank, Competency, No. of Respondents Using Competency	Percent of Time Competency Utilized	Ratio of Time Staff Hindered
1. Monitoring programs to insure the achievement of program objectives. (N=10)	6.15%	2.3750
2. Structuring: grouping work for effective and efficient production. (N=13)	13.07%	1.4389
3. Ability to supervise interns and volunteers. (N=11)	6.29%	1.2000
4. Linking: building and maintaining linkages with other organizations in the environment. (N=10)	35.77%	.9052
5. Measuring performance: assessing actual versus planned performance. (N=12)	20.25%	.6013
6. Recruiting and selecting volunteers: chosing appropriate volunteers, training rewarding and maintaining them. (N=10)	22.43%	.5833
7. Integrating: establishing conditions for effective teamwork among organizational units. (N=13)	44.62%	.5676
8. Knowledge of management theories and techniques. (N=11)	64.20%	.5272
9. Establishing procedures: determining consistent and systematic methods of handling work. (N=13)	43.90%	.4852
10. Analyzing problems:identifying and relating data related to the solution of a problem.(N=14)	57.58%	.4523

Process Issues

Following the completion of the Training Assessment Committee method and after checking to see if all members of this committee had completed their Self-assessment Questionnaires, the use of this method was discussed with these committee members. One committee member asked for a copy of the questionnaire as she wanted to have a list of the competencies for future use in evaluations and other tasks. They raised several concerns about how the response to the first question (How often do you deal with situations requiring this?) would then influence the response to the second question (How often would additional knowledge/skill pertaining to this competency have been helpful to you?). It was pointed out that the frequency of use of a competency might be related to the amount of knowledge/skill one had or confidence in that competency and that a change in column B might then result in a change in column A. If this was the case, then the value in column B would be higher than the value in column A. The wording of the question in column A was discussed with one staff member suggesting that the wording might read "How often do you have the opportunity to deal with situations requiring this?" A question was raised about the assumptions that went with each question. Specifically, "if a skill is not being used frequently by a staff member, would additional training result in that staff

person using that skill more frequently?" Another question was: "How can additional training affect something that was done in the past?".

Another staff member pointed out that there were no specific competencies listed pertaining to Substance Abuse. She noted that most of the other competencies were related but thought that there should be some additional competencies added to the overall questionnaire that related specifically to this division. Another staff member noted that it was hard to identify how often a skill was utilized.

A complete list of all 150 competencies, the number of respondents using a specific competency, percent of time competency utilized, and ratio of time hindered can be found in the Appendix, Item H.

Comparison of Identified Needs Across Assessment Methods

The training and staff development needs in the three areas of focus -- (a) clinical, (b) prevention and consultation and (c) administration training and staff development needs -- were identified by three separate methods in this multi-method framework. Each method involved different terminology, type of data to be collected and different groups of assessors. It was anticipated that the needs identified by each method would vary in terms of the wording, phrases utilized and statements listed. This did occur; however, the need statements were close enough in wording for an experienced Training Director to be able to compare need statements from the different methods and identify those that were focusing on similar needs.

The researcher decided that the prioritizing of needs generated by the three methods should be done on the basis of whether a need was identified by all three methods, two out of the three methods, or one method (allowing for variations in wording). Tables 5-A, 5-B, and 5-C were established in order to make this comparison. In addition, the researcher determined that although various needs were identified by more than one method, there was no corresponding comparison between the ranks of the needs as established by each of the methods. That is, although the same need was identified by

Table 5-A

Clinical Needs Identified by Method*

Needs		Methods		
		1	2	3
1.	Emergency, hospital pre-screening, and crisis intervention skills.	1A	1	0
2.	Training in psycho-social rehabilitation skills and techniques.	1	0	0
3.	Skills training in counseling and treatment modalities.	3	2,5, 7,9	0
4.	Treatment of children, adolescents and families; parenting and child management techniques.	4A	5	3,4, 6
5.	Family therapy.	4B	0	4
6.	Problem-solving and conflict management skills.	6A	10	5,10
7.	Formulation of treatment plans.	6B	0	0
8.	Diagnosis of child and adolescent disorders.	8A	3	2,3, 4,6
9.	Performance of psychological evaluations.	8B	0	0
10.	General diagnosis.	10A	3,8	2,3, 4,6, 9,10
11.	Performance of intake evaluations.	10B	1,3, 8	2,3, 4,6, 9,10

* If a broadly stated operational definition were used, than there would be some overlapping between these needs.

(table continued)

Table 5-A

Clinical Needs Identified by Method*

Needs	Methods		
	1	2	3
12. Working with families of substance abusers.	10C	0	3,4
13. Geriatric mental health.	10D	0	0
14. Skills in mental status exams.	0	1	1,10
15. Advanced group psychotherapy techniques (all disabilities).	7,8	2	0
16. Diagnostic skills using DSM III.	0*	3	10A
17. Human sexuality issues.	0*	4	0
18. Adolescent group therapy (all disabilities).	0*	5	0*
19. Knowledge of medications and related issues.	0	6	0
20. Behavioral management techniques (including handling risk of violence).	0	7	0*
21. Learning disabilities diagnostic skills.	2	8	0*
22. Cognitive therapy techniques.	9	9	3
23. Skills in setting up work activity programs (including data collection).	0	10	0

* If a broadly stated operational definition were used, than there would be some overlapping between these needs.

(table continued)

Table 5-A

Clinical Needs Identified by Method*

Needs	Methods		
	1	2	3
24. Knowledge of the benefit systems available to MR clients: Social Security, Medicaid, Employment.	0	0	1
25. Ability to assess developmental delays and distinguish these from mental retardation.	0*	8	2
26. Ability to identify adolescent alcoholics or drug abusers.	0*	0*	3
27. Ability to assess family interaction patterns, identifying family strengths, weaknesses, needs and problems as well as their ability to resolve problems.	4B	0	4
28. Ability to make relevant input into psychiatric team meetings on therapy programs and treatment direction.	0	0	5
29. Ability to identify sexual abuse, including incest.	0	0	6
30. Ability to foster trust-building relationships and participation between group members.	0	2	7
31. Ability to assist group participants to learn effective inter-personal behavior.	0	2	8

* If a broadly stated operational definition were used, than there would be some overlapping between these needs.

(table continued)

Table 5-A

Clinical Needs Identified by Method*

Needs	Methods		
	1	2	3
32. Ability to conceptualize a case given developmental data and diagnostic information from various theoretical frameworks.	3,6B, 10A	0*	9
33. Ability to organize and present facts, observations, critical incident information, and assessment results regarding a client in a case conference.	6B	3	10

* If a broadly stated operational definition were used, than there would be some overlapping between these needs.

Table 5-B

Prevention and Consultation Needs Identified by Method*

Needs	Methods		
	1	2	3
1. Community consultation and prevention skills (community agencies, professionals, schools, and hospitals).	1	1A, 1B, 3A, 5A, 5B,7 10	1,2,3, 4,5,6, 7,8,9, 10
2. Consultation and training skills to adult home staffs.	2	0	0*
3. Liaison skills with state hospital and community agencies.	3A	0	7
4. Advocacy for mental health.	3B	0*	1,2,3, 4,5,6, 7,8,9, 10
5. Public mental health education.	3C	0*	0*
6. Public relations/speakers bureau.	1	1A	2,4,6
7. Parenting skills workshops.	0*	1B.	9
8. Emergency services consultation skills.	1	3A.	0*
9. Training para-professionals.	0	3B.	0
10. Consultation with judical systems.	1	5A	0*
11. Effective public speaking.	0*	5B	2,4
12. "Caspar" training.	0	7	0

* If a broadly stated operational definition were used, than there would be some overlapping between these needs.

(table continued)

Table 5-B

Prevention and Consultation Needs Identified by Method*

Needs	Methods		
	1	2	3
13. Consultation to teachers re: classroom management.	0*	8A	0
14. Advanced volunteer management training.	0	8B	0
15. Employee assistance program development.	0	10	0
16. Knowledge of program development theory.	1	0	1
17. Ability to speak in public and facilitate audience participation.	1	1A, 5B	2
18. Knowledge of community organization concepts.	1,3B, 3C	0	3
19. Knowledge of large group dynamics theory.	0*	0*	4
20. Knowledge of and ability to use different programing models and methods.	1	0	5
21. Ability to communicate effectively to groups at various levels of sophiatication.	1	1A, 5B	6
22. Knowledge of networking theories and methods.	1	0	7
23. Ability to serve as a consultant to various community groups and agencies.	1,2	3A, 8A	8

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* If a broadly stated operational definition were used, than there would be some overlapping between these needs.

(table continued)

Table 5-B

Prevention and Consultation Needs Identified by Method*

Needs	Methods		
	1	2	3
24. Knowledge of family life education concepts.	1,3C	1B,7	9
25. Knowledge of the various roles that consultants can carry out in consulting relationships.	1	0*	10

* If a broadly stated operational definition were used, than there would be some overlapping between these needs.

Table 5-C

Administration Needs Identified by Method*

Needs		Methods		
		1	2	3
1.	Development of others within personnel.	1	0*	0*
	1A. General personnel relations.	1A	0*	0*
	1B. Effective communication at all levels of personnel.	1B	0*	0*
	1C. Managerial skills (eliciting cooperation).	1C	0*	0*
	1D. Assertiveness training and conflict management.	1D	0*	0*
	1E. Identification and resolution of problems.	1E	0*	0*
	1F. Acquisition of team skills.	1F	0*	7*
2.	Organizational management skills.	2	0*	8*
3.	Supervision and employee evaluation skills.	3	2,7	3,5
4.	Case management skills.	4	4,8C	0*
5.	Program planning and development skills.	5	0	0*
6.	Accounting.	6	0	0
7.	Orientation to work setting and job duties.	7	0	0
8.	Writing grants.	0	1	0

* If a broadly stated operational definition were used, than there would be some overlapping between these needs.

(table continued)

Table 5-C

Administration Needs Identified by Method*

Needs		Methods		
		1	2	3
9.	Supervision training.	3	2	3,7
10.	Program evaluation.	0	3	1,5
11.	Staff stress management.	1D	5	0
12.	Funding sources.	0	6	0
13.	Staff evaluation.	3	7	1,5
14.	Fee collecting.	0	8A	0
15.	Data base construction and application.	0	8B	0
16.	Effective charting.	0	8C	0
17.	Effective communication.	1B	8D	7
18.	Monitoring programs to insure the achievement of program objectives.	3	3	1
19.	Structuring: grouping work for effective and efficient production.	2	0*	2
20.	Ability to supervise interns and volunteers.	0*	0*	3
21.	Linking: building and maintaining linkages with other organizations in the environment.	1F	0	4
22.	Measuring performance: assessing actual versus planned performance.	0*	3,7	5

* If a broadly stated operational definition were used, than there would be some overlapping between these needs.

(table continued)

Table 5-C

Administration Needs Identified by Method*

Needs		Methods		
		1	2	3
23.	Recruiting and selecting volunteers: chosing appropriate volunteers, training rewarding and maintaining them.	0	0	6
24.	Integrating: establishing conditions for effective teamwork among organizational units.	1F	0	7
25.	Knowledge of management theories and techniques.	1A, 1B,1C, 1D,1E, 1F,2, 6,7	0*	8
26.	Establishing procedures: determining consistent and systematic methods of handling work.	2	0	9
27.	Analyzing problems: identifying and relating data pertinent to the solution of a problem.	1E	0	10

* If a broadly stated operational definition were used, than there would be some overlapping between these needs.

each of the methods, its rank varied widely in each of the methods and there was no correlation between the rank of a need as identified by any method and the rank of the same need as identified in any other one or more methods. Therefore, the rank order of a need as identified method was not a major factor in determining the importance or strength of a specific need.

Table 5-A lists the clinical staff development and training needs identified by each of the three methods. Items 1-13 are need statements generated from the Performance Evaluation Method. Items 14-23 are statements that originated from the Training Assessment Committee Method and items 24-33 originated from the Self-assessment Questionnaire Method.

Table 5-B lists the prevention and consultation staff development and training needs identified by each of the three methods. The specific wording of items 1-5 came from the Performance Evaluation Method. Items 6-15 were statements that originated from the Training Assessment Committee Method and items 16-25 originated from the Self-assessment Questionnaire Method.

Tables 5-C lists the administration staff development and training needs identified by each of the three methods. The specific wording of items 1-7 came from the Performance Evaluation Method. Items 8-17 were statements that originated from the Training Assessment Committee Method and items 18-27 originated from the Self-assessment Questionnaire Method.

Those needs that were identified by all three methods were evaluated to be the primary training and staff development in each of the three categories. Those that were identified by any two of the three methods were evaluated as the secondary training and staff development needs. Those that were identified by only one method were evaluated as having the lowest priority training and staff development needs. This produced a final ranking of the needs identified by the multi-method framework. Ultimately, the Rockbridge CSB itself will have to take this assessment and assign higher or lower priorities to any needs in these three grouping based upon variables of staff interest, licensing and accreditation standards, requirements of funding sources and other influential variables.

Tables 6-A1, 6-A2, 6-A3, 6-B1, 6-B2, 6-B3, 6-C1, 6-C2, and 6-C3 list the final prioritization of the total needs identified. A review of these tables will show that some needs are listed in both the primary and secondary categories. This is due to the wording of the specific need statements that produces needs that generally focus on a broad topic area, such as program evaluation, but when the individual need statements from a specific method are reviewed, they will be more specific in their statement of need. Methodologically, this is demonstrating that it is only possible to reduce need statements to common statements up to a point without losing the specificity of the original

statement.

Primary and Secondary Clinical Needs.

Table 6-A1 shows that six of these needs were identified by all three methods; Table 6-A2 lists the 13 needs that were identified by two of the three methods. Table 6-A3 lists those clinical needs that had the lowest priority.

The primary clinical needs fell into several patterns. One pattern focuses on issues pertaining to diagnosis in general and specifically to diagnosis of child and adolescent disorders. Also related to these needs were skills related to the performance of intake evaluations. A related need was the ability to organize and present facts, observations, critical incident information and assessment results regarding clients in case conferences.

The other pattern related to treatment planning and specifically the use of cognitive therapy techniques. There was a strongly related need for techniques related to the treatment of children, adolescents and families, including parenting and child management techniques. The last primary need was knowledge of and skills related to problem solving and conflict management skills.

The 13 secondary needs also fell into several patterns. One pattern focused on diagnosis or assessment skills related to emergency, hospital pre-screening, and mental status exams, learning disabilities and developmental delays, family

Table 6-A1

Primary Clinical Learning Needs

1. Treatment of children, adolescents and families; parenting and child management techniques.
2. Problem-solving and conflict management skills.
3. Diagnosis of child and adolescent disorders.
4. General diagnosis.
5. Performance of intake evaluations.
6. Cognitive therapy techniques.
7. Ability to organize and present facts, observations, critical incident information and assessment results regarding a client in a case conference.

Table 6-A2

Secondary Clinical Learning Needs

1. Emergency, hospital pre-screening and crisis intervention skills.
2. Skills training in counseling and treatment modalities.
3. Family therapy.
4. Working with families of substance abusers.
5. Skills in mental status exams.
6. Advanced group psychotherapy techniques.
7. Diagnostic skills using DSM III.
8. Learning disabilities diagnostic skills.
9. Ability to assess developmental delays and distinguish these from mental retardation.
10. Ability to assess family interaction patterns, identifying family strengths, weaknesses, needs and problems as well as their ability to resolve problems.
11. Ability to foster trust-building relationships and participation between group members.
12. Ability to assist group participants to learn effective inter-personal behavior.
13. Ability to conceptualize a case given developmental data and diagnostic information from various theoretical frameworks.

Table 6-A3

Lowest Grouped Clinical Learning Needs

1. Training in psycho-social rehabilitation skills and techniques.
2. Formulation of treatment plans.
3. Performance of psychological evaluations.
4. Geriatric mental health
5. Human sexuality issues.
6. Adolescent group therapy (all disabilities).
7. Knowledge of medications and related issues.
8. Behavioral management techniques (including handling risk of violence).
9. Learning disabilities diagnostic skills.
10. Skills in setting up work activity programs (including data collection).
11. Knowledge of the benefit systems available to MR clients: Social Security, Medicaid, Employment.
12. Ability to identify adolescent alcoholics or drug abusers.
13. Ability to make relevant input into psychiatric team meetings on therapy programs and treatment direction.
14. Ability to identify sexual abuse, including incest.

interactional patterns and those related to the use of DSM III were clearly identified. Also included was the ability to conceptualize a case given developmental data and diagnostic information from various theoretical frameworks.

The second cluster of needs were related to skills training in counseling and treatment modalities such as (a) family therapy, especially working with families of substance abusers, and (b) advanced group psychotherapy techniques. Two specific needs related to the latter were the ability to foster trust-building relationships, foster participation among group members and to assist group members to learn effective inter-personal behaviors.

Primary and Secondary Prevention and Consultation Needs.

A review of Table 6-B1 shows that six of these needs were identified by all three methods while 11 needs were identified by two of the three methods (see Table 6-B2). Table 6-B3 lists the lowest ranked prevention and consultation training and staff development needs.

Three specific patterns emerged when the top six primary needs were reviewed. One cluster of needs were for staff members to increase their skills in public speaking, and working with community groups in relation to various mental health/mental retardation prevention and public relations projects. Corresponding to an improvement in these skills, the assessors suggested that there was the need for

Table 6-B1

Primary Prevention and Consultation Learning Needs

1. Community consultation and prevention skills (community agencies, professionals, schools, and hospitals).
2. Public relations/speakers bureau.
3. Ability to speak in public and facilitate audience participation.
4. Ability to communicate effectively to groups at various levels of sophistication.
5. Ability to serve as a consultant to various community groups and agencies.
6. Knowledge of family life education concepts.

Table 6-B2

Secondary Prevention and Consultation Learning Needs

1. Liaison skills with state hospitals and community agencies.
2. Advocacy for mental health.
3. Parenting skills workshops.
4. Consultation with judical systems.
5. Effective public speaking.
6. Knowledge of community organization concepts.
7. Knowledge of and ability to use different programing models.
8. Knowledge of program development theory.
9. Knowledge of networking theories and methods.
10. Knowledge of various roles that consultants can carry out in consulting relationships.
11. Emergency services consultation skills.

Table 6-B3

Lowest Grouped Prevention and Consultation Learning Needs

1. Consultation and training skills to adult home staffs.
2. Public mental health education.
3. "Caspar" training.
4. Consultation to teacher re: classroom management.
5. Advanced volunteer management training.
6. Employee assistance program.
7. Knowledge of large group dynamics theory.

the development of a public relations unit and/or a speakers bureau within the Rockbridge CSB.

The other cluster of needs focused on consultation skills and primary prevention skills in general to a wide variety of community groups and agencies. Family life education was a frequently mentioned topic for which additional knowledge and skills in programing were sought.

With this method of analysis, the secondary list of needs also identified needs related to the above mentioned patterns. The processes of reduction and interpretation can allow for somewhat the same need to be listed in the primary and secondary need statements. The need for more effective public speaking skills was again identified (without a corresponding call for the development of a speaker's bureau), as was consultation skills related to the roles that consultants play, emergency consultation skills, consultation with judical systems, programing for parenting skills workshops and general advocacy for mental health. Two needs identified that also relate to these include knowledge of program development theory in general, especially different programing (teaching-learning) models.

Other needs identified include knowledge of community organization concepts, especially networking theories and methods. A special related need was for increased liaison skills that could be used with state hospitals and community agencies.

Primary and Secondary Administration Needs. A review of Table 5-C1 shows that five of these needs were identified by all three methods while 10 needs were identified by two of the three methods (see Table 5-C2). The primary administration needs relate to supervisory skills, especially those related to staff evaluation. The other identified prime need is also one of evaluation, with a focus on program evaluation. Effective communication among all levels of staff was a very broadly stated prime need.

Two secondary need statements focused on program evaluation, a focus of the primary identified needs. Eight need statements focused on various aspects of management theories and skills, including abilities to structure work in effective and efficient units, establishing effective teamwork among organizational units, and problem identification and solving skills. A related specific need was case management skills, which related to all professional staff.

One need statement corresponded with the primary need statements in that it focused on performance evaluation. One other specific identified need related to staff stress management.

Table 6-C1

Primary Administration Learning Needs

1. Supervision and employee evaluation skills.
2. Supervision training.
3. Staff evaluation.
4. Effective communication.
5. Monitoring programs to inaure the achievement of program objectives.

