A PROVIDER'S GUIDE

on How to Use Core Competencies in Behavioral Health

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration

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in Behavioral Health

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CHAPTER 1:

Introduction and Overview

Why is there a need for competencies in behavioral health?

At the foundation of behavioral health policy is recovery, the promise that those with mental health and substance use disorders can recover full and productive lives. But that promise is empty if there is not an available workforce, large enough and with sufficient competencies, to address mental health and substance use disorders. The challenge is to transform the workforce in the behavioral health fields, most of which have little history of collaboration, and to develop infrastructure that can support evidence-based behaviors and newly defined competencies at the individual, professional, organizational, and system levels.

The Annapolis Coalition called for the use of competency-based approaches to improve the behavioral health workforce.[1] The Substance Abuse and Mental Health Services Administration (SAMHSA) has responded by developing *A Provider's Guide: How to Use Core Competencies in Behavioral Health* and other activities to support the behavioral health workforce.

As prevention and treatment providers across the Nation struggle to recruit and retain prevention specialists, clinicians, and counselors, ensuring staff competencies is particularly crucial. As John Porter of the Northwest Frontier Addiction Technology Transfer Center (NFATTC) stated, "The workforce shortage is apparent in every state: There aren't enough people out there who are qualified or willing to work in the field or resources available to hire counselors qualified to do the work adequately. Agencies are hiring counselor and training them up, rather than hiring the qualified counselors they need."[2]

The goal of developing and implementing core competencies in behavioral health is to advance an understanding of the skill sets and competencies essential to educate and train a competitive workforce. Investing in the development and implementation of core competencies is an approach with the potential to yield measurable results such as improved levels of staff professionalism and enhanced quality of service.

Competency-based approaches to supervision, professional development, employee performance reviews, and career ladders can be key factors in transforming an entire provider agency's approach to prevention, treatment, and recovery. *The Change Book: A Blueprint for Technology Transfer* notes that although training is an important aspect of technology transfer, "brief flurries of training alone" will not create lasting change. True technology transfer "involves creating a mechanism by which a desired change is accepted, incorporated, and reinforced at all levels of an organization or system."[3]

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[1] Hoge, M.A., Tondora, J., & Marrelli, A.F. (2005). The fundamentals of workforce competency: Implications for behavioral health. *Administration and Policy in Mental Health, 32*, 5, 509-531.

[2] Personal communication. Porter is a technology transfer specialist on staff of NFATTC and also offers consultation through his own company, Pegasus Training & Consulting, which is based in Wilsonville, OR.

[3] Addiction Technology Transfer Center National Office. (2004). *The Change Book: A blueprint for technology transfer,* 2nd ed. Kansas City, MO: Author.

Dwayne Simpson, a researcher focused on implementing research to practice in behavioral health, notes that problems in implementing technology transfer are often the result of organizational factors, such as "leadership attitudes, staff resources, and organizational stress" more than any particular dissemination policy.[4] The focus on competency-based quality-improvement programs can provide the underlying organizational support for employees, their supervisors, and the clients they serve.

Purpose of these resources for competency diffusion

These resources have been developed to support the dissemination and implementation of competencies within the behavioral health field. A Providers Guide: How to Use Core Competencies in Behavioral Health is designed to provide a rich array of resources to use established competencies as the basis for operations, consistent job descriptions, recruitment and retention initiatives, educational and training requirements, curricula, and licensing and credentialing requirements.

Who should use these resources?

This guide is designed to support the use of competencies within behavioral health provider organizations. In addition, State, county, and local policymakers, colleges and universities, licensing and credentialing boards, professional associations, and others will be able to use this information to implement competency-based policies, courses, and tests, and for any other uses.

Organization of Guide

The guide is divided into eight chapters, with sections and subcategories in most sections:

- **Chapter 1: Introduction and Overview**—The introduction discusses the need for core competencies in behavioral health, the purpose of these resources, who should use them, and how they can be used.

- **Chapter 2: Competencies and Competency Models**—This chapter explains what a competency is, the benefits of implementing competencies, and how use of competencies can improve quality and professionalism. It helps organizations answer these questions: Why should an organization implement core competencies? What are the benefits to a provider organization (whether they are public programs, private nonprofits, or for-profit agencies)?