Table 6-C2

Secondary Administration Learning Needs

1. Case management skills.
2. Program evaluation.
3. Staff stress management.
4. Structuring: grouping work for effective and efficient production.
5. Linking: building and maintaining linkages with other organizations in the environment.
6. Measuring performance: assessing actual versus planned performance.
7. Integrating: establishing conditions for effective teamwork among organizational units.
8. Knowledge of management theories and techniques.
9. Establishing procedures: determining consistent and systematic methods of handling work.
10. Analyzing problems: identifying and relating data pertinent to the solution of a problem.
11. Organizational management skills.

Table 6-C3

Lowest Grouped Administration Learning Needs

1. Development of others within personnel

    1A. General personnel relations.

    1B. Effective communication at all levels of personnel.

    1C. Managerial skills (eliciting cooperation).

    1D. Assertiveness training and conflict management.

    1E. Identification and resolution of problems.

    1F. Acquisition of team skills.

2. Program planning and development skills.

3. Accounting.

4. Orientation to work setting and job duties.

5. Writing grants.

6. Funding sources.

7. Fee collecting.

8. Data base construction and application.

9. Effective charting.

10. Ability to supervise interns and volunteers.

11. Recruiting and selecting volunteers: chosing appropriate volunteers, training, rewarding and maintaining them.

Comparison of Three Different Assessment Methods

In looking at the methods themselves, a question can be raised as to what degree do two or more of the methods identify the same needs? A review of Tables 5-A, 5-B, and 5-C suggests that there is no strong correlation between any of the methods. Although different methods often frequently identify the same needs, there was no consistent pattern to the identification of needs by more than one method. Clearly, there is little or no correlation between the rank orders of any of the categories.

In order to evaluate the ability of each of the needs assessment methods individually and the multi-method framework collectively to assess the training needs of the Rockbridge CSB, the general characteristics of each of the methods in relation to the needs statements generated was reviewed. Each method has certain strengths and limitations. The needs each method generates then are developed from a certain perspective and by a specific and different group of

Performance Evaluation Method

Although the actual need assessment was made by a needs assessment committee, the committee reviewed data prepared by another specific group: the supervisors of the various administrative units. Thus, the needs assessed were those perceived by the middle management administrative staff of the agency. This group has designated responsibilities for overseeing the quality and efficiency of specific program

units. However, these supervisors were primarily assessing overall performance in in relation to personnel issues such as determining whether a staff member should be retained, receive a salary raise or in some cases, be promoted. They were not primarily interested in assessing training and staff development needs even though the performance evaluation format did contain a category where supervisors were to identify specific development and training needs. The evaluation format itself asked supervisors open-ended questions to answer about the professionals being evaluated. The evaluation statements in response thus tended to be general in nature and were not criterion based. As only one supervisor evaluated each employee, and the training and staff development need statements were taken then from these evaluations, the content validation of this data is unknown. This data is used by the assessors to make or develop training and staff development need statements and thus can reflect the bias of the original data in any need assessed.

This method identified the smallest number of needs for each category of any of the methods. The frequency associated with each identified need does not necessary have a direct relationship to the number of performance evaluations reviewed because the Rockbridge CSB evaluations are divided into sections and thus a specific need could be identified several times for the same person. In addition, the subsequent ranking of needs should be reviewed with some

caution as there is not an equal amount of distance between any of the ranked needs and the rankings themselves are an approximation of the overall strength of an identified need. The strength and uniqueness of the method was that it is provided data generated from the professional staff in the agency who have the final responsibility for the delivery of quality services which is strongly influenced by the competency level of the of the professional staff. These individuals also tend to have a perspective on professional practice that is broader in scope and focuses more on the needs of the CSB rather than the needs of one individual practitioner.

The inter-rater reliability of the two person committee doing the need assessment was high as they both read the same evaluations, stated the training and staff development needs that were listed and saw the same frequency of needs in almost every case. In those cases where they didn't agree, discussion and negotiation were used to decide upon the wording and definition of a need. The committee expressed a positive feeling about the use of the process at its completion and indicated that they felt that they had identified training and staff development needs of the CSB through this method. They felt that it provided them with a perspective that was not achieved without looking at all the performance evaluations in relation to training issues.

Training Assessment Committee Method

This method had been specifically designed for needs assessment and followed a set of instructions that had previously been field tested hundreds of times by Delbecq and his associates. The assessment committee was made up of five individuals who assessed the needs of their professional peers. The needs assessed by this method were normative for the agency in that the committee members were asked to identify needs for the entire CSB based upon their perspective and feedback from the colleagues with whom they had the most contact. This allowed for needs to be identified from more than one method and the use of nominal group weighing and ranking procedures allows for each assessor to have an equal influence on the outcome. The method provided quantitative information pertaining to the number of committee members who ranked a specific need, the actual rank of each member (and thus the range of ranks) and the total weighted score for each of the needs.

The assessment by this method produced many more clinical needs than prevention and consultation and administration needs. This may be explained by noting that this area is the one that relates the closest to community mental health professionals background, training and primary interests.

Self-assessment Questionnaire Method

This method involved the total population of the CSB in self-assessing their training and staff development needs. It used a criterion based method in that the competencies listed had been designed and previously tested in relation to those competencies that are generic to community mental health/mental retardation staff members. The method produced a wide variety of quantitative information including the number of professional staff utilizing each competency, the percent of time each used the competency, the amount of time additional knowledge or skills would have been helpful to staff, and the hindrance rate (or the amount of need) for each competency. In addition, the hindrance rate is a normative rate in that it was only computed for competencies that were used by at least 50% of the professional staff. The method did not allow for any estimate of reliability to be made.

Multi-method Overview

Each method by itself produced a list of needs that the assessors themselves felt had face validity. Each of the groups of assessor stated after each method had been used to assess needs, that the more persons involved in the actual assessment process, the more valid the method would be. Increasing the number of people involved in the assessment process beyond the 4-12 limit would prove to be a problem in the Training Assessment Committee method as this would

increase the amount of time the committee had to use to nominate and discuss needs prior to the two voting and ranking processes.

The list of primary learning needs in each of the three categories was data that had to be interpreted and then transposed somewhat in order to compare the data collected by the different methods. This process was reductionistic in nature and necessary due to the different groups of assessors used with each of the methods, the difference in their roles pertaining to the assessment (supervisor, peer, self-assessment) and the recognition that each assessing group will introduce a specific basis to the process.

No major problems arose in the field testing of each of the methods. The field testing of the multi-method framework demonstrated that it had the ability to assess the training needs of mental health professionals. The field testing revealed some minor problems in using each of the specific methods that should be corrected prior to further use of the framework. These problems primarily relate to the amount of time used in the processes by professional staff and can be decreased by streamlining the procedures. One problem with use of the multi-method framework involves correlating needs generated by different methods and different groups of assessors that are stated in different terms and phrases but must be compared in order to generate the list of primary and secondary needs. The use of the

multi-method framework did demonstrate that if only one method were used, any of the methods, that the list of needs generated will be a result of the method employed and the persons making the assessment.

CHAPTER FIVE

Summary, Conclusions and Recommendations

Summary

This research addressed the need for the development of a multi-method needs assessment framework that could be used by Training Directors within the 40 Community Service Boards in Virginia to identify the training and staff development needs of professional staff. This evaluation research was guided by five objectives: (a) to list criteria that could be used in the establishment of a needs assessment framework, (b) to develop a multi-method framework that could be used throughout the 40 CSB's in Virginia to assess the training and staff development needs, (c) to field test the framework in a CSB, (d) to list the staff development and training needs of a CSB assessed by the multi-method framework, and (e) to evaluate the multi-method needs assessment framework's potential for future use in CSB's throughout the state of Virginia.

The study was carried out over a one year time period. First, a multi-method needs assessment framework was developed, taking into account previous research, the concepts and ideas suggested by professional literature, and the goals of the Office of Prevention, Information and Training as established in their Five Step Training and Staff Development Plan. This framework was then sent to a panel of experts for their review and comments and revised

accordingly. The framework developed consisted of three different need assessment methods that were employed within the same CSB during a one month time period. These methods consisted of: (a) the review of performance evaluations by a three person committee in order to assess training and staff development needs, (b) the use of a nominal group technique by a five person Training Assessment Committee to assess training and staff development needs, and (c) the completion of a Self-assessment Questionnaire by 100% of the professional staff which led to the establishment of hindrance rates on 150 competencies which pertained to professional practice within community mental health and mental retardation. Each of these methods produced a list of the top ranked needs in relation to (a) clinical, (b) prevention and consultation and (c) administration training and staff development needs.

The multi-method framework was developed because of the assumption, supported by the professional literature, that both the method and the persons employing a specific needs assessment method will bias the actual assessment and ranking of needs. In order to manage this bias, the multi-method framework was utilized to list as the most valid needs those that were identified by all three methods. The multi-method assessment framework was field tested with 20 professional staff members of the Rockbridge CSB, located in Lexington, Virginia. Those needs that were identified by each of the

three methods that made up the multi-method framework were seen as the primary training and staff development needs:

1. The primary clinical needs were organized into three patterns. One pattern focused on issues pertaining to diagnosis in general and specifically on diagnosis of child and adolescent disorders. Related to these needs were skills related to the performance of intake evaluations and the ability to organize and present facts, observations, critical incident information and assessment results regarding clients in case conferences. The second pattern related to treatment planning and specifically the use of cognitive therapy techniques. There was a strongly related need for techniques related to the treatment of children, adolescents and families, including parenting and child management techniques. The final primary need was identified as knowledge and skills related to problem solving and conflict management skills.

2. The primary prevention and consultation needs fell into two clusters. One cluster of needs were for staff members to increase their skills in public speaking, and in working with community groups in relation to various mental health/mental retardation prevention and public relations projects. Corresponding to training in these skills, the need for the development of a public relations unit and/or a speakers bureau was cited.

The second cluster of needs focused on general consultation skills and primary prevention skills that would be able to be used with a wide variety of community groups and agencies. Family life education was a specific programatic focus in which additional knowledge and skills were sought.

3. The primary administration needs that were identified centered around (a) supervisory skills, especially those related to staff evaluation, (b) program evaluation and (c) effective communication among all levels of staff.

The study concluded that the multi-method needs assessment framework had sufficient utility for it to be used throughout Virginia in the 40 CSBs to assess training and staff development needs. The triangulation of data allowed the needs identified by one method to validate the needs identified by the other methods.

Conclusions

This research provided information on several related areas (see research questions, Chapter One, pages 11-12). It listed the primary and secondary training needs of the Rockbridge CSB and showed how individually, the three different methods of the multi-method framework will produce difference but related lists of training and staff development needs. The importance of triangulating the data to produce a master list of needs was demonstrated. The feasibility of the

multi-method framework was evaluated, and proven feasible, but in need of minor revisions. Also, the worth and utility of the data collected by the multi-method framework was verified and clarified. Finally, the research suggested several roles for the Office of Prevention, Information and Training to carry out with the 40 CSBs across the state.

Training and Staff Development Needs and Multi-method Issues

The use of the multi-method framework resulted in the assessment of the top ranked needs in relation to (a) clinical, (b) prevention and consultation, and (c) administration training and staff development needs. These three categories were appropriate ones that allowed need statements to be summarized into areas that related to the generic responsibilities of community mental health and mental retardation staff.

The specific method employed and the specific assessors involved in employing each of the specific needs assessment methods appears to have influenced the needs listed by each method in the field testing. However, the triangulation of data allowed the CSB to have assurance that the needs that they assessed were valid. The establishment of a master list of training and staff development needs was done by prioritizing needs according to whether they fit into a list of primary needs, secondary needs or lowest grouped needs.

It was important that each method rank order the training needs within each of the three categories as part of

the needs assessment process. This established parameters for the top needs and placed the focus on the top needs within each category. However, these rank orders were able to be utilized only as general rather than absolute reference points. They were not utilized in the placement of needs into the master list of primary, secondary, or lowest grouped needs because the rank of the needs that were assessed by all three methods differed from method to method. The assessment obviously generated more needs than can be met by any training and staff development program. The actual ranking of needs within the primary, secondary and lowest grouped needs must be done by the persons or groups that intend to translate them it into learning goals and objectives. This decision making process for this study can best be made by those professionals within the Rockbridge CSB who have direct responsibility for quality of services within a CSB and/or the training of professional staff. This is the next step in the planning process; however, it falls outside of the focus of this research.

In moving to the next step, the use of needs assessment information to plan training and staff development goals and objectives, outside influences such as licensure and accreditation standards, funding source requirements should be considered in deciding which needs within the lists of primary and secondary training and staff development needs are translated into training and staff development programs.

The multi-framework needs assessment process primarily provides a data base to be employed in decision making.

Performance Evaluations

Data Produced. The type of data produced by the performance evaluation method was influenced by the limitations of the method itself. The performance evaluations utilized narratives or descriptions of professional performance in several general categories. The evaluations were based upon observation and perceptions of the supervisors and no attempts were made to control for issues pertaining to rater reliability. In addition, the actual evaluations could vary widely in terms of the content across the CSB. Methodologically then, issues could then be raised about the reliability and validity of an individual evaluation; this in turn would effect the use of this data in the assessment of training and staff development needs.

The method did provide a list of the needs identified by supervisors, descriptions of those needs, and corresponding frequencies of how often a need was identified. The frequencies are nominal measurements, the lowest type of measurement. Since the frequencies themselves are counts of how often a specific need was identified and the performance evaluation itself was divided into sections, a specific need on several evaluations was identified several times. It is thus possible that a need can have a frequency that exceeds

the number of performance evaluations being reviewed (in essence, the population of the study). Furthermore, using the frequency of observation to rank order the needs did not produce absolute qualities nor equal intervals between the rankings.

Method Revisions. When appropriately supported by the Executive Director of the CSB, and with safeguards established to preserve the confidentiality of individual performance evaluations, this method will yield the best results when the assessment committee is (a) representative of those writing the evaluations throughout the CSB and (b) small enough to meet, nominate needs, indicate frequency of assessment and then clarify the need statements that are generated. In the field testing, this method only involved two assessors and the Training Director, who served as a facilitator and helped establish the statements that clarified each need assessed. The number of assessors used with this method could be increased up to 6-8 members, thus providing for additional input into the clarifying process about what should be the foci of different need statements.

Several of the steps involved in the review of the performance evaluations could be accomplished prior to a first meeting of the committee. If committee members were supplied with operational definitions of the three categories in which needs are to be assessed, instructed in the overall goals of the process and the steps to be carried out in the

assessment process, then each member should be able to review the performance evaluations individually and prepare an initial list of training needs prior to the first meeting of the committee. These lists, with their accompanying frequencies of assessment, could be written on newsprint by the Training Director prior to the first meeting so that the committee could quickly begin discussion and subsequent collapsing of the original need statements into generic need statements.

It would assist the overall collection of data if the same general terminology were used in writing need statements throughout the three methods. Supervisors who write performance evaluations could be given a list of generic competencies and asked to use these in writing their evaluations and in noting the training and staff development needs that exist for the staff members whom they supervise.

Training Assessment Committee Method

Data Produced. The data produced by the nominal group process, a weighted score, was interval data and allowed the researcher to assume that the differences between weights represent equal distances in the differences between strengths of needs. In addition, the listing of the number of assessors giving a weight to any need, could have been used as an indicator of the number of assessors that felt that a need is important.

The comparison of the data generated by this method with that generated by the other two methods was difficult, due primarily to the difference in terminology used in generating need statements by each of the different methods. This problem could be lessened if the Training Assessment Committee were presented with the list of competencies used in the Self-assessment Questionnaire method and asked to use these competencies whenever possible in nominating needs.

Method Revisions. The nominal group method utilized by the Training Assessment Committee method did experience several of the methodological problems predicted by Delbecq and colleagues (1975). The first problem related to the selection of representatives for nomination of and voting for identified needs. The strongly voiced concern by one committee member about only voting for his own units needs was a manifestation of this issue. He saw himself as only representing one specific section of the CSB and not having responsibilities for assessing needs for the entire CSB. He seemed unaware of how his votes would merge into those of other assessors to establish the normative needs of the CSB. This problem can be managed with careful division of a CSB into units that will allow equal representation from throughout the CSB and by giving assessors clear explanations of the concepts upon which the process is to be based. In addition, the Operations Manual needs revision to provide information on anticipated concerns that professional staff

will raise about the use of the method and suggestions on how to respond to these concerns.

The provision of operational definitions for the three categories of need helped add specificity to the question given the assessors to guide their work "What are the training and staff development needs of professional staff within your program unit in relation to the areas of clinical, prevention and consultation and administrative issues?" This helped focus the collective nomination and ranking of needs in a manner that produced few problems. Another frequent methodological concern, the transformation of raw data into standardized measurements units, was managed within the method by following the procedures outlined by Delbecq and colleagues (1975) as contained in the Operations Manual.

Self-assessment Questionnaire

Data Produced. The data produced by this method was evaluated in relation to generic professional competencies that the professional staff indicated that they were hindered in using to their fullest. Although the respondents were asked to indicate the amount of time that they use a competency and then the amount of time that they would have benefited from additional knowledge or skill, it was not to be inferred that each of the 150 competencies should be used each day. That is, if a staff member has a low usage rate on

family therapy issues, it may be because he has little or no knowledge of this area and thus is not using a needed but neglected competency. It also may be that his professional responsibilities do not allow him or require him to use that specific competency. This data on the first scale, the amount of time utilized, will need to be evaluated individually from staff member to staff member based upon job descriptions, professional expectations, and other related variables by those within the Rockbridge CSB who will be using the data to establish training and staff development programs.

The hindrance rate is a relative one. Because of the lack of equal distances between the five different time ratings that staff members were asked to give, the hindrance ratio can exceed one. One way to evaluate this type of data is to establish the median hindrance rate for each of the categories and then compare the rate on any competency with that rate.

Method Revisions. The Self-assessment Questionnaire was successful in presenting the professional staff with a list of generic competencies and a method to use in self-assessing training and staff development needs. However, the questionnaire should be expanded by 10-15 competencies to include competencies specific to professional staff members working with substance abusers. This was the only area in which the list of generic competencies appeared to be

deficient. This issue was raised by the validation panel but the researcher was unable to correct this deficiency prior to the beginning of the field testing.

The questions about the hindrance rate and the effect on answers in column B by the amount of time a competency was utilized can be viewed as typical questions that any respondent might ask. The method does allow for a wide range of hindrance ratios and views the actual ratio of hindrance as a relative score.

Although the content validity of the competencies was established by earlier research, this was the first time that they had been used in this instrument in relation to the percent of usage and amount of hindrance scores. Additional research is needed on the validity of the competencies themselves as they pertain to community mental health/ mental retardation practice in Virginia.

Statistically, it would also be helpful to establish standard deviations on each of the competencies to see how much respondents vary in their hinderances.

Feasibility of Multi-method Framework

The multi-method framework developed and field tested within this study is one that can be utilized by a CSB in the state of Virginia. Nothing in the field testing suggested that the results of needs assessment will be affected by the number of professional staff employed by a CSB. The framework

can be employed by a Training Director following two to four hours of training in the use of each of the methods and with the use of the Operations Manual. The one month timetable established for the use of the multi-method framework proved to be adequate in that all the methods were completed within that time frame and the professional staff were not overly involved time-wise in carrying out the assessment. The assessment did involve extensive amounts of time and involvement of the Training Director over a two month period.

Some revision of the multi-method framework will be necessary to make it maximally efficient. The Operations Manual proved to be a suitable guide for use by a Training Director in carrying out the multi-method framework, providing training was offered the Director prior to the actual use of the methods.

Worth/Utility of Data Collected and the Multi-method Framework

The data produced by the use of the multi-method assessment process allowed the results from one method to validate the results from another. Thus, the highest priority needs were those that were identified by all three methods. The framework itself was one that was able to be carried out within a one month time frame. It involved the total professional staff in the assessment process, with appropriate emphasis given to those with administrative responsibilities for the quality of services provided by professional staff. The attitude of the professional staff

throughout the process was positive. This should result in increased motivation to meet the training needs identified and also will validate the needs identified as being the most appropriate ones for the Rockbridge CSB to address at this time.

The Operations Manual provided specific instructions on the use of each of the methods. It was employed by a Training Director who had little experience in using any of the three methods. The Training Director benefited from the two hours of training that was provided him prior to the actual use of the methods. The manual needs some further clarification and would be improved by the addition of some graphics pertaining to the specific tasks involved with each section. The manual also needs to be edited so that it contains clearer instructions on combining the need lists from each of the methods into one final report.

The data from the Self-assessment Questionnaire was hand scored by the researcher. This was possible because only 20 professionals completed it. However, with a larger population, this would have been a major task. A computer program pertaining to the projected data analysis would simplify this process and allow for different cross-tabulations to be made between demographic characteristics and the questionnaire responses.

Roles and Relationships of Office of Prevention, Information and Training in Needs Assessment

As suggested by the Riesett report, the State Office of Prevention, Information and Training must continue to develop their relationships with the local CSBs and increase their leadership in areas pertaining to training and staff development. To do so, they must successfully deal with several needs assessment issues facing them and develop their expertise in carrying out the roles of broker, technical consultant and advocate.

Issues

Professional Autonomy.

Although the Rockbridge CSB volunteered to have the multi-method framework field tested in their CSB, and were extremely cooperative throughout the field testing, that stance would probably not be duplicated in many CSBs across Virginia at this time. The issues relating to professional autonomy, both on the part of individual mental health/mental retardation professionals and individual CSBs, are very strong and frequently are used to avoid review of professional practice and cooperative ventures. There already has been many concerns stated about the State Office of Prevention, Information and Training operating in ways that transgress on local authority. The state MH/MR system is a dichotomous one

with the state of Virginia supplying a large portion of the budget of many of the CSBs and thus seeking accountability from them on programatic and financial issues while at the same time allowing CSBs to have extensive local autonomy and decision making.

Low Budget Priority for Training and Staff Development

The State Mental Health and Mental Retardation System is facing a period of financial austerity and budget cutting. Typically, the budgets for training and staff development are the first categories that are reduced or even eliminated.

Need Assessment Competencies

The last issue facing the State Office is the recognition that most professional staff members of a CSB have not been trained in the concepts and methodologies of needs assessment. Without increased expertise in this area, most CSBs will use a needs assessment method that is the most convenient and/or has a high utility for their use, especially in terms of time involved and cost effectiveness, but which may not produce valid need statements.

Roles and Responsibilities of State Office

The roles that the State Office can best carry out in relation to needs assessment and training and staff development are those of broker, consultant, and advocate.

Broker

The State Office can implement its Five Step Training and Staff Development Plan for the assessment and planning of

training and staff development programs by coordinating the functioning of Regional Training Committees.

Technical Consultant

The role of technical consultant can be implemented in several ways. First, local CSBs could be assisted in becoming aware of the strengths and weaknesses of various needs assessment models and issues related to the carrying out of needs assessment through training on this subject supplied by the State Office. In addition, the multi-method framework developed in this study could be packaged for use by CSBs as a framework that has proven utility and reasonable cost-effectiveness in assessing the training and staff development needs of the professional staff of a CSB. The State Office can (a) offer training to each Training Director on needs assessment procedures, (b) supply copies of the Operations Manual and forms necessary to employ the multi-method framework, (c) develop a response sheet for the questionnaire that can be optically scanned, and (d) develop a computer program that can be used to summarize and evaluate the responses on the questionnaire.

Advocate

If the State Office would collect data yearly that pertained to the training and staff development needs of CSBs within each region of the state, they then could provide each local CSB with a data base to use in planning training and

staff development needs and in requesting monies for training and staff development projects. Also, the State Office could work in conjunction with the boards of local CSBs in order to lobby within the system to see that monies for training and staff development funds are not decreased and are in fact increased. The development of a data base by the Regional Planning Committees on training and staff development needs of professional staff would facilitate this process.

This was a latent goal of the Rockbridge CSB in terms of participating in this research. They recognized the necessity for continued training and staff development and felt hindered by: (a) the lack of a clearly stated, CSB-wide list of training and staff development needs, and (b) the lack of monies to carry out the training and staff development desired. The attitudes of the staff members participating in the Rockbridge field testing were influenced by their hope that the needs assessment would allow them to know more about their training and staff development needs and that additional monies might be allocated to their CSB for training and staff development.

Recommendations

Based on the research carried out, recommendations can be made on (a) the dissemination of the worth and utility of the multi-method needs assessment framework field tested in this study, (b) the revisions that should be made in each of

the three methods that will make the assessment processes more efficient, and (c) further research that can be carried out on needs assessment models pertaining to community mental health/mental retardation professionals.

The State Office of Prevention, Information and Training now has available to it a field tested multi-method framework that could be used with each of the 40 CSBs to generate lists of the training and staff development needs of community mental health and mental retardation professionals. This research should be shared with the 40 CSBs in a manner that is facilitative to the implementation of the Five Step Plan for Training and Staff Development.

Prior to its use in another CSB, the multi-method framework should be revised in several minor ways. The Self-assessment Questionnaire should be expanded by 10-15 competencies to include competencies specific to professional staff members working with substance abusers. This was the only area in which the list of generic competencies appeared to be deficient. In addition, questionnaires pertaining to specific competencies in each of the three areas of clinical, prevention and consultation, and administration could be developed and used for additional self-assessment with selected staff members. There has been research employed in each of the three areas that could be used to guide the development of these competencies.

Further field testing of the questionnaire would

provide comparison data about the hindrance rates of mental health/ mental retardation professionals on specific competencies. Standard deviations should be computed to show the range of variance on each competency. Cross-tabulations could be performed on hindrance ratios and various demographic characteristics.

A computer program should be developed that will analyze the responses to the Self-assessment questionnaire. This would greatly facilitate the analysis of the data. In addition, the response sheet for the questionnaire should be designed so that it could be optically scanned and thus greatly reduce the staff time involved in recording and recoding responses from individual questionnaires. If this were done by the State Office, this service would be a concrete one that could be made available to each CSB by this office and which would facilitate the collection of data from CSB's across the state so that data may be compared and used by the Regional Training Committees in their program planning.

The Performance Evaluation method needs to be reviewed by representatives of each CSB to determine if it is feasible for these processes to be standardized across the state to some degree. The processes do not have to be identical but should be similar enough to allow this method to generate data in formats that will allow aggregate data on the training and staff development needs from each CSB to be

compared.

The terminology utilized in the needs statements generated by each of the three methods needs to be standardized as much as possible to allow for the comparison of need statements. One process that might facilitate this would be to utilize the competencies from the Self-assessment Questionnaire in each of the three methods. The supervisors who write the performance evaluations could be asked to include statements from this list as frequently as possible in their evaluations. The Training Assessment Committee members could nominate their original list of needs in conjunction with the terminology used in the competency statements. They should not be restricted to only nominating needs from this list, but should use the list as a guide in the wording of need statements as frequently as possible.

The Self-assessment questionnaire needs to be normed in terms of establishing the median hindrance rates for each of the competencies. The reliability of the questionnaire has not been established. Additional research should be carried out in terms of the items on this instrument as well as ways to validate the data collected from this method. This method is the most cost-effective method among the three and should be improved as much as possible.

Research needs to be done on the multi-method framework that involves different and more specific quantitative research designs. A factor analysis of the questionnaire

items and responses following completion by approximately 1000 community mental health professionals would provide useful information on their use of generic competencies and the needs of community mental health/mental retardation professionals in Virginia.

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APPENDIX A

MEMBERSHIP ROSTER OF THE VALIDATION PANEL

VALIDATION PANEL

Chico Costin, Prevention Coordinator
Hampton-Newport News Community Services Board
Suite 202
1520 Aberdeen Road
Hampton, Virginia 23666

Betty Martin, Training Director
Southwest Virginia Training Center
2100 Stepping Stone Square
Chesapeak, Virginia 23320

John Sabean, Director
Prevention Services
Mental Health Services of the Roanoke Valley
920 S. Jefferson Street, Suite 400
Roanoke, Virginia 24016

William Vogel, CSB Facility Liasion
Health Services Area 5
Virginia Department of Mental Health and Mental Retardation
P.O. Box 1797
Richmond, Virginia 23214

Carla Fortunato
Substance Abuse Services of the New River Valley
201 South Main Street
Blacksburg, Virginia

Glen Fisher, Director of Training
ADAPTS
1005 W. Brooklyn Park Blvd.
Suite 101
Richmond, Virginia 23220

Ken Micurik, Assistant Director for Training and Education
Virginia Department of Mental Health and Mental Retardation
P.O. Box 1797
Richmond, Virginia 23214

APPENDIX B

Operations Manual
Multi-method Needs Assessment

Self-assessment Questionnaire

A NEEDS ASSESSMENT FRAMEWORK: THE TRAINING AND STAFF DEVELOPMENT NEEDS OF COMMUNITY MENTAL HEALTH PROFESSIONALS

An Operations Manual

DRAFT VERSION FOR USE IN FIELD TESTING
10 January 1985

Dennis Cogswell, ACSW
Doctoral Candidate:Virginia Tech
For Dissertation Requirements

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Introduction

This manual has been designed to guide Training Directors in Community Services Boards to assess the training and staff development needs of the professional staff in the agency. This process is important in that training and staff development programs should be based upon accurate information about the learning needs of community mental health professionals rather than established by uninformed decision makers in the role of workshop leaders and program developers.

This manual contains step-by-step instructions on the use of three different needs assessment methods that will allow for the assessment of training and staff development needs of professional staff throughout the CSB. The data collected by this framework will be used by the CSB and the State Office of Prevention, Information and Training through its Regional Committees to plan Training and Staff Development programs for mental health professionals around the state. Three different methods are used because research has shown that data collected by only one method frequently does not accurately identify the learning needs that exist. The three methods that will be employed are: (1) the review of performance evaluations, (2) the use of a Training Assessment Committee and (3) the use of a ___ item questionnaire that deals with knowledge and abilities related

to the central roles of community mental health professionals. A summary of the rationale for each method is listed below.

Performance Evaluation Method

Each CSB in Virginia employs some form of a performance evaluation system where professional performances are rated in a summary fashion by supervisors and other administrative personnel. In addition to being used in relation to salary and other personnel issues, this process can yield useful data in for assessing the staff development and training needs. As the state of Virginia does not employ a standardized performance evaluation system, the analysis of data from these evaluations must be done in a way that takes into account a diverse system that varies from CSB to CSB in the way that evaluations are carried out and written.

Training Assessment Committee Method

All work groups have key members of their system who are at the center of information and decision making within a unit. Through the use of a nominal group assessment technique, these persons can work to provide a ranked list of the learning needs of the professional staff of a CSB in relation to (1) Clinical, (2) Prevention and Consultation and Administration Training and Staff Development Needs.

Questionnaire Method

A questionnaire has been developed to allow each staff member to evaluate his/her knowledge and skills in relation to clinical, prevention and consultation and administration training and staff development needs. After respondents are asked for standard demographic information, they are then asked to respond to 150 MH/MR competencies in terms of: (1) frequency of usage of this knowledge/skill (How often do you deal with situations requiring this ability?) and (2) frequency of when additional knowledge/skill would have been helpful to the service provider (How frequently would additional skill/knowledge pertaining to this competency have been helpful to you?

How to Use This Manual

This manual contains step-by-step instructions for each of the assessment methods. As Training Director of your CSB you will serve as the coordinator of this project and provide the leadership for two ad hoc committees and the administration of a questionnaire with the entire professional staff. Pages 3 to 4 of the manual give you step-by-step instructions on the use of the manual. Forms to be used throughout are placed in the Appendix of the manual on pages 28-37. The last section of the manual contains a copy of the questionnaire that is to be given out to all professional staff members employed by or under contract to

the CSB. Prior to beginning the assessment process, you will be offered training in use of each of the assessment process by the Office of Training, Information and Prevention. If consultation is needed during the course of your assessment, please contact Ken Howard in the Office of Training, Information and Prevention.

The Multi-method Assessment Process

Step One: Beginning the Needs Assessment Process

The Executive Director of each CSB will appoint a staff member to be the coordinator of the needs assessment process and the CSB's representative on the Regional Staff Development Committee. For almost all the CSB's, this person will be the staff member who serves as Training Director. At the same time, the Executive Director will notify the entire professional staff about goals and objectives of the project and will request that they work with the Training Director to see that an accurate assessment of training and staff development needs is accomplished. This announcement can best be carried out by discussion at staff meetings throughout the CSB following the receipt of a memo by each professional staff member. A sample cover letter is found on pages 22-23 of the Appendix of this manual.

Step Two: Organization of the Needs Assessment

The first task of the Training Director is to develop a

list of those professional persons who will be participating in the assessment process. The list should contain the names and job titles of all those individuals who hold professional or paraprofessional positions and who are employed directly by the CSB or by an agency under contract to the CSB. Clerical and office support staff are not included in this definition; administrators and supervisors with responsibilities for the provision of professional services at all levels of the system are included. The goal of the process is to collect summary data about the training needs of staff collectively throughout the CSB. It is not the intent of the process to link a specific need with specific individuals. The list of names is needed to administer the questionnaire and to review the disguised performance evaluations.

The second task is to schedule a timetable of events for the data collection process. This timetable should be construed so that it can be completed within a one month timespan. A sample timetable is contained on page 19 of this manual. A checklist of major tasks that must be accomplished is contained on pages 20-21 following the timetable. Once the timetable has been developed, a letter should be sent to all professional staff explaining the goals of the project, the general timetable as it applies to them, and requesting their involvement. A sample introductory letter is contained

on pages 24-25 of the Appendix to this manual.

Step Three: Performance Evaluations

3A.

Secure from the appropriate office within the CSB a copy of the latest performance evaluation of each professional staff member. As confidentiality is a key concern in relation to this process, the copies to be reviewed should have all identifying information such as name, and job title removed or covered . The exception to this standard would be if all members of this committee would typically see all professional evaluations as a result of their position in the CSB. These evaluations should not be shared with the committee members prior to the first meeting of the committee.

3B.

Appoint two other staff members from the CSB to serve with you on the ad hoc committee for assessing learning needs from these evaluations. These two members of the committee should be selected on the basis on their professional and personal qualifications. They should have had at least several years experience within the CSB, have held both clinical and administrative responsibilities, be from different programs of the CSB and preferably should have had some professional experience in training and staff development. The goal of this committee is to list the

training and staff development needs of the professional staff as indicated through the performance evaluations for the areas of (1) clinical, (2) prevention and consultation, and (3) administration. This committee should need to meet only once or twice in order to accomplish their tasks.

3C.

Begin the first meeting by reviewing and clarifying the objectives of this needs assessment process. Discuss the process the committee will follow in their work. Once these are clarified and agreed upon, the assessment can begin.

Each committee member, within the committee setting, should individually review the evaluations, and make notes about the (a) strengths, (b) weakness, and (c) recommendations noted in the evaluation that could be remedied by training or staff development. When possible, the exact words of the supervisor should be copied in the notes. Then, as a group, the committee will seek to identify recurring themes and patterns in the evaluations that can be related to (1) clinical, (2) prevention and consultation and (3) administration training and staff development needs.

3D.

Once each committee member has a list of training and staff development needs in relation to each of the three areas, the Training Director will write them on newsprint so each list can be viewed by the entire group. Then, through

discussion and consensus voting, a master list will be developed with a corresponding compilation of the number of times each need was identified in the individual evaluations. These needs then should be divided into the categories of (1) clinical, (2) prevention and consultation and (3) administration needs and rank ordered within each category according to frequency.

3E.

The last task of the committee is to write a descriptive and/or clarifying statement about each of the needs that will then be contained in the final report. Once this is accomplished, the committee can be dismissed with the Training Director carrying out the next step on his/her own.

3F.

The Training Director should write a summary report listing up to ten of the top ranked needs in each of the three categories. Included with each need statement should be a statement of clarification for each need. This report will be utilized in writing the final summary section on Training and Staff Development Needs of the professionals in the CSB.

Step Four:Training Assessment Committee Method

4A.

The membership of the Training Assessment Committee should not be larger than 12 members. The optimal size of the committee should be between 8 and 12 voting members. The

Training Director serves as the coordinator of this committee in a non-voting role and his/her membership on the committee should not be counted towards the total number of voting members. Instead of using standard divisions according to programs, the CSB may be divided into any number and size of units that is deemed appropriate in order to obtain the best total representation. The actual selection of members for this committee should be done by those persons within the divisions established by the Training Director. Each division should select one representative, with the total number not exceeding twelve.

4B.

This committee will meet twice with each meeting lasting two to four hours. The first meeting will involve the nomination and rank ordering of needs and the second session will involve a discussion of the needs that are assessed in order to add an explanation or description of each need. Prior to the first meeting of this committee, each member of the committee should be mailed a list of committee members, a statement of the objectives of the committee and an explanation of the processes to be employed in the assessment process. A sample cover letter that may be utilized is contained on page 26-27 of the Appendix of this manual.

4C.

Prior to the beginning of the first meeting, secure newsprint, 400 three by five note cards, pencils and magic markers for use in the assessment processes. Seat the committee in a circular setting, around a series of tables, where each has his/her own space to write and where each can see the newsprint used to record the needs that are nominated. Begin the meeting with an exercise to introduce the committee members to each other. Present the objectives of this committee and the processes to be used in the nomination and ranking of needs. Explain why each member was chosen, the research underway and the theory and processes of the nominal group technique.

4D.

When the group is ready to proceed with the assessment, make a paraphrasing of the following statement (Delbecq,Van de Ven & Gustafson,1975, p. 45):

> You will notice that the question which is the focus of our meeting is the following: What are the training and staff development needs of professional staff within your program unit in relation to the areas of clinical issues, prevention and consultation and administrative issues?

I would like each of you to take ten minutes to list your ideas in response to this question, in a brief phrase or a few words, on the worksheet [Worksheet 1] in front of you (see page 28 for a copy of the worksheet to be given each member). Please work independently of other members in identifying the training and staff development needs of the professional staff of your program unit in relation to each of these areas During this period of independent thinking I ask that you not talk to other members, interrupt their thinking, or look at their work sheets. Since this is the opportunity for each of us to prepare his or her contributions to the meeting, I would appreciate intense effort during the next ten minutes. At the end of the ten minutes, I will call time and suggest how we can proceed to share our ideas. Let's proceed then with our individual effort for the next ten minutes.

4E.

At the end of ten minutes, reconvene the group and go around the table to each member one at a time asking for one need for each of the three categories: (1) clinical, (2) prevention and consultation and (3) administration. The needs reported should be recorded on newsprint for all members to see; no discussion is allowed. This process continues in a circular fashion until no more needs exist to be nominated.

[Operations Manual Page Eleven]

4F.

When all the needs have been recorded, read each one out loud and ask for clarification, allowing members to make statements of agreement and disagreement in relation to the need, its parameters, and degree of importance. Individuals should not be asked to clarify their own ideas; clarification is a group task. If there is not unilateral agreement in which of the three categories a specific need is to be placed, the actual placement of the need should be decided by a majority vote of the group.

4G.

The next task involves selecting the needs that have the highest priority in relation to the CSB in relation to each of the three areas listed above. Each of the next steps should be repeated for each of the three subject areas. Begin this process by paraphrasing or repeating these instructions (Delbecq, et.al, 1975, p. 58):

> We have now completed our discussion of the entire list of ideas, have clarified the meaning of each idea, and have discussed the areas of agreement and disagreement. At this time, I would like to have the judgement of each group member concerning the most important ideas on the list in relation to each category.

To accomplish this step I wonder if each of you would take thirty 3 X 5 index cards (The leader hands a set of index cards to participants at the table).
I would like you to select the ten most important items from our list of ____ items in relation to the Clinical Training and Staff Development Needs. This will require careful thought and effort on your part.

As you look at the flip chart sheets and find an item which you feel is very important, please record the item on an index card. (The leader goes to the flip chart and draws an index card).

Please place the number of the item in the upper left-hand corner of the card. For example, if you feel Item 13 is very important, you would write C13 in the upper left-hand corner. (The leader writes C13 in the upper left-hand corner of the card he has drawn on the flip chart; C stands for Clinical, PC stands for Prevention and Consultation and A stands for Administration).

Then write the identifying words or phase on the card. (The leader writes the phrase for item 13 on the card).

Do this for each of the ten most important items from our list of _____ items. When you have completed this task, you should have ten cards, each with a

separate phrase written on the card and with identifying numbers using the numbering system from our list of ideas on the flip chart.

Do not rank-order the cards yet. Spend the next few minutes carefully selecting the ten cards. We will all rank-order the cards together. Are there any questions ?

The same set of instructions should be given for the remaining categories of Prevention and Consultation, and Administration Training and Staff Development Needs. [See Appendix, page 29 for a Sample 3 x 5 Card].