- **Chapter 3: Case Studies of Implementation of Competency Models in Behavioral Health**—This chapter features case studies on competency development and implementation in three areas: prevention of substance use disorders, treatment of substance use disorders, and treatment of co-occurring disorders (COD).

- **Chapter 4: Planning for the Implementation of Core Competencies**—This chapter describes the importance of planning for organizational change.

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[4] Simpson, D. D. (2002). A conceptual framework for transferring research to practice. *Journal of Substance Abuse Treatment, 22*(4), 171-182.

- **Chapter 5: Using Competencies in Certification, Licensing, and Credentialing**—This chapter discusses the many connections between competencies and certification and credentialing.

- **Chapter 6: Using Competencies in Human Resources: Career Ladders, Job Descriptions, and Supervision**—Competencies can be used to develop career ladders/lattices, to write job descriptions, and for effective supervision. This chapter provides an example of a career ladder in treatment of substance use disorders.

- **Chapter 7: Planning for Training and Professional Development Linked to Competencies**—This chapter contains several assessment measures and learning plans that can be used or adapted to identify areas needed for training and to document learning.

- **Chapter 8: Links and Bibliographic References for Implementing Competencies**—This chapter contains a list of Web links and resources, as well as an extensive bibliography, on competency-related issues.

In addition there are a number of resources mentioned in this Guide that are available for download in Appendix A.

Use and adaptation of these strategies and resources

The materials and documents that can be downloaded from this Web site were designed and collected for widespread use. Some are protected by copyright and may not be altered without permission of the copyright holder. Additionally, some of the links refer to materials that are free but are still protected by copyright; those materials cannot be changed or republished, including by posting on another Web site, without permission from the copyright holder. Only a very few links will refer to Web sites offering materials that must be purchased.

CHAPTER 2:

Competencies and Competency Models

SECTION 2.1: What are competencies and how are they used?

A ***competency*** is the capability to apply a set of related knowledge, skills, and abilities (KSAs)[5] in a defined work setting to successfully perform job duties and responsibilities. Competencies may also include other characteristics such as attitudes, values, and traits required for successful performance. Competencies correlate with performance on the job, can be measured against well-accepted standards, and can be acquired and improved through experience and training.

Individual competencies are often grouped into competency models to facilitate discussion and understanding of how to apply multiple competencies on the job. A ***competency model*** is a collection of competencies that together define successful performance in a particular job, job group, occupation, organization, or industry. They may include skills and abilities required for different levels of mastery, as well as information about the level of competence required.

Competency models serve as the foundation for important human resource functions such as recruitment and hiring, training and development, and performance management, because they specify what characteristics must be selected, trained, and developed. In doing so, competency models add quality-of-work performance value to the whole organization. More information on competency models is available at the [Competency Model Clearinghouse](#) or at [O*NET](#).

For an example of a generic competency model, see Appendix A, Resource for Section 2.1.

Benefits of implementing core competencies

Competencies are a critical tool in workforce planning. They are a means to focus employee development efforts to eliminate gaps between existing and desired capabilities. The goal of developing and implementing core competencies in behavioral health is to advance an understanding of the skill sets and competencies essential to educating and training a competitive workforce. "A competent workforce is one of the key components of the Nation's public health infrastructure: a workforce that has the basic knowledge, skills, abilities, and attitudes that allow for delivery of essential public health services in all program areas, in a way that is culturally competent and effective."[6]

By developing and implementing competency-based models within the field, providers, policymakers, and educational and training programs can develop resources that they can then customize and enhance in a

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[5] Some competency models use the term "attitudes" instead of abilities. Others use abilities but will also add "personal characteristics" to cover the more personal strengths needed to succeed in a position, instead of attitudes.

[6] Association for Prevention Teaching and Research (APTR) and the Center for Health Policy, Columbia University School of Nursing. (2008). [Competency to Curriculum Toolkit: Developing Curricula for Public Health Workers](#).

variety of ways. Those resources can be used to foster talent development, support collaborative efforts to develop and promote career pathways, and bridge the gap between behavioral health programs and educational program providers to ensure a supply of workers with the appropriate skills. Given the shortages of behavioral health workers in general, and the emphasis on using emerging evidence-based practices to improve quality, the development of competency models in behavioral health can be a key component to expand and improve talent-development efforts in the behavioral health workforce.