4H.

The next step is to assist the members in rank ordering the needs for each category using the set of priority cards. Instruct them to decide which need is most important and then to write a number 10 in the lower right hand corner of the card containing that need and then circle that number. Ask them to chose the next most important need, giving that a weight of 9 and so on until all ten individually identified needs are ranked. Collect the cards, and then announce that a ten minute break of the committee will be held here. Do not allow more than this time unless absolutely necessary.

During this break, shuffle the cards, and record the rank order scores of each item number from each of the cards on newsprint. This ranking might look like this:

Clinical Training and Staff Development Needs

Item one	7-4-2
two	5
three	9-10-6
four	1-4-4-7
etc.	

This step is repeated for the other two categories.

4I.

Once this listing is written on newsprint, reconvene the committee and invite the group members to discuss the preliminary vote. Limit the discussion to clarification and note the clarification on newsprint. Resist pressure to get committee members to change their votes.

4J.

In the final assessment step, ask committee members to vote for the most important items using the Rating Form For Nominal Group Final Voting [Worksheet 2A,2B,2C] (see pages 30-32 of the Appendix of this manual). Hand out these forms at the beginning of this step. Sufficient copies of this form for use with this committee will be supplied by the Office of Prevention, Information and Training for use with this assessment method.

Next, collect the Rating Forms and thank the committee members for their work. Tell them the date, time, and location of the next meeting. The summation of the rankings

will be given to then at that time.

4K.

As soon as possible after the first meeting, summarize the rankings given you by the key informants using the form entitled Summary Ranking of Training and Staff Development Needs. This is a three page form, found on pages 34-36 of the Appendix. Items are to be ranked on this sheet from highest to lowest importance. A sample completed worksheet for Clinical Training Needs is contained on page 33 of the Appendix.

A copy of this summary should be given to each committee member at the beginning of the second meeting. To avoid further discussion or ranking outside of the confines of the committee, this information should not be shared with any member prior to the meeting.

4L.

Reconvene the last session of the committee at the date and time announced at the end of the last session. Begin the meeting by passing out the summary rankings and following several minutes of quiet for committee members to read the summary, involve them in a discussion of each of the needs listed for the purpose of clarifying and adding an explanation of the need listed. Record these statements recorded on newsprint for use in the final summary report. A tape recorder may be used in this session to give a backup

system of information for writing the final report. Once the clarification process is completed, thank the committee for their work and tell them that a final copy of this process will be sent to each member.

4M.

As the final step, write a final report that lists the top ranked needs in terms of each of the areas of (1) clinical, (2) prevention and consultation and (3) administration. Following each statement of need, the clarification statement relating to each need that was developed by the key informant group should be listed. Send a copy of the report to each committee member, and keep a copy for use in writing the final summary report.

Step Five: Administering the Questionnaire

5A.

Secure enough copies of the questionnaire for each professional staff member. Distribute the questionnaires to the appropriate supervisors and instruct them in how the questionnaire is to be completed by individual staff members. With each supervisor, plan a distribution and collection process that will allow the questionnaire to be distributed by the appropriate supervisor, completed by the staff member, returned to the supervisor and then returned to you within ten days. Give out the questionnaire during the first ten days of the overall assessment time frame to the appropriate

supervisors for distribution and collection. This will allow for follow-up to be done with those few individuals who do not fill out the questionnaire in the 10 days. It is estimated that it will take each staff member less than one hour to fill out the questionnaire.

5B.

Once all the questionnaires have been returned, utilize the program supplied to you by the Office of Prevention, Information and Training in your computer system to analyze the data and generate a report that includes tables and other summary statements including a ranking of the top 10 needs identified in relation to each of the three categories of (1) clinical, (2) prevention and consultation and (3) administration training and staff development needs.

Step Six: Writing of the Summary Report

6A.

Take each of the lists of training needs and accompanying narrative generated by each of the three assessment methods and write a Master Summary Report. Section One of that report should contain the three individual reports as they were written. Section Two will be a grand summary of the total assessment. It should summarize the high priority needs assessed for the areas of (1) clinical, (2) prevention and consultation and (3) administration training

and staff development needs, and compare the findings from the different methods. It is possible that different needs will be identified by the different methods. Where there is agreement on needs and priorities for each of the three areas, identify these. Where there is disagreement, indicate this in your narative. End your Grand Summary by include any summarizing analysis you wish to make in relation to the needs identified by the multi-method framework.

6B.

Send copies of the final report to the Regional Training Committee for that region of the state, the Office of Prevention, Information and Training, and the Executive Director of the CSB.

APPENDIX

Sample Timetable for Multi-method Needs Assessment

January 4, 1985: Cover letter and timetable sent to all professional staff members.

January 10, 1985: Ad hoc committee using performance evaluations needs assessment process meets.

January 11, 1985: Questionnaires distributed to all professional staff members through immediate supervisors.

January 14, 1985: First Meeting of Training Assessment Committee

January 20, 1985: Questionnaire Returned to Training Director by all Professional Staff Members.

January 23, 1985: Second Meeting of Training Assessment Committee

January 28, 1985: Final Summary Report Written by Training Director With Copies Made Available to Professional Staff.

January 31, 1985: Needs Assessment Process Completed!

CHECKLIST
NEEDS ASSESSMENT TASKS

The following checklist contains the major steps in the multi-method assessment process. Although they are listed in an approximate order of completion, they may be completed in a different sequence than is listed here.

___ Executive Director of CSB appoints a Training Director to coordinate the multi-method needs assessment process.

___ Executive Director informs professional staff of the project and generally explains the assessment methods.

___ Training Director establishes a timetable pertaining to the employment of the three assessment methods.

___ Training Director develops a list of all the professional and para-professional staff that will be participating in the project.

___ Training Director sends a letter to all professional staff outlining the specific steps of the needs assessment process and the timetable of event.

___ Training Director selects the ad hoc committee to review the Performance Evaluations.

___ Training Director coordinates the selection of the Training Assessment Committee that will employ the nominal group method in assessing training needs.

___ Performance Evaluations are prepared for use by the Performance Evaluation Assessment Committee in the needs assessment.

___ Performance Evaluation Committee meets and assesses training needs.

___ Training Director prepares distribution/collection plan in relation to the questionnaire that goes to professional staff.

___ Questionnaire is distributed to all professional and para-professional staff members for completion along with the due date for returning it to their appropriate supervisor.

___ Training Director prepares materials to be used with the Training Assessment Committee in the nominal group process.

___ Training Assessment Committee meets for the first time and nominates needs through the nominal group method.

___ Training Director tallies the final (second) vote of the Training Assessment Committee and prepares the preliminary report that goes to this committee at the beginning of their second meeting.

___ Training Assessment Committee meets for the second time.

___ Questionnaires are returned to the Training Director and the results analyzed.

___ Training Director writes the summary report regarding the needs identified and ranked by the Performance Evaluation Committee.

___ Training Director writes the summary report regarding the needs identified by the Training Assessment Committee.

___ Training Director writes the summary report regarding the needs identified by the Questionnaire.

___ Training Director takes the three summary reports and combines them into the Final Report.

___ Copies of the final report are distributed to the professional staff, the Executive Director, the Regional Training Committee, and the Office of Prevention, Information and Training.

___ The Training Director Rests!!

SAMPLE COVER LETTER TO PROFESSIONAL STAFF
FROM THE CSB EXECUTIVE DIRECTOR

Dear _____:

Our agency is participating in a project sponsored by the Office of Prevention, Information and Training of the State Office of Mental Health and Mental Retardation to design and provide training and staff development opportunities for professional staff in community mental health centers in relation to the learning needs of professional staff. The first step in this process is the assessment of the these needs which will be done through a multi-method needs assessment process that will involve all professional staff members in three related processes that will identify training and staff development needs.

To coordinate our needs assessment process, I have appointed _____, Training Director to coordinate our activities. The process will involve up to one hour of each staff members time in filling out a questionnaire and additional time by several other staff members to serve on two ad hoc committees. I think that you will find the entire process interesting and that it will help develop more effective training and staff development programs. You will be hearing from _____ shortly in relation to the month long needs assessment process in our agency. Please give him(her) your full cooperation.

Sincerely,

[Operations Manual Page Twenty-three]

SAMPLE COVER LETTER FROM TRAINING DIRECTOR TO PROFESSIONAL STAFF

Dear _____:

The assessment of training and staff development needs of professional staff is about ready to begin. This process will involve selected staff members in serving on two ad hoc committees and each of you in filling out a questionnaire. Research suggests that needs assessment of training and staff development needs be done through the use of more than one method and the data collected and correlated. A brief summary of the three methods we will be using is as follows:

Needs Assessment Using Performance Evaluations. Our performance evaluation system where professional performances are evaluated can yield useful data in relation to assessing the training and staff development needs of professional staff. A three person committee has been selected (list the names of committee members) to review each of the performance evaluations and assess the training and staff development needs that these evaluations indicate. The identifying data from each employees evaluation has been removed in order to preserve your confidentiality. The committee is interested only in CSB-wide pattern and trends.

Needs Assessment Using a Training Assessment Committee. All work groups have key members of their system that are in a position to be at the center of information and decision making within a unit. Brought together, and through the use

these persons can work to provide a list of the learning needs of the professional staff of a CSB. A ____ person Training Assessment Committee to represent all the various parts of our CSB has been selected. Included in this committee are: (list committee members). They will be meeting twice to nominate training and staff development needs and will welcome your input.

Needs Assessment Through Use of a Self-assessment Questionnaire. A questionnaire has been developed that will allow each staff member in less than an hour to evaluate his knowledge and skills in relation to knowledge and ability areas related to professional practice. You will be asked to rate each knowledge area/ability as to:

1. How often do you deal with situations requiring this ability?

2. How frequently would additional knowledge/skills pertaining to this competency have been helpful to you?

Enclosed a copy of the timetable for our CSB needs assessment. The results of this needs assessment will be used to plan training and staff development programs locally and regionally. This will benefit each professional staff member and help improve the quality of services that we offer. You will receive a copy of the final report that are written once we assess our learning needs.

Sincerely,

[Operations Manual Page Twenty-five]

SAMPLE COVER LETTER TO TRAINING ASSESSMENT COMMITTEE MEMBERS

Dear _____

Thank you for agreeing to represent _____(list program unit(s) they are representing) in our center-wide training and staff development needs assessment. All work groups have key members who are in a position to be at center of information and often decision making within a unit. It is felt that you are one of those persons. Along with other committee members, you have have agreed to meet twice during the next month to nominate and then rank order training and staff development needs of yourself and your colleagues for these areas: (1) clinical, (2) prevention and consultation and (3) administration.

The first meeting will involve the nomination and rank ordering of needs and the second session will involve a discussion of the needs that are assessed in order to add an explanation or description of each need. In order to prepare yourself for the first meeting which will be held on _____ at _____ in _____, discuss with your colleagues their training and staff development needs in relation to the three categories listed above. In the first meeting you will be asked to write out identified needs that will be listed on newsprint for all committee members to view. Using an

assessment technique called the nominal group method that has been used extensively in similar projects in human service agencies across the country, you will as a group nominate needs, discuss them and then through a voting procedure rank order them. I am acting as Coordinator of this ad hoc committee and will lead you through these steps in our first meeting.

Following the first meeting, we will then meet again for the last time on _____ at _____ to discuss and provide background information on each need that was nominated. Our final product will be a report that will go to _____, Executive Director, the Regional Staff Development and Training Committee and the State Office of Prevention, Information and Training. A copy of the report will also be sent to you to share with your program unit.

I look forward to working with you on this project. I will see you on _____ at _____.

Sincerely,

WORKSHEET NUMBER ONE
PRELIMINARY NEEDS ASSESSMENT NOMINATING FORM

In one sentence or less, list any training or staff development needs that you feel are possessed by yourself or other professional staff members:

Clinical Needs

1.

2.

3.

4.

5.

6.

Prevention and Consultation Needs

1.

2.

3.

4.

5.

6.

Administration Needs

1.

2.

3.

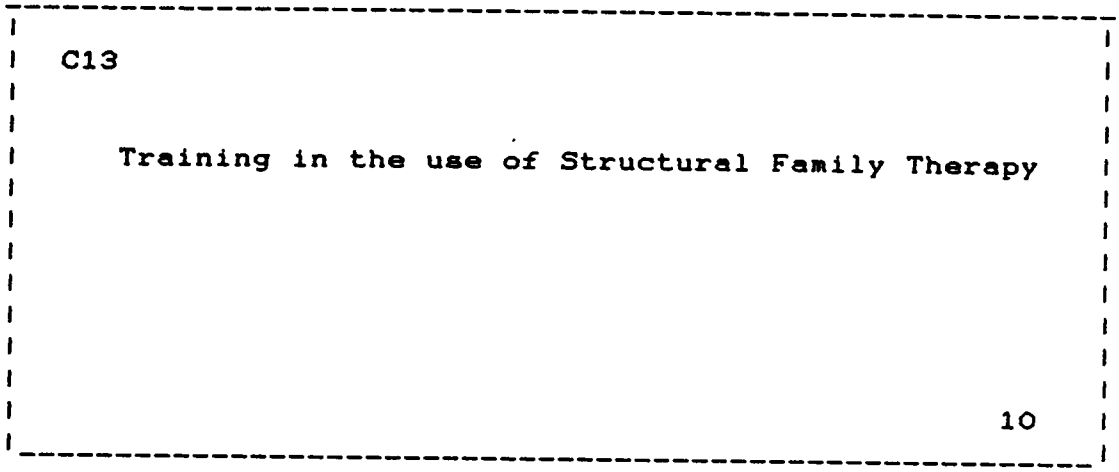
4.

5.

6.

SAMPLE NOTECARD TO BE USED

IN NOMINAL GROUP PRELIMINARY VOTING



C13 = The number of the item listed on the newsprint that the rater has chosen to rate in the top ten.

10 = The rank (weight) this rater places on this item. In this case, 10 represents the maximum and thus the most important of the Clinical Training Needs.

WORKSHEET 2A
A RATING FORM FOR NOMINAL GROUP FINAL VOTING

Clinical Training and Staff Development Needs

Instructions:
Chose the ten most important items from the flip chart, and list them in rank-order above. Identify the items by using the number and description from the flip chart.

No. from flip chart	Item Description	Rank
------		10
------		9
------		8
------		7
------		6
------		5
------		4
------		3
------		2
------		1

WORKSHEET 2B
A RATING FORM FOR NOMINAL GROUP FINAL VOTING
Prevention and Consultation
Training and Staff Development Needs

Instructions:

Chose the ten most important items from the flip chart, and list them in rank-order above. Identify the items by using the number and description from the flip chart.

No. from flip chart	Item Description	Rank
------		10
------		9
------		8
------		7
------		6
------		5
------		4
------		3
------		2
------		1

WORKSHEET 2C
A RATING FORM FOR NOMINAL GROUP FINAL VOTING
Administration Training and Staff Development Needs

Instructions:

Chose the ten most important items from the flip chart, and list them in rank-order above. Identify the items by using the number and description from the flip chart.

No. from flip chart	Item Description	Rank
------		10
------		9
------		8
------		7
------		6
------		5
------		4
------		3
------		2
------		1

SAMPLE OF COMPLETED WORKSHEET)
WORKSHEET 3A

SUMMARY RATING SHEET
TRAINING AND STAFF DEVELOPMENT NEEDS
Clinical

Instructions: Take each item listed on each of the rating sheets for the Clinical area and compute a total rating. Also list the number of times each item received a rating. On this sheet list the top ten items, ranked according to the weighted score. Include a description of each need, the number of votes per item, the specific weight given the item by each rater who ranked it and the total of the rankings given each item.

Item	# of Votes per Item	Individual Votes	Total Weighted Votes
13C: Structural Family Therapy: models and techniques to use.	7	10,10,4 6,8,6,8	52
2C: Knowledge of various group intervention theories.	7	9,9,5,5 7,2,8	45
7C: Working with personality-disordered clients: models and techniques	6	10,7,7,7 6,7	43
18C:Use of fee payments as a therapeutic intervention.	8	2,4,3,9,7 4,5,5	39
4C: Ability to use behavioral modification theories in the management of clients with DD.	4	9,9,9,10	37
22C: Knowledge of the therapeutic effects of the most commonly used chemotherapeutic agents.	8	5,6,3,7,7 2,2,2	34
18C: Ability to write progress progress notes behaviorally.	5	5,5,5,4,5	29
9C: Ability to select and justify intervention techniques.	4	10,8,3,5	28

Note: only six listed because of space limitations.

WORKSHEET 3A
SUMMARY RATING SHEET
TRAINING AND STAFF DEVELOPMENT NEEDS

Clinical

Instructions: Take each item listed on each of the rating sheets for the Clinical area and compute a total rating. Also list the number of times each item received a rating. On this sheet list the top ten items, ranked according to the weighted score. Include a description of each need, the number of votes per item, the specific weight given the item by each rater who ranked it and the total of the rankings given each item.

Item	# of Votes per Item	Individual Votes	Total Weighted Votes
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----

WORKSHEET 3B
SUMMARY RATING SHEET
TRAINING AND STAFF DEVELOPMENT NEEDS

Prevention and Consultation

Instructions: Take each item listed on each of the rating sheets for the Clinical area and compute a total rating. Also list the number of times each item received a rating. On this sheet list the top ten items, ranked according to the weighted score. Include a description of each need, the number of votes per item, the specific weight given the item by each rater who ranked it and the total of the rankings given each item.

Item	# of Votes per Item	Individual Votes	Total Weighted Votes
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----

WORKSHEET 3C
SUMMARY RATING SHEET
TRAINING AND STAFF DEVELOPMENT NEEDS

Administration

Instructions: Take each item listed on each of the rating sheets for the Clinical area and compute a total rating. Also list the number of times each item received a rating. On this sheet list the top ten items, ranked according to the weighted score. Include a description of each need, the number of votes per item, the specific weight given the item by each rater who ranked it and the total of the rankings given each item.

Item	# of Votes per Item	Individual Votes	Total Weighted Votes
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----
	-----	-----	-----
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TECHNICAL AND ADMINISTRATIVE SUPPORT

KEY CONTACT PERSONS

Office of Prevention, Information and Training

Ken Howard, Assistant Director
Training Resource Development and Networking
Department of Mental Health and Mental Retardation
P.O. Box 1797
Richmond, Virginia 23214

College of Education, Virginia Tech
%Dennis Cogswell, Research Consultant
P.O. Box 5762
Radford, University. Virginia 24142

TRAINING AND STAFF DEVELOPMENT NEEDS

AN INVENTORY FOR COMMUNITY MENTAL HEALTH PROFESSIONALS

A SELF-ASSESSMENT QUESTIONNAIRE

This questionnaire has been designed to provide community mental health/mental retardation/substance abuse professionals with a method of assessing their professional training and staff development needs. All professionals opertate from the awareness that continued professional development is important in relation to their ability to deliver quality mental health/mental retardation/substance abuse services.

The questionnaire contains 150 competencies that research has shown are generic to a wide variety of mental health, mental retardation and substance abuse professionals. You will be asked to respond to each competency in terms of two questions: (1) How often do you deal with situations requiring this? (2) How often would additional knowledge/skill pertaining to this competency have been helpful to you? Following each questions, you will circle a number that applys to your answer:

N/A	Seldom	Quart-erly	Once month	Once week	Every day
0	1	2	3	4	5

Some of the competencies will not apply to your present professional position. Use the N/A response (Not Applicable) if a specific competency does not apply to your professional responsibilities. For example, only psychologists do psychological testing and usually only mental retardation specialists relate to competencies in that area. A N/A response will usually mean that you will make no response to the second question. However, if additional knowledge/skill in a particular area would allow you to use this competency, than you may wish to respond to the second question.

The first page of the questionnaire asks you for basic information about yourself. The data collected will be compiled on your entire CSB's professional staff and individual responses will not be identified. We are interested in the main learning needs of the entire CSB, not just one individual. There are no right or wrong answers. All professionals have training needs; this process is one method to help you and others learn what those are.

This questionnaire has been used by other community mental health professionals like yourself who have validated the questions and who used approximately an hour or less to respond.

Thank you for your time and contribution to the professional development of community mental health professionals throughout Virginia.

Office of Prevention, Information and Training
Virginia Department of mental health and Mental Retardation

DRAFT VERSION FOR USE IN FIELD TESTING
JANUARY 1985

Dennis Cogswell, ACSW

TRAINING AND STAFF DEVELOPMENT NEEDS

AN INVENTORY FOR COMMUNITY MENTAL HEALTH PROFESSIONALS

AGE: 20-25 ___ 26-30 ___ 31-35 ___ 36-40 ___ 41-45 ___

46-50 ___ 51-55 ___ 56-60 ___ 60-65 ___ 65+ ___

SEX: FEMALE ___ MALE ___

RACE: WHITE ___ BLACK ___ OTHER ___

HIGHEST HELD EDUCATIONAL DEGREE:

ASSOCIATE DEGREE ___ BACHELOR'S DEGREE ___

MASTER'S DEGREE ___ DOCTORATE ___

M. D. ___

EDCUATIONAL MAJOR OF HIGHEST HELD DEGREE:

SOCIAL WORK ___ PSYCHOLOGY ___ NURSING ___ MEDICINE ___

EDUCATION ___ LIBERAL ARTS ___ MINISTRY ___ LAW ___

SOCIOLOGY ___ ENGLISH ___ CRIMINAL JUSTICE ___

OTHER ___ : (PLEASE LIST) _____

NUMBER OF YEARS SINCE LAST DEGREE WAS AWARDED:

1 YEAR OR LESS ___ 2-5 YEARS ___ 6-10 YEARS ___ 11-20 YEARS

21- 30 YEARS ___ 31 OR MORE YEARS ___.

PRESENT JOB TITLE: _____

NUMBER OF YEARS EMPLOYED BY THE PRESENT MENTAL HEALTH AGENCY:

1 YEAR OR LESS ___ 2-5 YEARS ___ 6-10 YEARS ___ 11-20 YEARS

21- 30 YEARS ___ 31 OR MORE YEARS ___.

DIVISION OF CSB WHERE EMPLOYED: MENTAL HEALTH SERVICES ___

SUBSTANCE ABUSE SERVICES MENTAL RETARDATION SERVICES ___

KNOWLEDGE/ABILITY	HOW OFTEN DO YOU DEAL WITH SITUATIONS REQUIRING THIS?						HOW OFTEN WOULD ADDITIONAL KNOWLEDGE/ SKILL PERTAINING TO THIS COMPETENCY HAVE BEEN HELPFUL TO YOU?				
	N/A	Seldom	Quart-erly	Once month	Once week	Every day	Seldom	Quart-erly	Once month	Once week	Every day
Clinical											
1. Ability to make on-the-spot determinations of the type and extent of service required by clients in crisis.	0	1	2	3	4	5	1	2	3	4	5
2. Ability to make professional judgements relative to client suicidal ideation.	0	1	2	3	4	5	1	2	3	4	5
3. Knowledge of the levels of severty of the abnormal behaviors.	0	1	2	3	4	5	1	2	3	4	5
4. Knowledge of psychological tests in relation to which tests are appropriate for which clients.	0	1	2	3	4	5	1	2	3	4	5
5. Ability to administer psychological tests.	0	1	2	3	4	5	1	2	3	4	5
6. Ability to interprete psychological tests and reports.	0	1	2	3	4	5	1	2	3	4	5
7. Knowledge of signs of over perscription and under prescription of chemotherapeutic agents.	0	1	2	3	4	5	1	2	3	4	5
8. Ability to use DSM-III in relation to the establishment of diagnostic criteria.	0	1	2	3	4	5	1	2	3	4	5
9. Ability to document client problems in behavior-specific terms.	0	1	2	3	4	5	1	2	3	4	5
General Counseling											
10. Ability to facilitate reality-based feedback to clients.	0	1	2	3	4	5	1	2	3	4	5
11. Ability to foster and encourage client responsibility.	0	1	2	3	4	5	1	2	3	4	5

KNOWLEDGE/ABILITY Clinical	HOW OFTEN DO YOU DEAL WITH SITUATIONS REQUIRING THIS? N/A | Seldom | Quart-erly | Once month | Once week | Every day						HOW OFTEN WOULD ADDITIONAL KNOWLEDGE/SKILL PERTAINING TO THIS COMPETENCY HAVE BEEN HELPFUL TO YOU? Seldom | Quart-erly | Once month | Once week | Every day				
12. Ability to select and justify intervention techniques.	0	1	2	3	4	5	1	2	3	4	5
13. Skill at appropriate self-disclosure in counseling.	0	1	2	3	4	5	1	2	3	4	5
14. Skill at confrontation in the counseling relationship.	0	1	2	3	4	5	1	2	3	4	5
15. Skill at demonstrating awareness of content and feeling in counseling sessions.	0	1	2	3	4	5	1	2	3	4	5
16. Knowledge of the steps for terminating a therapeutic relationship.	0	1	2	3	4	5	1	2	3	4	5
17. Ability to match techniques to personal abilities.	0	1	2	3	4	5	1	2	3	4	5
18. Ability to judge when techniques are appropriate and meaningful to the client.	0	1	2	3	4	5	1	2	3	4	5
19. Ability to recognize the client's defense mechanisms.	0	1	2	3	4	5	1	2	3	4	5
20. Ability to foster client independence and self-sufficiency.	0	1	2	3	4	5	1	2	3	4	5
21. Knowledge of the appropriate use of behavioral contracts.	0	1	2	3	4	5	1	2	3	4	5
22. Knowledge of transference and countertransference issues.	0	1	2	3	4	5	1	2	3	4	5
23. Knowledge of different aspects of short and long term counseling.	0	1	2	3	4	5	1	2	3	4	5

KNOWLEDGE/ABILITY	HOW OFTEN DO YOU DEAL WITH SITUATIONS REQUIRING THIS?						HOW OFTEN WOULD ADDITIONAL KNOWLEDGE/ SKILL PERTAINING TO THIS COMPETENCY HAVE BEEN HELPFUL TO YOU?				
	N/A	Seldom	Quart-erly	Once month	Once week	Every day	Seldom	Quart-erly	Once month	Once week	Every day
Clinical											
Family Counseling											
24. Ability to accept family decisions differing with counselor's values.	0	1	2	3	4	5	1	2	3	4	5
25. Knowledge of various family intervention theories and strategies.	0	1	2	3	4	5	1	2	3	4	5
26. Ability to assess family interaction patterns, identifying family strengths, weaknesses, needs and problems as well as their ability to resolve problems.	0	1	2	3	4	5	1	2	3	4	5
27. Ability to identify sexual abuse, including incest.	0	1	2	3	4	5	1	2	3	4	5
28. Ability to identify physical and emotional abuse or neglect.	0	1	2	3	4	5	1	2	3	4	5
29. Ability to identify adolescent alcoholics or drug abusers.	0	1	2	3	4	5	1	2	3	4	5
Group Counseling											
30. Ability to explain confidentiality and role expectations to group members.	0	1	2	3	4	5	1	2	3	4	5
31. Knowledge of various group intervention theories.	0	1	2	3	4	5	1	2	3	4	5
32. Ability to clearly define goals, structure and limits of group counseling.	0	1	2	3	4	5	1	2	3	4	5
33. Ability to assist group participants to learn effective inter-personal behavior.	0	1	2	3	4	5	1	2	3	4	5
34. Ability to foster trust-building relationships and participation between group members.	0	1	2	3	4	5	1	2	3	4	5

KNOWLEDGE/ABILITY	HOW OFTEN DO YOU DEAL WITH SITUATIONS REQUIRING THIS?						HOW OFTEN WOULD ADDITIONAL KNOWLEDGE/SKILL PERTAINING TO THIS COMPETENCY HAVE BEEN HELPFUL TO YOU?				
	N/A	Seldom	Quart-erly	Once month	Once week	Every day	Seldom	Quart-erly	Once month	Once week	Every day
Clinical											
35. Knowledge of the basic concepts of group dynamics.	0	1	2	3	4	5	1	2	3	4	5
36. Ability to interact with members to build group cohesion.	0	1	2	3	4	5	1	2	3	4	5
37. Ability to foster group leadership.	0	1	2	3	4	5	1	2	3	4	5
38. Ability to negotiate contracts with group members.	0	1	2	3	4	5	1	2	3	4	5
39. Ability to select members for groups according to basic group dynamics guidelines.	0	1	2	3	4	5	1	2	3	4	5
40. Ability to process group interaction.	0	1	2	3	4	5	1	2	3	4	5
41. Ability to use role playing and other active techniques in groups to enable others to perceive and try new behaviors, attitudes, etc.	0	1	2	3	4	5	1	2	3	4	5
Human Behavior											
42. Knowledge of verbal and non-verbal attending behaviors.	0	1	2	3	4	5	1	2	3	4	5
43. Knowledge of differences between cognitive and affective thinking.	0	1	2	3	4	5	1	2	3	4	5
44. Knowledge of common defense mechanisms.	0	1	2	3	4	5	1	2	3	4	5
45. Knowledge of sexual transitions and stages.	0	1	2	3	4	5	1	2	3	4	5
46. Knowledge of common personality types or patterns.	0	1	2	3	4	5	1	2	3	4	5

KNOWLEDGE/ABILITY	HOW OFTEN DO YOU DEAL WITH SITUATIONS REQUIRING THIS?						HOW OFTEN WOULD ADDITIONAL KNOWLEDGE/ SKILL PERTAINING TO THIS COMPETENCY HAVE BEEN HELPFUL TO YOU?				
	N/A	Seldom	Quart-erly	Once month	Once week	Every day	Seldom	Quart-erly	Once month	Once week	Every day
Clinical											
47. Knowledge of impact on personality development of diverse cultures, values ethnic and economic backgrounds.	0	1	2	3	4	5	1	2	3	4	5
48. Knowledge of definitions and concepts of psychopathology.	0	1	2	3	4	5	1	2	3	4	5
49. Ability to work with different special population client systems.	0	1	2	3	4	5	1	2	3	4	5
Intervention Strategies											
50. Ability to demonstrate both verbal and non-verbal attending behaviors.	0	1	2	3	4	5	1	2	3	4	5
51. Ability to identify abrupt shifts in conversation or recuring references that expose the client's problems.	0	1	2	3	4	5	1	2	3	4	5
52. Ability to design intervention programs for personality disordered persons.	0	1	2	3	4	5	1	2	3	4	5
53. Ability to design intervention programs for psychotic persons.	0	1	2	3	4	5	1	2	3	4	5
54. Ability to design intervention programs for neurotic persons.	0	1	2	3	4	5	1	2	3	4	5
55. Ability to conduct play therapy sessions with children.	0	1	2	3	4	5	1	2	3	4	5
56. Ability to negotiate and utilize fee payments as a therapeutic intervention.	0	1	2	3	4	5	1	2	3	4	5

KNOWLEDGE/ABILITY Clinical	HOW OFTEN DO YOU DEAL WITH SITUATIONS REQUIRING THIS? N/A	Seldom	Quarterly	Once month	Once week	Every day	HOW OFTEN WOULD ADDITIONAL KNOWLEDGE/SKILL PERTAINING TO THIS COMPETENCY HAVE BEEN HELPFUL TO YOU? Seldom	Quarterly	Once month	Once week	Every day
57. Knowledge of and ability to use psychoanalytic theories and methods.	0	1	2	3	4	5	1	2	3	4	5
58. Knowledge of and ability to use behaviorism theories and methods.	0	1	2	3	4	5	1	2	3	4	5
59. Knowledge of and ability to use transactional analysis theories and methods.	0	1	2	3	4	5	1	2	3	4	5
60. Knowledge of and ability to use gestalt theories and methods.	0	1	2	3	4	5	1	2	3	4	5
61. Knowledge of and ability to use rational-emotive theories and methods.	0	1	2	3	4	5	1	2	3	4	5
62. Knowledge of and ability to use reality therapy theories and methods.	0	1	2	3	4	5	1	2	3	4	5
63. Knowledge of and ability to use family systems theories and methods.	0	1	2	3	4	5	1	2	3	4	5
64. Knowledge of and ability to use crisis intervention theories and methods.	0	1	2	3	4	5	1	2	3	4	5
65. Knowledge of and ability to do dream work with clients.	0	1	2	3	4	5	1	2	3	4	5
66. Knowledge of life span development theory, including concepts of neonatal development, early, mid and late adolescence, adult development, aging and dying.	0	1	2	3	4	5	1	2	3	4	5
67. Knowledge of the therapeutic effects of the most commonly used chemotherapeutic agents, i.e.:anticonvulsants, sedatives, tranquilizers, narcotics, energizers, etc.	0	1	2	3	4	5	1	2	3	4	5

KNOWLEDGE/ABILITY	HOW OFTEN DO YOU DEAL WITH SITUATIONS REQUIRING THIS?						HOW OFTEN WOULD ADDITIONAL KNOWLEDGE/ SKILL PERTAINING TO THIS COMPETENCY HAVE BEEN HELPFUL TO YOU?				
Clinical	N/A	Seldom	Quart-erly	Once month	Once week	Every day	Seldom	Quart-erly	Once month	Once week	Every day
68. Knowledge of the similarities and differences among individual, family and group counseling.	0	1	2	3	4	5	1	2	3	4	5
69. Ability to use confrontation to facilitate client growth.	0	1	2	3	4	5	1	2	3	4	5
70. Ability to use feedback on non-verbal behaviors to facilitate client growth.	0	1	2	3	4	5	1	2	3	4	5
Record Keeping and Report Writing											
71. Ability to write an intake evaluation which includes presenting problem, diagnostic formulation and treatment recommendations.	0	1	2	3	4	5	1	2	3	4	5
72. Ability to provide treatment summary information for use by other professionals.	0	1	2	3	4	5	1	2	3	4	5
73. Ability to make records and reports that confirm to the agencies medical record system.	0	1	2	3	4	5	1	2	3	4	5
74. Ability to write and maintain behaviorally oreiented progress notes.	0	1	2	3	4	5	1	2	3	4	5
Treatment Planning											
75. Ability to make relevant input into psychiatric team meeting on therapy programs and treatment direction.	0	1	2	3	4	5	1	2	3	4	5
76. Ability to organize and present facts, observations, critical incident information, and assessment results regarding a client in a case conference.	0	1	2	3	4	5	1	2	3	4	5

KNOWLEDGE/ABILITY	HOW OFTEN DO YOU DEAL WITH SITUATIONS REQUIRING THIS?						HOW OFTEN WOULD ADDITIONAL KNOWLEDGE/ SKILL PERTAINING TO THIS COMPETENCY HAVE BEEN HELPFUL TO YOU?				
	N/A	Seldom	Quart-erly	Once month	Once week	Every day	Seldom	Quart-erly	Once month	Once week	Every day
Clinical											
77. Ability to generate a working hypothesis from a comprehensive conceptualization of a case.	0	1	2	3	4	5	1	2	3	4	5
78. Ability to conceptualize a case given developmental data and diagnostic information from various theoritical frameworks.	0	1	2	3	4	5	1	2	3	4	5
Mental Retardation (MR)											
79. Knowledge of theories and events/stages relating to normal human development.	0	1	2	3	4	5	1	2	3	4	5
80. Ability to assess developmental delays and distinguish these from mental retardation (MR).	0	1	2	3	4	5	1	2	3	4	5
81. Knowledge of MR, epilepsy, cerebral palsy: causes, classifications, effects of and generalized client needs.	0	1	2	3	4	5	1	2	3	4	5
82. Knowledge of medical terminology related to MR.	0	1	2	3	4	5	1	2	3	4	5
83. Knowledge/abilities in CPR and appropriate first aid methods.	0	1	2	3	4	5	1	2	3	4	5
84. Knowledge of MR programs within the community: day treatment, residential, foster, respite, infant intervention, and education.	0	1	2	3	4	5	1	2	3	4	5
85. Knowledge of the benefit systems available to MR clients: Social Security, Medicaid, Employment.	0	1	2	3	4	5	1	2	3	4	5

KNOWLEDGE/ABILITY Clinical	HOW OFTEN DO YOU DEAL WITH SITUATIONS REQUIRING THIS? N/A	Seldom	Quart-erly	Once month	Once week	Every day	HOW OFTEN WOULD ADDITIONAL KNOWLEDGE/SKILL PERTAINING TO THIS COMPETENCY HAVE BEEN HELPFUL TO YOU? Seldom	Quart-erly	Once month	Once week	Every day
86. Knowledge of community resources for MR clients including speech, health, transportation, social services, occupational therapy, physical therapy, leisure time, and educational resources.	0	1	2	3	4	5	1	2	3	4	5
87. Knowledge of rehabilitation techniques, systems, and programing strategies related to MR.	0	1	2	3	4	5	1	2	3	4	5
88. Knowledge of early assessment and intervention procedures and strategies for MR.	0	1	2	3	4	5	1	2	3	4	5
89. Knowledge of parenting models and activities to teach to parents of MR clients.	0	1	2	3	4	5	1	2	3	4	5
90. Ability to assess client's potentials/handicaps in relation to the areas of: cognitive skills, self-help skills, motor skills, vocational skills, domestic living skills and community/social adjustment.	0	1	2	3	4	5	1	2	3	4	5
91. Ability to use behavior modification theories in the management of MR clients.	0	1	2	3	4	5	1	2	3	4	5
92. Knowledge of programing in day treatment residential MR programs.	0	1	2	3	4	5	1	2	3	4	5
93. Knowledge of programing techniques related to the acceleration of functional skills.	0	1	2	3	4	5	1	2	3	4	5
94. Knowledge of programing techniques for the deceleration of maladaptive behaviors including aggression.	0	1	2	3	4	5	1	2	3	4	5

KNOWLEDGE/ABILITY Prevention and Consultation	HOW OFTEN DO YOU DEAL WITH SITUATIONS REQUIRING THIS? N/A	Seldom	Quart-erly	Once month	Once week	Every day	HOW OFTEN WOULD ADDITIONAL KNOWLEDGE/ SKILL PERTAINING TO THIS COMPETENCY HAVE BEEN HELPFUL TO YOU? Seldom	Quart-erly	Once month	Once week	Every day
95. Knowledge of Carpman's and Schien's consultation models.	0	1	2	3	4	5	1	2	3	4	5
96. Knowledge of the various roles that consultants can carry out in consulting relationships.	0	1	2	3	4	5	1	2	3	4	5
97. Knowledge of stress management techniques.	0	1	2	3	4	5	1	2	3	4	5
98. Knowledge of employee assistance program design.	0	1	2	3	4	5	1	2	3	4	5
99. Ability to communicate effectively to groups at various levels of sophistication.	0	1	2	3	4	5	1	2	3	4	5
100. Ability to speak in public and facilitate audience participation.	0	1	2	3	4	5	1	2	3	4	5
101. Ability to serve as a consultant to various community groups and agencies.	0	1	2	3	4	5	1	2	3	4	5
102. Knowledge of survey feedback methods.	0	1	2	3	4	5	1	2	3	4	5
103. Knowledge of and skill in using a variety of needs assessment methods.	0	1	2	3	4	5	1	2	3	4	5
104. Knowledge of marketing approaches to mental health services.	0	1	2	3	4	5	1	2	3	4	5
105. Knowledge of learning theories and methods.	0	1	2	3	4	5	1	2	3	4	5
106. Knowledge of program development theory.	0	1	2	3	4	5	1	2	3	4	5
107. Knowledge of family life education concepts.	0	1	2	3	4	5	1	2	3	4	5
108. Ability to work with the mass media.	0	1	2	3	4	5	1	2	3	4	5

KNOWLEDGE/ABILITY	HOW OFTEN DO YOU DEAL WITH SITUATIONS REQUIRING THIS?						HOW OFTEN WOULD ADDITIONAL KNOWLEDGE/ SKILL PERTAINING TO THIS COMPETENCY HAVE BEEN HELPFUL TO YOU?				
Prevention and Consultation	N/A	Seldom	Quart-erly	Once month	Once week	Every day	Seldom	Quart-erly	Once month	Once week	Every day
109. Knowedge of community organization concepts.	0	1	2	3	4	5	1	2	3	4	5
110. Knowledge of prevention theories and and concepts.	0	1	2	3	4	5	1	2	3	4	5
111. Knowledge of networking theories and methods.	0	1	2	3	4	5	1	2	3	4	5
112. Knowledge of and ability to use different programing models and methods.	0	1	2	3	4	5	1	2	3	4	5
113. Knowledge of journalism concepts.	0	1	2	3	4	5	1	2	3	4	5
114. Knowledge of large group dynamics theory.	0	1	2	3	4	5	1	2	3	4	5