Competency models serve as a starting point for articulating and analyzing regional skill needs. They help identify industry needs by:

- providing a common language to facilitate discussion and collaboration between behavioral health and education partners;

- documenting and communicating changes in skill needs and competency requirements;

- providing a resource for developing behavioral health program skill surveys; and

- detailing short-term training needs.

By clearly articulating behavioral health workforce needs, competency models provide a voice for the industry to articulate to educational program providers the skills needed to train a competent and competitive behavioral health workforce.

Competency models are used in a variety of other human resource solutions including development of strategies (e.g., career pathways) to prepare and attract new workers in an industry; creation of competency-based position descriptions to facilitate recruitment, job matching, and performance appraisals; and establishment of talent development programs, such as apprenticeships or employee enrichment programs. They can also be used to assess succession plans in preparation for reorganizations or pending retirements.

Competency-based career guidance

Career guidance activities help individuals explore career interests and educational options. Competency models are used in guidance activities to:

- define work-readiness in terms of in-demand competencies;

- interpret career assessment results so individuals can view their strengths and weaknesses in the context of in-demand careers and industries;

- identify and discuss individual skill gaps;

- suggest relevant postsecondary education and training opportunities;

- help students plan their courses in accordance with industry demands; and

- match the skills of graduating students to appropriate industry networks.

Competency-based career pathways

Career pathways identify the educational, experiential, and competency requirements needed to prepare a worker for entry into and advancement within a designated career area. Career pathway resources are often the result of talent development efforts and must be created, implemented, and maintained collaboratively by program managers, human resource professionals, and those outside of an agency, such as higher education and training programs. They provide a framework that enables individual staff members with transferable, competency-based skills to progress in the behavioral health field by meeting both workforce and individual needs. Competency-based career pathways may be used in a variety of ways:

- attracting individuals to an industry by showing potential career development and career progression beyond entry points;

- showing workers how different jobs interconnect within careers in an industry; and

- informing workers about the training, education, and developmental experiences that would enable them to accomplish their career objectives.

Competency-based certifications and assessments

Competency-based assessments are used to document mastery of technical competencies that allow workers to embark or advance along a career pathway. For example, the information gained from certifications and assessments can be used by individuals as credentials to better manage their education and career, and by employers to gain a better understanding of their workers' skills.

Competency models inform assessment development by detailing essential competencies included in professional certification and licensure requirements, and by informing the development of tests that measure desirable work-related KSAs. Competency models:

- identify the basic literacy, numeracy, and academic competencies required for success in behavioral health occupations;

- identify the foundational and workplace competencies expected in specific behavioral health occupations and jobs;

- detail the essential competencies to be included in professional certification and licensure requirements; and

- inform the development of tests that measure desirable work-related knowledge and skills such as understanding the treatment and recovery process, and being able to screen and assess situations and symptoms.

Competency models used for education and training

Competency models are used in higher education and continuing education to select appropriate education and training programs to remedy knowledge or skill gaps and ensure that future workers have the right qualifications. They allow higher education and training programs to design and develop course and program curricula based on emerging and declining skills, determine which competencies are in highest demand, and help students plan their courses accordingly. The use of competency models also can help colleges, universities, and human resources professionals interpret career assessment tools so that students and workers view their strengths and weaknesses, and their likes and dislikes, in the context of the workplace.

Behavioral health experts can use competency models to ensure that behavioral health curricula and professional and technical programs are responsive to identified skill requirements. Basing courses on competencies can reduce the course and program curriculum development time, eliminate redundancy across courses, improve instructional materials, and provide the field with better-trained employees who need less additional training.

For example, many 2- and 4-year colleges with substance use disorder treatment programs currently use accepted addiction counseling competencies to develop syllabi and/or curricula.[7] These competencies are used in to develop courses, as well as to negotiate articulation agreements between 2- and 4-year institutions. Articulation agreements are a critical, but often thorny, issue in higher education; community colleges need to assure their students that courses will be accepted by colleges and universities that grant Bachelor's degrees, and 4-year institutions need reassurance that the courses are sufficiently rigorous to meet the standard for the Bachelor's degree. Using industry-standard competencies as the basis for curricula can reassure both parties.

State licensing and credentialing groups can collaborate with college educators and others to disseminate information about texts that are used to support courses for entry-level licensure to meet competency standards.

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[7] CSAT's Technical Assistance Publication (TAP) 21: *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice,* and TAP 21-A, *Competencies for Substance Abuse Treatment Clinical Supervisors*.