KNOWLEDGE/ABILITY Administration	HOW OFTEN DO YOU DEAL WITH SITUATIONS REQUIRING THIS? N/A	Seldom	Quart-erly	Once month	Once week	Every day	HOW OFTEN WOULD ADDITIONAL KNOWLEDGE/SKILL PERTAINING TO THIS COMPETENCY HAVE BEEN HELPFUL TO YOU? Seldom	Quart-erly	Once month	Once week	Every day
115. Forecasting- estimating the future of the organization.	0	1	2	3	4	5	1	2	3	4	5
116. Setting program objectives-determining results to be obtained.	0	1	2	3	4	5	1	2	3	4	5
117. Programing: establishing a plan of action to follow in reaching objectives.	0	1	2	3	4	5	1	2	3	4	5
118. Scheduling: establishing time requirements for objectives or programs.	0	1	2	3	4	5	1	2	3	4	5
119. Policy-making: establishing rules and regulations from predetermined decisions.	0	1	2	3	4	5	1	2	3	4	5
110. Establishing procedures: determining consistent and systematic methods handling work.	0	1	2	3	4	5	1	2	3	4	5
120. Analyzing problems: identifying and relating data pertinent to the solution of a program.	0	1	2	3	4	5	1	2	3	4	5
121. Structuring: grouping work for effective and efficient production.	0	1	2	3	4	5	1	2	3	4	5
123. Integrating: establishing conditions for effective teamwork among organizational units.	0	1	2	3	4	5	1	2	3	4	5
124. Linking: building and maintaining linkages with other organizations in the environment.	0	1	2	3	4	5	1	2	3	4	5
125. Selectiong personnel: identifying and appointing people to organizational positions.	0	1	2	3	4	5	1	2	3	4	5

KNOWLEDGE/ABILITY Administration	HOW OFTEN DO YOU DEAL WITH SITUATIONS REQUIRING THIS? N/A	Seldom	Quart-erly	Once month	Once week	Every day	HOW OFTEN WOULD ADDITIONAL KNOWLEDGE/SKILL PERTAINING TO THIS COMPETENCY HAVE BEEN HELPFUL TO YOU? Seldom	Quart-erly	Once month	Once week	Every day
126. Recruiting and selecting volunteers: chosing appropriate volunteers, training rewarding and maintaining them.	0	1	2	3	4	5	1	2	3	4	5
127. Measuring performance: assessing actual versus planned performance.	0	1	2	3	4	5	1	2	3	4	5
128. Monitoring programs to insure the achievement of program objectives.	0	1	2	3	4	5	1	2	3	4	5
129. Developing program evaluation strategies.	0	1	2	3	4	5	1	2	3	4	5
130. Budgeting: determining and assigning the resources required to reach objectives.	0	1	2	3	4	5	1	2	3	4	5
131. Knowledge of accounting procedures necessary for fiscal management.	0	1	2	3	4	5	1	2	3	4	5
132. Knowledge of motivational factors; influencing professionals to perform in a desired manner.	0	1	2	3	4	5	1	2	3	4	5
133. Knowledge of and ability in interagency coordination.	0	1	2	3	4	5	1	2	3	4	5
134. Knowledge of and ability to develop fund-raising techniques.	0	1	2	3	4	5	1	2	3	4	5
135. Developing and writing contracts.	0	1	2	3	4	5	1	2	3	4	5
136. Managing and monitoring contracts to insure the delivery of services.	0	1	2	3	4	5	1	2	3	4	5
137. Knowledge of and ability to design and implement a needs assessment study.	0	1	2	3	4	5	1	2	3	4	5
138. Knowledge of and ability to write grants.	0	1	2	3	4	5	1	2	3	4	5

KNOWLEDGE/ABILITY Administration	HOW OFTEN DO YOU DEAL WITH SITUATIONS REQUIRING THIS? N/A | Seldom | Quart-erly | Once month | Once week | Every day						HOW OFTEN WOULD ADDITIONAL KNOWLEDGE/ SKILL PERTAINING TO THIS COMPETENCY HAVE BEEN HELPFUL TO YOU? Seldom | Quart-erly | Once month | Once week | Every day				
139. Knowledge of and ability to develop a public information program to promote agency programs.	0	1	2	3	4	5	1	2	3	4	5
140. Knowledge of and ability to work with agency boards to achieve program goals.	0	1	2	3	4	5	1	2	3	4	5
141. Ability to develop training programs for board members.	0	1	2	3	4	5	1	2	3	4	5
142. Ability to supervise interns and volunteers.	0	1	2	3	4	5	1	2	3	4	5
143. Knowledge of management theories and techniques.	0	1	2	3	4	5	1	2	3	4	5
144. Knowledge of and ability of marketing approaches for mental health services.	0	1	2	3	4	5	1	2	3	4	5
145. Knowledge of interorganizational theory.	0	1	2	3	4	5	1	2	3	4	5
146. Knowledge of networking theory.	0	1	2	3	4	5	1	2	3	4	5
147. Knowledge of matrix management concepts.	0	1	2	3	4	5	1	2	3	4	5
148. Knowledge of planned change theories.	0	1	2	3	4	5	1	2	3	4	5
149. Knowledge of bargaining/negotiation concepts.	0	1	2	3	4	5	1	2	3	4	5
150. Knowledge of public policy change stategy.	0	1	2	3	4	5	1	2	3	4	5

APPENDIX C

Memo To Validation Panel
Summarizing Their Feedback

Questionnaire Sent to Validation Panel
Regarding Feedback and Validation
of Multi-method Framework

To: Member of Validation panel
Needs Assessment Project
Community Mental Health/Mental Retardation Professionals

From: Dennis Cogswell, ACSW
Doctoral Candidate: Adult and Continuing Education
Virginia Tech

Date: 25 January 1985

Thank you for completing the "Review and Comment" Questionnaire and returning it to me so promptly in December. I have reviewed them carefully and have used your feedback to guide the final revision of the three needs assessment methods, especially the Self-assessment Questionnaire. The manual was revised in response to several suggestions that you offered. I have listed each of your comments verbatim as you stated them so that you each could see what others said in response to the same questions. For your additional information, I am enclosing (1) a list of the Validation Panel so you can see what distinguished company you keep; and (2) a summary reprot of your comments. I did not identify any of the respondents in relation to the comments; you are listed as Respondent #1, Respondent #2, and so on. The numbers assigned are not directly related to the list of panel members. I listed the respondents randomly as I sat down to type the final summary report.

Your feedback aided me specifically in these ways:

(1) The questionnaire now contains competencies pertaining to mental retardation. There were none in my original questionnaire because no one to my knowledge had developed such a list through research. However, they certainly should be included in a questionnaire that includes generic competencies pertaining to a wide variety of MH/MR professionals.

(2) The manual was revised so that the instructions were stated in a much clearer manner. I added several forms or sample reports to explain the steps involved.

(3) A checklist was developed for use by a Training Director to record steps accomplished and those left to be taken.

(4) The pages of the manual now correspond to the Table of Contents. I finally figured out the problem; I was printing out of two different files on my word processor and this put the page numbers slightly out of sequence.

(5) The term "key informants" was replace throughout with the term "Training Assessment Committee".

(6) A dry run was done with the questionnaire. Six professionals from the New River Valley CSB who held a wide variety of professional positions with varying professional backgrounds and years of experience filled out the questionnaire. They made suggestions about wording changes and all reported that they completed the questionnaire in less than one hour.

All of your concerns and suggestions have been noted and they have influenced the refinement of the three methods. The next step is to field test the methods in a CSB to see what this process reveals about the framework and its ability to assess training needs. The Rockbridge CSB has volunteered to participate in this part of the research and I am presently working closely with Mike Gilmore and Ken Lane on the field testing. Sometime in March or April 1985 the field testing should be completed and a report sent to Ken Howard.

Thank you again for taking some of your valuable time and sharing your expertise with me. I hope the results benefit all of us and especially the Community Mental Health/Mental Retardation System in Virginia. Let me know if I may return the favor at sometime in the future.

NEEDS ASSESSMENT OF
THE TRAINING AND STAFF DEVELOPMENT NEEDS
OF COMMUNITY MENTAL HEALTH PROFESSIONALS

ASSESSMENT OF THE FRAMEWORK
REVIEW AND COMMENT QUESTIONNAIRE

State Office of Prevention, Information and Training
Training Resource Development and Networking
Ken Howard, Assistant Director

Virginia Polytechnic Institute and State University
College of Education
Adult and Continuing Education Program
Dennis Cogswell, Research Consultant

December 1984

VALIDATION COVER LETTER AND CHECKLIST

Dear _____:

Thank you for agreeing to help with the development of a multi-method needs assessment framework to assess the Training and Staff Development needs of community mental health professionals. Your task is to review the Operations Manual related to this research that explains in a step-by-step basis the use of each of the three needs assessment methods being employed in this study. Then, there are six questions to be answered that will give me feedback about the needs assessment process that is proposed.

At this time, please read the rest of this Feedback Summary, paying specific attention to the six questions to which you will be responding. When you have completed reading this Feedback Summary, read the Operations Manual and then turn to page 3 of this packet and offer your rating and comments.

Mail the rating sheet and comments to me by December ___, 1984. I will send you information on the comments made by other members of the validating panel and tell you what revisions were made. Thank you for assisting the Office of Prevention, Information and Training in the development of a multi-method needs assessment procedure for use throughout our entire system.

Sincerely,

Dennis Cogswell
Research Consultant

NEEDS ASSESSMENT FRAMEWORK EVALUATION CHECKLIST

Introduction

The three needs assessment methods employed in this study are (1) use of performance evaluations to assess learning needs, (2) use of key individuals (key informants) within each program unit of a CSB to suggest training and staff development needs and (3) use of a questionnaire to assess needs related to the main professional responsibilities of mental health professionals. Each method will assess needs in relation to (1) clinical, (2) prevention and consultation and (3) administration training and staff development needs. These methods were chosen because of their utility of use within the typical CSB and the need to gather data from three different sources in order to establish the validity of the needs assessed.

Guiding Criteria For the Framework

This research process began with the establishment of criteria or normative statements to use in guiding the development of a multi-method needs assessment framework. From these criteria a specific needs assessment framework was developed. These criteria were derived from professional literature, the goals of the State Office of Prevention, Information and Training for their 1984 training and staff development plan and consultation with various professionals

within the Community Service Board Service Delivery System in Virginia. These criteria are:

1. The data to be collected must be related to the assessment of gaps between the current functioning levels of mental health professionals and the required or the desired level of functioning. Furthermore, the needs statements must relate to the main professional responsibilities of community mental health professionals.

2. The data to be collected must facilitate the Regional Staff Development Committee's development of their Five Step Training and Staff Development Plan.

3. Following appropriate training and with the aid of the Operations Manual, the Training Director of a CSB must be able to successfully administer the multi-method needs assessment framework within his/her CSB and then interpret and report the data to the Executive Director of his/her CSB and the Regional Staff Development Committees.

4. The needs assessment framework employed must involve those persons within the system with administrative responsibility for Training and Staff Development and those professionals whose needs are being assessed in the data collection, summarization and analysis process.

5. The multi-method assessment framework must produce need statements that can be compiled and analyzed on a yearly basis for use in the Five Step Planning Process. It must also yield needs statements that can be summarized and compared

over an extended time frame of many years.

6. The data collected through the multi-method framework must use terminology and relate to generic areas of practice that correspond to the professional activities of a wide variety of community mental health professionals.

7. The framework developed must be one that can be implemented in relation to the time and the technical resources available within a CSB or supplied by the Office of Prevention, Information, and Training.

Familarization with the Operations Manual

The actual techniques to be used and step-by-step procedures for each of the methods is contained in the Operations Manual on pages 3-18. Please refer to them now.

Evaluation Processes

Once you have familiarized yourself with the Operational Manual, please review each of the questions listed below and offer your comments and feedback in relation to each question.

FEEDBACK/VALIDATION QUESTIONS

1. What additional criteria or modifications of the criteria listed to guide the development of a multi-methods framework can you offer?

2. What difficulties would you anticipate in the use of the proposed framework to assess the Training and Staff Development needs of mental health professionals in a CSB in Virginia?

3. What help would you need in carrying out each of the following needs assessment methods:

(a) Performance evaluation assessment method?

(b) Key informant assessment method?

(c) Questionnaire assessment method?

4. What improvements would you suggest in the wording of each of these sections of the manual?

Step One: Establishment of a Timetable for Data Collection

Step Two: Data Collection Through Three Different Methods

Performance Evaluations

Key Informants

Questionnaire

Step Three: Writing of the Report

4. How much staff time do you think it would take to fully use and complete a needs assessment using each of these methods:

(a) Performance Evaluation Assessment Process?

(b) Key Informant/Nominal Group Assessment Process?

(c) Dissementation, Completion and Collection of the Questionnaire?

6. What additional or summary comments would you offer about the multi-method assessment framework and the needs assessment research being proposed?

Thank you for your help in this research process!!!!

Mail this completed questionnaire in the enclosed envelope. A summary report of comments of the review committee will be mailed to you.

Dennis Cogswell
Research Consultant

APPENDIX D

Field Notes Regarding Multi-method Framework:

Performance Evaluation Method

Training Assessment Committee Method

Self-assessment Questionnaire

FIELD NOTES
PERFORMANCE EVALUATION METHOD

January 31, 1985

The Performance Evaluation Committee met for three hours from 9:00am to 12:00pm to carry out the needs assessment process utilizing the Performance Evaluations that had been done on every staff member. A copy of the form used in these evaluations is contained in the Appendix of this study. A decision had been reached prior to the actual meeting of this committee to change its structure from a three person committee to a modified two person committee. This was done because of the initial concern about confidentiality. The two members of the committee were chosen because they had already read all the evaluations because of their job responsibilities within the center. These two persons were Michael Gilmore, Ph.D., Executive Director and Kathy Causey, Administrative Assistant. As the Director of this entire assessment process, Ken Lane was the third member of the committee. He coordinated the process and served as a facilitator in the decision making process. He provided direct input in the form of his own opinion in the collasping of need statements into the final statements.

The process began with Ken paraphrasing the instructions from the Instruction Manual and answering questions about the process. Questions were raised about the different categories into which needs were to be placed (Clinical, Prevention and Consultation, and Administration) and what were the boundaries of these categories. Ken Lane provided the members with definitions for each of the three categories. The committee then discovered that they did not have performance evaluations for each of the twenty professional staff members that were participating in the needs assessment. Several were unavailable because they were new staff members and had not yet been with the center one year, two was missing from their files and one had not been done because the individual had just changed positions within the agency and had not been evaluated in the normal evaluation process.

The committtee members separately read each evaluation and took notes on the training and staff development needs that the evaluations listed or that could be inferred from rater's remarks. In most cases, the actual words of the rater were copied. The committee reviewed 12 performance evaluations in one hour, passing evaluations back and forth. There was little direct exchange of information about a specific professional that would

then bias the other rater's review. When all the evaluations had been reviewed, Ken Lane had each rater read the notes that they had taken and he in turn wrote them on newsprint. A slash mark was placed after each need noted in relation to the number of times that need was identified. Different colors were used for each of the raters so that the actual frequency of needs could be computed. The inter-rater reliability seemed high as both raters frequently had the same need statements and the same number of times noted.

Ken Lane then "joined" the other two raters and the three committee members reviewed the need statements on the newsprint, discussed them and collasped them into need statements that all could agree to. The committee in general agreed on the need statements with some exceptions as to which statements should be collapsed into which other statements. Once this was accomplished, there was general agreement as to the needs of the staff and the frequency these needs had been noted. Ken Lane was then given the responsibility of taking the needs statements from the newsprint and rank ordering them according to frequency in each of the three categories. He agreed to do this, stating that he would write a draft of this report and circulate it among the committee members asking for verification of the report or editing to correct any statements or interpretations. (This was done approximately one week later; his report was accepted as drafted with no corrections).

The committee members then discussed the assessment process. They agreed that their concerns about confidentiality were now not a major issue and that they wished that the supervisors who had written the evaluations had been involved in the rating and discussion process. They did not feel that confidentiality was as major an issue as had been perceived and that the process was an interesting and revealing one.

Researcher's Observations

The process went smoothly for a first time event for all three raters. The inter-rater reliability appeared to be high as many of the needs were stated by one of the assessors and then confirmed by the other i.e "I noted that need also, in those exact terms." The fact that Mike Gilemore is the Executive Director of the entire CSB did not seem to have an overt effect upon the process. There was ample discussion of needs and all three members contributed to the process. From the beginning, it appeared important that operational definitions be written for each of the categories of Clinical, Prevention and Consultation and Administration Training and Staff Development Needs and then supplied in writing to each rater. It was important that the

needs first be written on newsprint as the raters interpreted them from the evaluations and then collapsed into more generic categories. There was regular agreement on the number of times each need was identified.

The Rockbridge CSB Performance Evaluation forms have a place for supervisors to make statements in regard to this statement : "DEVELOPMENT AND TRAINING - (a) indicate recommendations for future development and training for purposes of preparing the employee for additional responsibilities for the improvement of current job performance; (b) Identify any training or developmental activities the employee has completed since his/her last performance evaluation. Such training was (check one) taken as a result of the supervisor's recommendation ___, or the employee's initiative___. Even with this specific directive, the statements made were very general and varied greatly from supervisor to supervisor in terms of content, terminology and whether the directive was actually carried out.

The ranking of needs in each of the three categories was done on the basis of frequency of need as noted by the raters. The use of different colors marks on the newsprint helped avoid any confusion about duplication and the frequency listed in the summary report then listed the maximum total number of times a specific need was identified throughout the CSB. Because of the way these frequencies were generated, the ranking of needs by frequency should be done with the realization that there is not equal distance between any of the ranks and that the ranking is an approximation of the overall strength of the need.

FIELD NOTES
TRAINING ASSESSMENT COMMITTEE METHOD

February 7, 1985

The Training Assessment Committee was selected by Ken Lane prior to the first meeting. Ken decided that the Rockbridge CSB could best be represented if five of the seven main divisons of the CSB were each represented on the committee by one member. These divisions are : Adult Outpatient Services, Child/Adolescent Services, Psychiatric/Medical Services, Continuing Care Services, Alcohol/Drug Services, Administrative Support, and Mental Retardation Services. Each unit was told about the overall assessment process through first a memo from Michael Gilmore, Executive Director, and then Ken Lane, who had been identified by Dr. Gilmore as being the coordinator of this project. They were asked to nominate a member of their staff to represent their unit in the needs assessment process. No representatives were nominated by the Psychiatric/Medicine Unit because this unit is staffed by two part-time physicians who did not put a high priority on their participation in this project nor by the Administrative Support Unit because this unit does not contain any MH/MR professionals whose training and staff development needs were being assessed. The committee members nominated were: (1) Julie Jennings, Ph.D., Coordinator, Adult Outpatient Services, (2) Lance Becker, M.P.S., Coordinator, Child/Adolescent Services, (3) Marsha Bedwell, BSW, Sr. Program Specialist, Continuing Care Services, (4) Anne McThenia, Ed.S., Sr. Substance Abuse Counselor, Alcohol/Drug Services and (5) Paulette Robinson, Coordinator, Mental Retardation Services. Ken Lane served as the facilitator of the needs assessment process throughout; at no time did he participate in the nomination or ranking of needs.

The committee finally settled into work at 9:45am and after introductions, Ken explained the processes to be followed and gave definitons for the three different categories (Clinical, Prevention and Consultation and Administration) for which needs were to be nominated. Utilizing the manual, instructions were given for the first step, the individual writing of needs by each representative on Worksheet 1. Worksheets were given out for each of the three categories. One representative came with a pre-thought out list, the others wrote their lists in the session itself. The committee was orginally given 10 minutes to complete this taks. This proved not to be enough time for some members and it was lenghtened to about 18 minutes. The members finished at different times, ranging from five to 18 minutes.

Taking each of the three categories separately, Ken then asked each member to nominate a need and continued around the

room until no more needs remained to be nominated. He wrote each need on newsprint as stated, using a different color marking pen fopr each of the three categories. Each need was coded with an identifying number, e.g. C1, C2, PC1, PC2, etc. When all the needs had been nominated, a quick review showed that there were 35 Clinical need listed, 14 Prevention and Consultation needs and 17 Administration needs.