SECTION 2.2: How competencies can improve quality

With the challenge of decreased resources and increased demand, effectively developing and utilizing human capital is critical to successful delivery of services. Investing in the development and implementation of core competencies is an approach with the potential to yield noticeable results such as improved levels of staff professionalism and enhanced quality of service. The following "Case in Point" stories briefly illustrate how competencies have been used in health fields to foster employee development, improve performance, and enhance service to the client.

> *Case in Point*: The Florida State University School of Social Work, Institute for Family Violence Studies, developed *Domestic Violence: A Competency-Based Training Manual for Community Mental Health Center Staff* to help community mental health counselors correctly identify clients affected by domestic abuse. The heart of the manual teaches professionals how to spot the signs of abuse, ask a potential victim about abuse, and assist victims with special services. The competency-based training manual was used in the Community Mental Health Counselor Training Pilot Project. The Apalachee Center for Human Services, a local mental health counseling agency with outreach programs in six other counties, served as the pilot's focus. Counselors were provided with training, and after a 6-month follow-up, were found to have significantly increased their identification of clients who were victims of domestic violence and abuse. For more information, view the Competency-Based Training Manual.

> *Case in Point*: The University of California San Diego Medical Center developed the Nursing Competency-Based Orientation Pathway (CBO) to provide comprehensive and consistent orientation to their acute care nursing units. The CBO guides new employees in understanding the expectations of the University. The competencies identified in the CBO provide a foundation for employee development efforts that promote high standards of nursing practice. New hires complete a self-assessment before orientation begins. The results of the self-assessment inform the development of individualized orientations tailored to the learning needs of the employee. For more information, view the CBO.

> *Case in Point*: The Nursing Career Lattice Program, sponsored by the Council for Adult and Experiential Learning and the U.S. Department of Labor, addresses the current national nursing shortage with the development of a career lattice program intended to increase the number of Certified Nursing Aides (CNAs), Licensed Practical Nurses, and Registered Nurses in the United States. The program allows nurses to advance in their careers through competency-based apprenticeship and training programs. The Harris County Hospital District (HCHD) in Houston, Texas used the nursing career lattice model to address significant shortages in CNA nursing staff, as even more CNAs were needed for a large community health program that was expanding.[8] The career lattice initiative helped HCHD meet its projected needs, increase morale, and improve the quality of service.

> Two noteworthy outcomes of the initiative illustrate both improved staff professionalism and enhanced quality of service. First, 60 percent of those who have already completed the CNA apprenticeships indicate that they plan to continue advancing in their nursing careers. Second,

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[8] *How Career Lattices Help Solve Nursing and Other Workforce Shortages in Healthcare* (http://www.cael.org/pdfs/13_Career_Lattice_guidebook).

waiting times in clinics decreased from 4 hours to 70 minutes because community health clinics were able to proceed with their staffing redesign projects on schedule. The lattice helped incumbent administrative staff become CNAs, thus increasing the pool of CNAs at HCHD and achieving HCHD's goal of expanding access to clinics.

SECTION 2.3: Competency development in related fields

Many segments of the behavioral health field are developing and implementing competencies to improve the quality of their workforces. These initiatives can be classified into four categories: Substance Use Disorders, Disciplines, Populations, and Special Approaches to Care.

MAJOR AREAS OF COMPETENCY DEVELOPMENT IN BEHAVIORAL HEALTH			
Substance Use Disorders	**Disciplines**	**Populations**	**Special Approaches to Care**
• Addiction Counseling • Interdisciplinary Health Professionals	• Marriage and Family Therapy • Professional Psychology • Psychiatric-Mental Health Nurse Practitioners • Psychiatric Rehabilitation • Psychiatry • Social Work	• Children • Serious and Persistent Mental Illness	• Recovery • Cultural Competency • Peer Specialists

Behavioral health is not alone; other health care fields are developing competencies as well. Although many of these projects are in their infancy, public health, marriage and family therapy, and health care leadership are among the vanguard in competency development.

Public health competencies

The 1988 Institute of Medicine report *The Future of Public Health* found that public health education should be more focused on practice-specific training and research. Consequently, the Public Health Faculty/Agency Forum developed recommendations for making public health education more relevant to public health practice in the field. The Council on Linkages Between Academia and Public Health Practice, an outgrowth of the Public Health Faculty/Agency Forum, developed the Core Competencies for Public Health Professionals. Originally adopted in April 2001, the resulting competencies were reviewed by more than 1,000 public health professionals and aligned with the Essential Public Health Services, and describe the public health activities necessary in all communities. Mechanisms for feedback included email focus groups, sessions at conferences, and the competencies Web site.