After reading over the list for clarification, the directions from the manual were used to help the committee list the ten needs that they thought were the most important in each of the three categories on three by five cards. Several of the group memembers raised the concern of having to limit themselves to only ten needs in the Clinical category because there were many more needs listed there to chose from in comparision to the other two areas. Ken acknowledged their concerns but asked them to limit themselves to ten needs in each category. Also, at this point in time the committee members asked for additional time to discuss the needs listed on newsprint and to clarify, broaden or limit specific statements. This had been asked for earlier, with little response. The pressure of actually having to chose seemed to prompt committee members to seek clarification, compromise and promotion for specific needs. The committee then settled into individually selecting ten needs in each category. At this time, one member asked if he had to select ten needs in each category as he felt that his unit only had a few needs in certain categories and he didnt want to be put in a position where he had to nominate needs that didn't pertain to his unit or on specialities of others. This was a strong concern and it was not easily satisfied. After consulting with the manual, Ken again explained that this was a preliminary vote and that the system asked each member to nominate ten needs. The concerned committee member was asked to follow the instructions and "to trust that it will work out ok." He agreed to do so.

Once each member had selected ten needs for each category, listed them on cards, and had ranked them from one to ten as instructed, the committee was given a 15 minute break. Ken took the cards and listed each weighted rank opposite the need. This was done in each category.

When the committee reconviened, the first ranking was discussed and clarified. With the rankings of their fellow committee members in front of them on newsprint, the committee members then were asked to pick their top ten choices of needs in each of the three categories and to list them in ranked order on Worksheet Three. The previously mentioned concern was again voiced by the same individual and after acknowledging it, he was again asked to follow the instructions. It was discussed that

this was a field testing of this method and the concerns raised would be reviewed for future use. As committee members finished their final ratings, they were allowed to leave. Ken reminded them of the final meeting, scheduled for 8:30am on February 19, 1985.

February 19, 1985

All the members of the committee were again present for the second meeting. The meeting began with Ken distributing the results of the nominating/ranking that the committee had done in its first meeting (see Table _____). Taking each of the ten ranked needs, the committee was invited to discuss the needs and offer statements about that particular need that would help a trainer develop a workshop pertaining to that need. This was done for each of the three categories; the committee spent about 20 minutes per category discussing and clarifying need statements. This process lacked some of the interest and enthusiam that was exhibited earlier. The process evolved into one where Ken frequently would suggest meanings and the group would give a general consent. Open-ended questions were utilized by Ken in relation to each of the categories but they did not result in as much input from the committee as was expected. Consensus was reached about the definitions of all the need statements. The group was thanked for their input and contribution to the research. The last fifteen minutes of the meeting was spent discussing the nominal group process. The comments were generally positive. The first question raised was the concern about whether each participant had to use all ten votes in the ranking procedure.

Researcher's Observations

The process can be streamlined so that less time is spent together in committee. Step One, the nomination of needs by representatives of a work unit, could be done by the individual committee members prior to the first meeting on Worksheet #One and this information turned into the Training Director. S(he) then could have the first set of needs written on newsprint prior to the first meeting. After the introductions and discussion of the overall nomination and ranking process, these needs then could be discussed one at a time, with editing permitted and others needs added. This might save as much as one-half hour time

of the committee.

The size of this committee was 5 nominators plus the facilitator. If the procedure was followed as outlined in the manual for step one with a committee of 9 to 12 members, this would take at least an hour and perhaps longer. It would be difficult to keep the attention of the entire group during that time. Two options come to mind. One is to change the procedures as indicated in the prior paragraph. Another would be to divide the committee into two sections for the first portion of the nominating process and then bring the full committee together for discussion prior to the first round of ranking.

The question related to whether each committee member must use all ten votes is an interesting one. The response that I would suggest involves these two points: (1). Each committee member is participating as a representative of a specific unit and as a representative of the overall agency. The process is designed to give nominators equal say of helping identify the training and staff development needs of the entire agency. The main goal is to have the committee identify CSB-wide needs, rather than just speak for one unit of the CSB. At the same time, it is recognized that each nominator will primarily represent a specific perspective. With this purpose in mind, nominators are not required to use all ten of their votes to rank needs if they do not wish to do so. It should be noted that this then will increase the weight of other rankers votes, as they all work together to identify nominal needs of the CSB.

FIELD NOTES
SELF-ASSESSMENT QUESTIONNAIRE METHOD

February 5, 1985

A memo was sent to the twenty professional staff members who met the original criteria for inclusion in the need assessment process (see Appendix, Item ___) by Ken Lane, Coordinator, Training Needs Assessment Project. The memo explained the goals of this assessment method and requested that the completed questionnaire be returned to Ken Lane by February 15, 1985. A copy of the questionnaire was enclosed with the memo.

February 15, 1985

Ken Lane decided to extend the deadline for completion of the questionnaires to February 19, 1985 because of the workload pressaures of some of the staff.

February 19, 1985

I met with Ken on this date to observe the second meeting of the Training Assessment Committee. He gave me 19 completed questionnaires and said that he would have the last questionnaire to me within several days.

The Training Assessment Committee members had all returned their questionnaires to Ken by this date so that I was able to discuss this assessment method with them and seek their feedback on this item. One committee member asked for a copy of the questionaire as she wanted to have a list of the compethencies utilized. Some concerns were raised about how the response to the first question (How often do you deal with situations requiring this?) would then influence the response to the second question (How often would additional knowledge/skill pertaining to this competency have been helpful to you?). It was pointed out that the frequency of use of a competency might be related to the amount of knowledge/skill one had or confidence in that competency and that a change in column B might then result in a change in column A. If this was the case, then the value in column B would be higher than the value in column A. The wording of the question in column A was discussed with one staff member suggesting that the wording might read "How often do you have the opportunity to deal with situations requiring this?" A question was raised about the assumptions that went with each question. Specifically, "if a skill is not being used frequently by a staff member, would additional training result in that staff person using that skill more frequently?" Another question was: "How can additional training affect something that was done in the past?".

Another staff member pointed out that there were no specific competencies listed pertaining to Substance Abuse. She noted that most of the other competencies were related but thought that there should be some additional competencies added to the overall questionnaire that related specifically to this division. Another staff member noted that it was hard to identify how often a skill was utilized.

February 23, 1985

I received the last questionnaire in the mail from Ken Lane. All twenty staff members, including one physician, completed the questionnaire.

APPENDIX E

Performance Evaluation Forms Used by Rockbridge CSB

Rockbridge Area Community Services Board

CONFIDENTIAL PERFORMANCE EVALUATION

****

MANAGERIAL AND PROFESSIONAL EMPLOYEES

Rockbridge Area Community Services Board

CONFIDENTIAL PERFORMANCE EVALUATION
MANAGERIAL AND PROFESSIONAL EMPLOYEES

4 - exceeds normal job requirements
3 - meets normal job requirements
2 - improvement is needed to meet job requirements
1 - fails to meet job requirements

Acceptable satisfactory performance requires an average rating of 2.75, when rated goals, objectives, and performance factors are combined.

Name_____Social Security Number_____

Program_____Class Title_____

Date Entered Present Position_____Date of Evaluation_____

Describe Briefly the Principal Duties in Present Job_____

The following performance evaluation is designed to measure the performance of managerial and professional employees. Where management by objectives is established in an agency, the employee should be evaluated on those predetermined and predefined goals or objectives. These goals or objectives should be approved and identified in writing. In cases where management by objectives is not established, the supervisor should identify the major duties and/or responsibilities of the job and evaluate the employee accordingly. In still other cases, there may be special assignments performed by the employee as assigned by the supervisor. When evaluating employees in the above-mentioned situation, the supervisor should identify on the performance evaluation form those major projects, job duties, and/or special assignments that are important to the overall performance of the operation and the employee.

PART I - List five major predetermined goals or objectives on which the employee is to be evaluated. Where predetermined goals and objectives are not used, the employee should be evaluated on projects, job duties and special assignments. Circle the appropriate performance level.

1. Goal/Objective/Project/Major Job Duty/Special Assignment_____ 4 3 2 1

2. Goal/Objective/Project/Major Job Duty/Special Assignment_____ 4 3 2 1

3. Goal/Objective/Project/Major Job Duty/Special Assignment_____ 4 3 2 1

4. Goal/Objective/Project/Major Job Duty/Special Assignment _____ 4 3 2 1

5. Goal/Objective/Project/Major Job Duty/Special Assignment _____ 4 3 2 1

PART II - PERFORMANCE FACTORS - The following performance factors tend to reinforce the performance levels identified in Part I. The supervisor in completing Part II should indicate the employee's performance level by circling the appropriate level of performance. Use the remarks section to record your comments.

1. WORK HABITS - To what extent does the employee demonstrate adaptability and a sense of priorities? 4 3 2 1

Remarks _____

2. PLANNING AND ANALYTICAL ABILITY - To what extent does the employee demonstrate the skills to analyze and solve problems? 4 3 2 1

Remarks _____

3. MANAGERIAL SKILLS - To what extent does the employee effectively work well with and through others to complete assignments in a timely and productive manner? 4 3 2 1

Remarks _____

4. COMMUNICATIONS SKILLS - To what extent can the employee effectively express himself/herself orally and in writing including correspondence and reports and presentations at conferences, seminars, workshops, etc., as required by the job? 4 3 2 1

Remarks _____

5. DEVELOPMENT OF OTHERS - To what extent does the employee develop others to become more effective in work assignments and better prepared for future job opportunities? 4 3 2 1

Remarks

Determining the overall evaluation - Add the number circled from Parts I and II. Divide by the number ten (10) to determine the overall evaluation. Indicate the overall evaluation score by circling, or inserting and circling, the overall evaluation score on the scale provided.

Performance Levels		Scale
Employee's performance regularly exceeds the job requirements.	(3.50 and above)	4.00 3.75 3.50
Employee's performance meets normal job requirements on a sustained basis.	(2.75 to 3.49)	3.25 3.00 2.75
Employee's performance reflects that there is a need for improvement on a sustained basis.	(2.00 to 2.74)	2.50 2.25 2.00
Employee's performance fails to meet the job requirements.	(1.99 and below)	1.75 1.50 1.25

SUPERVISOR'S COMMENTS CONCERNING THE OVERALL EVALUATION:

Does performance merit longevity increase? Yes No

PART III - DEVELOPMENTAL TRENDS

1. SIGNIFICANT CHANGES - Indicate any significant changes in performance since the employee's last evaluation.

2. DEVELOPMENT AND TRAINING - (a) Indicate recommendations for further development and training for purposes of preparing the employee for additional responsibilities for for the improvement of current job performance.

(b) Identify any training or developmental activities the employee has completed since his/her last performance evaluation. Such training was (check one) taken as a result of the supervisor's recommendation____, or the employee's initiative____.

Evaluated by_____Title_____

Reviewed by_____Title_____

TO THE EMPLOYEE:

You are requested to sign on the line provided to indicate only that you have had an opportunity to review and discuss your performance evaluation with your supervisor. YOUR SIGNATURE DOES NOT INDICATE THAT YOU AGREE WITH THE EVALUATION.

EMPLOYEE COMMENTS:

Employee's Signature_____Date_____

APPENDIX F

Training Assessment Committee Method
Pre-test Used in Training Program for Training Director

NOMINAL GROUP TECHNIQUE: A PRE-TEST

1. How many committee members should serve on the Training Assessment Committee? How should these members be chosen?

2. What paper and writing materials will be needed?

3. What are the basic concepts behind the nominal group technique?

4. What are the three categories under which needs will be nominated?

5. What should the Training Director do if committee members do not agree on the procedures to be used in the assessment?

6. What is Worksheet # 1 used for?

7. When is Worksheet #1 used?

8. When and in what way will the 3 by 5 cards be used?

9. Numbers are to be written in what corners of the 3 by 5 cards?

10. What does each number stand for?

11. What goes in the middle of the card?

12. What do you do with the cards once the numbers have been entered?

13. Why are members of the committee asked to vote on needs twice?

14. Describe the steps involved in the two step voting process.

15. When are the results of the second voting of the Training Assessment Committee given to committee members?

APPENDIX G

Rockbridge Training Director's Clarifying Statements On Needs Assessed By Performance Evaluation Method and Training Assessment Committee Method

PERFORMANCE EVALUATION METHOD
TOP TEN RANKED CLINICAL NEEDS

RANK, NEED STATEMENT	FREQUENCY NOTED
1A. Emergency, Hospital Pre-screening, and Crisis Intervention Skills	14
1B. Training in psycho-social rehabilitation skills and techniques	14
3. Skills training in counseling and treatment modalities	8
4A. Treatment of children, adolescents and families; parenting and child management techniques	4
4B. Family Therapy	4
6A. Problem-solving and conflict management skills	3
6B. Formulation of treatment plans	3
8A. Diagnosis of child and adolescent disorders	2
8B. Performance of psychological evaluations	2
10A. General diagnosis	1
10B. Performance of intake evaluations	1
10C. Working with families of substance abusers	1
10D. Geriatric mental health	1

Commentary: Clinical Needs

The two salient training needs are (a) Psychiartic Emergency, Hospital Pre-screening, and Crisis Intervention Skills, and (b) Training in Psychosocial Rehabilitation.

The first need pertains to the respective staffs of Mental Health and Alcohol Services, all of whom are required to rotate on emergency on-call service. The specific skills include interviewing, mental status assessing, doing suicide prevention counseling, referring and networking, and problem-solving. Knowledge of hospital admissions criteria and of commitment statutes are also important components.

The second need applies in large part to social and task skill training of chronic mentally and/or emotionally disabled adults. Both mentally ill and mentally retarded persons are implied. Specific skills include behavioral assessments and goal-setting, teaching of behavioral programs around activities of daily living. Application to disturbed adolescents is also relevant to training needs.

Next in order of ranking is the area of training in counseling and various current treatment modalities. It is difficult to determine the level or types of training called for, through basic counseling skills training is recommended for the Continuing Care staff who tend to lack formal training in this area.

PERFORMANCE EVALUATION METHOD
TOP TEN RANKED PREVENTION AND CONSULTATION NEEDS

RANK,	NEED STATEMENT	FREQUENCY NOTED
1.	Community Consultation and Prevention Skills (Community Agencies, Professionals, Schools, and Hospitals).	8
2.	Consultation and Training Skills to Adult Home Staffs	2
3A.	Liaison skills with State Hospital and Community Agencies	1
3B.	Advocay for mental health	1
3C.	Public mental health education	1

Commentary:Prevention and Consultation Needs

One interesting feature in this category is the comparative lack of responses. What responses there are reflect a variety of consultation/education needs. Staff members come in contact with a diversity of agencies calling for distinct specialities such as child and adolescent development, classroom management, alcohol and drug abuse prevention, and disposition recommendations to physicians regarding their patients.

PERFORMANCE EVALUATION METHOD
TOP TEN RANKED ADMINISTRATION NEEDS

RANK, NEED STATEMENT	FREQUENCY NOTED
1. Development of Others Within Personnel	39
1A. General Personnel Relations	13
1B. Effective Communication at all levels of personnel	11
1C. Managerial Skills (Eliciting Cooperation)	9
1D. Assertiveness Training and Conflict Management	3
1E. Identification and Resolution of Problems	2
1F. Acquisition of team skills	1
2. Organizational Management Skills	12
3. Supervision and Employee Evaluation Skills	9
4. Case Management Skills	6
5. Program Planning and Development Skills	5
6. Accounting	2
7. Orientation to Work Setting and Job Duties	1

Commentary: Administration

There is a general need reflected for training in the area of getting along effectively with fellow staff. Improving the quality of daily interactions among all levels and divisions of personnel seem implied from the responses. Skills include constructive feedback, making positive requests, expressing feelings and handling interpersonal conflict effectively.

On a much larger scale, managerial skills training is seen as a need. In contrast to personnel management, this area of skill concerns the formation and maintenacne of organizational systems involving communication of information, planning and decision-making, and evaluation.

TRAINING ASSESSMENT COMMITTEE METHOD
TOP TEN RANKED CLINICAL NEEDS

Item	# of Votes per Item	Individual Votes	Total Weighted Votes
1. Skills in Mental Status Exams	4	4,8,4 10	26
2. Advanced Group Psychotherapy Techniques (All Disabilities)	3	10,7,5	22
3. Diagnostic Skills Using DSM III	3	10,1,9	20
4. Human Sexuality Issues	2	9,10	19
5. Adolescent Group Therapy (All Disabilities)	3	1,10,7	18
6. Knowledge of Medications and Related Issues.	5	3,2,2, 4,4	15
7. Behavioral Management Techniques (Including handling risk of violence)	2	7,5	12
8. Learning Disabilities Diagnostic Skills	2	2,9	11
9. Cognitive Therapy Techniques	3	3,1,6	10
10. Skills in Setting Up Work Activity Programs (Including Data Collection)	2	8,2	10

Commentary: Clinical Needs

The top-ranked item, Mental Status Skills, consists of both cognitative knowledge of the major categories and practical skills in applying that knowledge in an interview situation with mentally ill persons. The use of role play and audio-visual process recall is recommended.

The second item, Advanced Group Psychotherapy Techniques, includes the generic skills of marketing, selection, development, termination and follow-up of group therapy. Issues as problems of confidentiality among clients in a small community are also implied. Secondly, this item calls for speciality training for individual staff in such areas as parenting, schizophrenics, Vietnam veterans, singles groups, depression, marital, substance abuse, and adolescents.

The third item on this list, DSM III Diagnostic Skills, addresses the desire for didactic teaching of recognition of the various disorders and differential diagnosis, and also practical application of this knowledge in the clinical setting.

Next on this list is Human Sexuality Issues, seen as a generic topic going across all disabilities. Specific areas of interest are knowledge and treatment of sexual dysfunction, background information on sexual identity, growth and development, pregnancy and its prevention, sex abuse, and partnering issues. "We have no one on staff clinically trained in any of these areas," was one observation made.

The fifth item is seen as a subset of the number two topic. The sixth, Medications, is the only subject on this ranking that is unanimously reflected as an interest, although no one ranked it high. Knowledge of the new psychiotropic drugs, the side effects of these drugs, the interaction of medications for the polypharmacy user, medications for the elderly population, and issues and risks of substance abusers receiving medication were given as specific needs. Other related subjects included the use of street and over-the-counter drugs, clinical implications of medication therapy, and the effects of medications on psychological test performance.

TRAINING ASSESSMENT COMMITTEE METHOD
TOP TEN RANKED PREVENTION AND CONSULTATION NEEDS

Item	# of Votes per Item	Individual Votes	Total Weighted Votes
1A. Public Relations/Speakers Bureau	4	7,8,6 6	27
1B. Parenting Skills Workshops	5	3,5,7 8,4	27
3A. Emergency Services Consultation Skills	4	9,6,3 7	25
3B. Training Paraprofessionals	3	10,6,9	25
5A. Consultation With Judical Systems	5	5,10,1, 1,5	22
5B. Effective Public Speaking	3	8,4,10	22
7. "Caspar" Training	4	7,9,3 2	21
8A. Consultation to Teachers re: Classroom Management	4	4,2,10 3	19
8B. Advanced Volunteer Management Training	3	6,5,8	19
10. Employee Assistance Program	3	1,9,8	18

Commentary: Prevention and Consultation Needs

The first item ranked is Public Relations/Speakers Bureau. The intention is to provide a team of representative staff members with training in planning and implementing an overall public relations strategy toward our catchment area community. Such an effort would include presentation delivery, use of brochures and audio-visual aids, use of the media and the mail and other public relations marketing approaches.

The next topic is Parenting Skills Workshops. The specific focus of this subject includes organizing and developing parent training groups, learning different teaching approaches for teaching parenting skills, understanding stages of growth for children and adolescents, and creative use of group interaction. In addition, the special needs of adult children of mentally disabled parents are a subject where additional training would be helpful.

Third on the list is Emergency Services Consultation Skills. This area of skills applies to the role most staff members play at times as consultants to gatekeepers, family members or other caregivers and service providers who are dealing with persons in psychiatric crisises. These skills are educational in nature: how to teach police, court service personnel, medical hospital staff, and family members how to identify and manage behavioral symptoms of persons in crisis. Typical target populations include potentially violent persons, emotionally troubled youth, substance abusers, and acutely psychotic or depressed persons. Another aspect is the skill of promoting effective networking and collaboration of resources for the person in crisis.

Training Paraprofessionals is next in order and includes marketing and recruitment techniques for involving volunteers; volunteer training and management within the Board Services system. Another target clientele are the staff aides and the operators of adult homes for training inpatient management.

The "Caspar" training on the list refers to a specific curriculum on substance use/abuse education aimed at school-age children and adolescents. Its focus is on growth and development issues, value clarification and decision-making. The recipients of the training would be public school teachers.

Employee Assistance refers to early identification and intervention of persons with psychiatric or substance abuse disturbance by employers in the community.

TRAINING ASSESSMENT COMMITTEE METHOD
TOP TEN RANKED ADMINISTRATION NEEDS

Item	# of Votes per Item	Individual Votes	Total Weighted Votes
1. Writing Grants	5	9,4,8, 4,10	35
2. Supervision Training	4	2,10, 10,7	29
3. Program Evaluation	5	5,6,7 9,1	28
4. Case Management	4	10,7,3 3	23
5. Staff Stress Management	3	10,6,3	19
6. Funding Sources	4	8,3,1 6	18
7. Staff Evaluation	4	4,1,8 4	17
8A. Fee Collecting	2	7,8	15
8B. Data Base Construction and Application	2	6,9	15
8C. Effective Charting	2	9,6	15
8D. Effective Communication	2	7,8	15

Commentary: Administration Needs

The skills involved in writing grants is both top-ranked and unanimous among the participants. This category is also linked with the sixth-ranked topic, Location of Funding Sources. This area of expertise is meant to include both technical skills of needs assessment, the organizaing and prioritizing of data, but also the political skills of developing and moblizing consistuency groups and fostering the support of decision-makers. This training would target the management level staff of the Board.

Case Management is placed under Administration because of arbitrary distimctions made in this needs assessment process. This topic includes training in the identification, assessment, referring, monitoring and follow-up process aimed at the multi-need client. Implicit also is training in the establishment of a case management system, both internally within the Board Services and on an interagency level.

Data Case Construction and Application refers to the skills involved in organizing various MIS data pertaining to clients, their demographics, symptoms, and treatment goals so that correlational studies can be done. The use of such analysis could have implications in the design and implementation of new services, group therapy compositions, staff patterning, and heightened fisical and services accountability.

APPENDIX H

USEAGE PERCENTAGE AND HINDRANCE RATIO RE: 150 COMPETENCIES OF THE SELF-ASSESSMENT QUESTIONNAIRE

TRAINING AND STAFF DEVELOPMENT NEEDS
SELF-ASSESSMENT QUESTIONNAIRE SUMMARY

COMPETENCY	PERCENT OF TIME COMPETENCY UTILIZED	RATIO OF TIME HINDERED
Assessment		
1. Ability to make on-the-spot determinations of the type and extent of service required by clients in crisis. (N =14)	40.00%	.1769
2. Ability to make professional judgements relative to client suicidal ideation. (N=17)	24.62%	.1407
3. Knowledge of the levels of severty of the abnormal behaviors. (N=17)	70.77%	.2860
4.Knowledge of psychological tests in relation to which tests are appropriate for which clients. (N=13)	29.23%	.4274
5. Ability to administer psychological tests. (N=6*)	27.69%	.1944
6. Ability to interprete psychological tests and reports. (N=12)	24.62%	.2917
7. Knowledge of signs of over perscription and under prescription of chemotherapeutic agents. (N=17)	45.38%	.4271
8. Ability to use DSM-III in relation to the establishment of diagnostic criteria. (N=16)	48.08%	.3220
9. Ability to document client problems in behavior-specific terms. (N=18)	57.69%	.2872

COMPETENCY	PERCENT OF TIME COMPETENCY UTILIZED	RATIO OF TIME HINDERED
General Counseling		
10. Ability to facilitate reality-based feedback to clients. (N=15)	88.46%	.2636
11. Ability to foster and encourage client responsibility. (N=17)	94.39%	.1965
12. Ability to select and justify intervention techniques. (N=17)	78.46%	.2260
13. Skill at appropriate self-disclosure in counseling.(N=16)	73.08%	.1384
14. Skill at confrontation in the counseling relationship. (N=16)	83.08%	.2234
15. Skill at demonstrating awareness of content and feeling in counseling sessions. (N=17)	70.00%	.2536
16. Knowledge of the steps for terminating a therapeutic relationship. (N=12)	25.77%	.1005
17. Ability to match techniques to personal abilities. (N=17)	83.85%	.1510
18. Ability to judge when techniques are appropriate and meaningful to the client. (N=17)	80.38%	.2230
19. Ability to recognize the client's defense mechanisms.(N=16)	90.00%	.2137
20. Ability to foster client independence and self-sufficiency. (N=17)	84.62%	.2116
21. Knowledge of the appropriate use of behavioral contracts.(N=16)	37.69%	.2704

COMPETENCY	PERCENT OF TIME COMPETENCY UTILIZED	RATIO OF TIME HINDERED
22. Knowledge of transference and countertransference issues. (N=14)	87.30%	.2211
23. Knowledge of different aspects of short and long term counseling. (N=15)	47.31%	.0803
Family Counseling		
24. Ability to accept family decisions differing with counselor's values. (N=17)	31.15%	.0928
25. Knowledge of various family intervention theories and strategies. (N=18)	25.00%	.4795
26. Ability to assess family interaction patterns, identifying family strengths, weaknesses, needs and problems as well as their ability to resolve problems. (N=17)	21.54%	.7448
27. Ability to identify sexual abuse, including incest. (N=15)	6.54%	.6000
28. Ability to identify physical and emotional abuse or neglect. (N=17)	7.31%	.4810
29. Ability to identify adolescent alcoholics or drug abusers. (N=11)	18.85%	.7629
Group Counseling		
30. Ability to explain confidentiality and role expectations to group members.(N=11)	10.38%	.2000
31. Knowledge of various group intervention theories. (N=14)	25.38%	.2609

COMPETENCY	PERCENT OF TIME COMPETENCY UTILIZED	RATIO OF TIME HINDERED
32. Ability to clearly define goals, structure and limits of group counseling. (N=14)	25.38%	.2870
33. Ability to assist group participants to learn effective inter-personal behavior. (N=15)	25.12%	.5551
34. Ability to foster trust-building relationships and participation between group members. (N=15)	31.48%	.5602
Clinical		
35. Knowledge of the basic concepts of group dynamics. (N=14)	38.02%	.1676
36. Ability to interact with members to build group cohesion. (N=14)	39.34%	.3128
37. Ability to foster group leadership. (N=13)	53.07%	.4031
38. Ability to negotiate contracts with group members. (N=14)	31.42%	.5560
39. Ability to select members for groups according to basic group dynamics guidelines. (N=12)	23.85%	.1774
40. Ability to process group interaction. (N=13)	40.82%	.3623
41. Ability to use role playing and other active techniques in groups to enable others to perceive and try new behaviors, attitudes, etc. (N=16)	12.69%	.5227

COMPETENCY	PERCENT OF TIME COMPETENCY UTILIZED	RATIO OF TIME HINDERED
Human Behavior		
42. Knowledge of verbal and non-verbal attending behaviors. (N=19)	86.39%	.2880
43. Knowledge of differences between cognitive and affective thinking. (N=19)	76.36%	.2290
44.Knowledge of common defense mechanisms. (N=18)	80.17%	.2090
45. Knowledge of sexual transitions and stages. (N=19)	33.77%	.0935
46.Knowledge of common personality types or patterns. (N=17)	89.77%	.1774
47. Knowledge of impact on personality development of diverse cultures, values ethnic and economic backgrounds. (N=17)	61.90%	.1629
48. Knowledge of definitions and concepts of psychopathology. (N=17)	76.47%	.2343
49. Ability to work with different special population client systems. (N=16)	68.07%	.1723
Intervention Strategies		
50. Ability to demonstrate both verbal and non-verbal attending behaviors. (N=18)	81.54%	.1954
51. Ability to identify abrupt shifts in conversation or recuring references that expose the client's problems. (N=17)	75.56%	.1604
52. Ability to design intervention programs for personality disordered persons. (N=15)	49.94%	.2752

COMPETENCY	PERCENT OF TIME COMPETENCY UTILIZED	RATIO OF TIME HINDERED
Clinical		
53. Ability to design intervention programs for psychotic persons. (N=13)	52.36%	.2282
54. Ability to design intervention programs for neurotic persons. (N=15)	58.15%	.1481
55. Ability to conduct play therapy sessions with children. (N=5*)	2.15%	.4286
56. Ability to negotiate and utilize fee payments as a therapeutic intervention. (N=6*)	52.30%	.1373
57. Knowledge of and ability to use psychoanalytic theories and methods. (N=13)	45.33%	.4490
58. Knowledge of and ability to use behaviorism theories and methods. (N=18)	58.97%	.3000
59. Knowledge of and ability to use transactional analysis theories and methods. (N=11)	59.16%	.2695
60. Knowledge of and ability to use gestalt theories and methods. (N=13)	42.49%	.3203
61. Knowledge of and ability to use rational-emotive theories and methods. (N=12)	63.46%	.4738
62. Knowledge of and ability to use reality therapy theories and methods. (N=14)	66.15%	.3439
63. Knowledge of and ability to use family systems theories and methods. (N=14)	42.42%	.4560

COMPETENCY	PERCENT OF TIME COMPETENCY UTILIZED	RATIO OF TIME HINDERED
Clinical		
64. Knowledge of and ability to use crisis intervention theories and methods. (N=15)	43.59%	.2682
65. Knowledge of and ability to do dream work with clients. (N=4*)	6.15%	.3750
66. Knowledge of life span development theory, including concepts of neonatal development, early, mid and late adolescence, adult development, aging and dying. (N=18)	30.43%	.5506
67. Knowledge of the therapeutic effects of the most commonly used chemotherapeutic agents, i.e.:anticonvulsants, tranquilizers, sedatives, narcotics, energizers, etc. (N=18)	51.97%	.5428
68. Knowledge of the similarities and differences among individual, family and group counseling. (N=16)	25.38%	.2176
69. Ability to use confrontation to facilitate client growth. (N=17)	69.95%	.1824
70. Ability to use feedback on non-verbal behaviors to facilitate client growth. (N=18)	80.38%	.2845
Record Keeping and Report Writing		
71. Ability to write an intake evaluation which includes presenting problem, diagnostic formulation and treatment recommendations. (N=17)	28.68%	.2114

COMPETENCY	PERCENT OF TIME COMPETENCY UTILIZED	RATIO OF TIME HINDERED
Clinical		
72. Ability to provide treatment summary information for use by other professionals. (N=17)	25.97%	.1777
73. Ability to make records and reports that confirm to the agencies medical record system. (N=15)	60.41%	.3005
74. Ability to write and maintain behaviorally oreiented progress notes. (N=19)	44.93%	.3243
Treatment Planning		
75. Ability to make relevant input into psychiatric team meeting on therapy programs and treatment direction. (N=14)	29.01%	.6402
76. Ability to organize and present facts, observations, critical incident information, and assessment results regarding a client in a case conference. (N=17)	18.00%	.5577
77. Ability to generate a working hypothesis from a comprehensive conceptualization of a case. (N=17)	30.31%	.3582
78. Ability to conceptualize a case given developmental data and diagnostic information from various theoritical frameworks. (N=18)	28.03%	.5579

COMPETENCY	PERCENT OF TIME COMPETENCY UTILIZED	RATIO OF TIME HINDERED
Clinical		
Mental Retardation (MR)		
79. Knowledge of theories and events/stages relating to normal human development. (N=17)	37.73%	.4053
80. Ability to assess developmental delays and distinguish these from mental retardation (MR). (N=11)	24.05%	.9826
81. Knowledge of MR, epilepsy, cerebral palsy: causes, classifications, effects of and generalized client needs. (N=9*)	37.09%	.7096
82. Knowledge of medical terminology related to MR. (N=8*)	16.92%	.9432
83. Knowledge/abilities in CPR and appropriate first aid methods. (N=2*)	10.76%	1.03571
84. Knowledge of MR programs within the community: day treatment, residential, foster, respite, infant intervention, and education. (N=9*)	17.60%	.3107
85. Knowledge of the benefit systems available to MR clients: Social Security, Medicaid, Employment. (N=11)	19.72%	1.5957
86. Knowledge of community resources for MR clients including speech, health, transportation, social services, occupational therapy, physical therapy, leisure time, and educational resources. (N=9)	24.96%	.5753

COMPETENCY	PERCENT OF TIME COMPETENCY UTILIZED	RATIO OF TIME HINDERED
Clinical		
87. Knowledge of rehabilitation techniques, systems, and programing strategies related to MR. (N=8*)	39.23%	.7304
88. Knowledge of early assessment and intervention procedures and strategies for MR. (N=4*)	26.92%	1.0714
89. Knowledge of parenting models and activities to teach to parents of MR clients. (N=4*)	26.92%	1.1000
90. Ability to assess client's potentials/handicaps in relation to the areas of: cognitive skills, self-help skills, motor skills, vocational skills, domestic living skills and community/social adjustment. (N=9*)	37.44%	1.0228
91. Ability to use behavior modification theories in the management of MR clients. (N=7*)	46.81%	.7089
92. Knowledge of programing in day treatment residential MR programs. (N=4*)	51.53%	.5299
93. Knowledge of programing techniques related to the acceleration of functional skills. (N=7*)	49.45%	.7200
94. Knowledge of programing techniques for the deceleration of maladaptive behaviors including aggression. (N=8*)	21.54%	1.3750

COMPETENCY	PERCENT OF TIME COMPETENCY UTILIZED	RATIO OF TIME HINDERED
Prevention and Consultation		
95. Knowledge of Carpman's and Schien's consultation models. (N=4*)	11.54%	.3267
96. Knowledge of the various roles that consultants can carry out in consulting relationships. (N=15)	20.21%	.9441
97. Knowledge of stress management techniques. (N=17)	41.90%	.7991
98. Knowledge of employee assistance program design. (N=6*)	6.15%	3.2083
99. Ability to communicate effectively to groups at various levels of sophistication. (N=17)	19.46%	1.1209
100. Ability to speak in public and facilitate audience participation. (N=14)	5.71%	1.9423
101. Ability to serve as a consultant to various community groups and agencies. (N=14)	10.99%	1.0100
102. Knowledge of survey feedback methods. (N=4*)	31.54%	.2195
103. Knowledge of and skill in using a variety of needs assessment methods. (N=7*)	19.12%	.4368
104. Knowledge of marketing approaches to mental health services. (N=8*)	16.15%	1.7143
105. Knowledge of learning theories and methods. (N=14)	17.58%	.7250
106. Knowledge of program development theory. (N=13)	6.98%	2.8813

COMPETENCY	PERCENT OF TIME COMPETENCY UTILIZED	RATIO OF TIME HINDERED
Prevention and Consultation		
107. Knowledge of family life education concepts. (N=10)	6.15%	1.0000
108. Ability to work with the mass media. (N=9*)	2.95%	4.4100
109. Knowedge of community organization concepts. (N=10)	6.92%	1.9130
110. Knowledge of prevention theories and and concepts. (N=17)	11.13%	.9186
111. Knowledge of networking theories and methods. (N=15)	14.87%	1.1103
112. Knowledge of and ability to use different programing models and methods. (N=14)	13.84	1.4603
113. Knowledge of journalism concepts. (N=9*)	13.16%	1.1039
114. Knowledge of large group dynamics theory. (N=12)	12.69%	1.6122

COMPETENCY	PERCENT OF TIME COMPETENCY UTILIZED	RATIO OF TIME HINDERED
Administration		
115. Forecasting- estimating the future of the organization. (N=8*)	2.69%	5.3571
116. Setting program objectives-determining results to be obtained. (N=12)	18.72%	.1918
117. Programing: establishing a plan of action to follow in reaching objectives. (N=11)	32.02%	.4148
118. Scheduling: establishing time requirements for objectives or programs. (N=11)	23.36%	.1737
119. Policy-making: establishing rules and regulations from predetermined decisions. (N=7*)	7.69%	4.2571
120. Establishing procedures: determining consistent and systematic methods handling work. (N=13)	43.90%	.4852
121. Analyzing problems: identifying and relating data pertinent to the solution of a program. (N=14)	57.58%	.4523
122. Structuring: grouping work for effective and efficient production. (N=13)	13.07%	1.4389
123. Integrating: establishing conditions for effective teamwork among organizational units. (N=13)	44.62%	.5676
124. Linking: building and maintaining linkages with other organizations in the environment. (N=10)	35.77%	.9052

COMPETENCY	PERCENT OF TIME COMPETENCY UTILIZED	RATIO OF TIME HINDERED
Administration		
125. Selecting personnel: identifying and appointing people to organizational positions. (N=3*)	3.59%	1.0000
126. Recruiting and selecting volunteers: chosing appropriate volunteers, training rewarding and maintaining them. (N=10)	22.43%	.5833
127. Measuring performance: assessing actual versus planned performance. (N=12)	20.25%	.6013
128. Monitoring programs to insure the achievement of program objectives. (N=10)	6.15%	2.3750
129. Developing program evaluation strategies. (N=7*)	2.86%	6.2300
130. Budgeting: determining and assigning the resources required to reach objectives. (N=7*)	18.24%	1.0000
131. Knowledge of accounting procedures necessary for fiscal management. (N=5*)	37.88%	.4772
132. Knowledge of motivational factors; influencing professionals to perform in a desired manner. (N=9*)	89.90%	.3480
133. Knowledge of and ability in interagency coordination. (N=12)	23.85%	.3602
134. Knowledge of and ability to develop fund-raising techniques. (N=3*)	41.54%	.9012
135. Developing and writing contracts. (N=5*)	21.85%	1.0143

COMPETENCY	PERCENT OF TIME COMPETENCY UTILIZED	RATIO OF TIME HINDERED
Administration		
136. Managing and monitoring contracts to insure the delivery of services. (N=4*)	11.54%	2.5333
137. Knowledge of and ability to design and implement a needs assessment study. (N=3*)	2.56%	15.4000
138. Knowledge of and ability to write grants. (N=3*)	2.56%	15.8000
139. Knowledge of and ability to develop a public information program to promote agency programs. (N=7*)	2.85%	2.2307
140. Knowledge of and ability to work with agency boards to achieve program goals. (N=5*)	3.38%	2.0000
141. Ability to develop training programs for board members. (N=2*)	1.54%	1.5000
142. Ability to supervise interns and volunteers. (N=11)	6.29%	1.2000
143. Knowledge of management theories and techniques. (N=11)	64.20%	.5272
144. Knowledge of and ability of marketing approaches for mental health services. (N=4*)	50.77%	.1288
145. Knowledge of interorganizational theory. (N=5*)	41.23%	.6194
146. Knowledge of networking theory. (N=9*)	14.87%	1.0345
147. Knowledge of matrix management concepts. (N=5*)	2.15%	11.7143
148. Knowledge of planned change theories. (N=4*)	1.54%	17.7500

COMPETENCY		PERCENT OF TIME COMPETENCY UTILIZED	RATIO OF TIME HINDERED
Administration			
149. Knowledge of bargaining/ concepts.	(N=4*)	3.85%	9.5000
150. Knowledge of public policy change stategy.	(N=2*)	10.76%	5.8571

* Because of the small sample size, a response was counted in the ranking of the top needs in each of the three main categories only if 10+ persons of the respondent group indicated that they utilized this item in their professional practice at least quarterly.

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ASSESSING THE TRAINING AND STAFF DEVELOPMENT NEEDS OF MENTAL HEALTH/MENTAL RETARDATION PROFESSIONALS: A MULTI-METHOD FRAMEWORK

by

Dennis Robert Cogswell

Committee Chairman: Harold Stublefield
Adult and Continuing Education

(ABSTRACT)

This research addressed the need for the development of a multi-method needs assessment framework that could be used by Training Directors within the 40 Community Service Boards in Virginia to identify the training and staff development needs of professional staff. The study was carried out over a one year time period. First a multi-method needs assessment framework was developed. This framework consisted of three different needs assessment methods designed to produce a list of the top ranked needs in relation to (a) clinical, (b) prevention and consultation and (c) adminstration training and staff development needs. These methods were: (a) the review of performance evaluations by a three person committee, (b) the use of a nominal group technique by a five person Training Assessment Committee and (c) the completion of a Self-assessment Questionnaire by the professional staff on the rate of hindrance on each of 150 competencies that pertain to community mental health and mental retardation

professional practice.

Following review and varification by a panel of experts, this multi-method framework was field tested in the Rockbridge Mental Health Center, Lexington, Virginia. Those needs that were identified by all three methods of the multi-method framework for this CSB were listed as the primary training and staff development needs.

The research concluded that the multi-method needs assessment framework had sufficient utility for it to be used throughout Virginia in the 40 CSBs to assess training and staff development needs. The triangularization of data allowed the needs identified by one method to validate the needs identified by the other methods.