The public health competencies were designed to foster workforce development by:

- helping academic institutions and training providers develop curricula and course content;
- helping them evaluate public health education and training programs;
- providing a framework for hiring and evaluating staff; and
- assessing organization-wide gaps in skills and knowledge.

The Core Competencies for Public Health Professionals model incorporates three job categories or workforce segments: front-line staff, senior-level staff, and supervisory and management staff. Each competency is assigned a skill level (aware, knowledgeable, or advanced) for each workforce segment.

The competencies are currently being used by academic institutions and health departments around the country as well as by The Centers for Disease Control and Prevention, The Center for Public Health Preparedness, and The Health Resources and Services Administration's Public Health Training Centers. They were included in the objectives and recommendations set forth in *Healthy People 2010* and the Institute of Medicine's reports *Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21*st *Century* and *The Future of the Public's Health in the 21*st *Century*. Public health sectors are developing competencies to complement the core competencies or using them as a foundation for more specific competencies.

Examples of how organizations are applying the Core Competencies for Public Health Professionals:

- [The New York/New Jersey Public Health Training Center](#) used an assessment instrument adapted from the core competencies to conduct a training needs assessment in the New York and New Jersey Health Departments. The results of this assessment are guiding the design and evaluation of all Center training initiatives.

- [The University of Illinois at Chicago Public Health Preparedness Center](#) used the core competencies as a framework for designing courses for online training programs. These programs, focused on public health and bioterrorism preparedness, help users assess their own competencies and then find training opportunities to address their weaknesses.

- The core competencies were incorporated in *Community and Public Health Nursing*, a text used at many undergraduate and graduate schools of nursing throughout the U.S.

- The University of Texas at Brownsville integrated the core competencies into their M.S. Public Health Nursing and M.S. Public Health curricula.

- The Public Health Department of Washtenaw County, Michigan, uses the core competencies for behaviorally based interviewing in their recruitment and hiring process. Managers write job descriptions based on competencies defined for each position.

- The Connecticut Department of Public Health uses the core competencies to evaluate staff, conduct gap analyses to identify training needs, and provide appropriate educational opportunities.

- [The University of Connecticut Masters of Public Health](#) program uses the competencies to survey its alumni to assess how well their educational experience prepared them for their professional roles.

Examples of how public health sectors are using the Core Competencies for Public Health Professionals:

- [The Informatics Competencies for Public Health Professionals](#) were designed to complement the core competencies. They use the same skill level and job category systems. Some of the core

competencies are included as informatics competencies while acknowledging their dual role as core competencies.

- [The National Training Initiative for Injury and Violence Prevention](#) developed competencies needed to implement injury and violence prevention programming to identify requirements for its workforce.

- The Centers for Disease Control and Prevention's [Applied Epidemiology Competencies](#) were developed within the framework of the Core Competencies for Public Health Professionals.

- The Core Competencies Workgroup of the Public Health Foundation updated the [Public Health Competencies](#) to reflect new developments in the field. In addition, the foundation has developed the [TrainingFinder Real-time Affiliate Integrated Network (TRAIN) Web site](#) that enables learners to search for courses by different sets of public health competencies.

Marriage and Family Therapy Core Competencies

In 2003, the American Association for Marriage and Family Therapy (AAMFT) convened a task force to develop [Marriage and Family Therapy Core Competencies](#) (MFTCC). The MFTCC were developed with consideration of the broader behavioral health system and relied on three reports to provide a framework: *Mental Health: A Report of the Surgeon General (1999)*, the President's New Freedom Commission on Mental Health's *Achieving the Promise: Transforming Mental Health Care in America (2003)*, and the Institute of Medicine's *Crossing the Quality Chasm (2001).* The ultimate goal of the MFTCC is to improve the quality of services provided by marriage and family therapists. The MFTCC are organized around six primary domains and five secondary domains. The primary domains are:

- admission to treatment;
- clinical assessment and diagnosis;
- treatment planning and case management;
- therapeutic interventions;
- legal issues, ethics, and standards; and
- research and program evaluation.

The secondary domains categorize the types of skills or knowledge marriage and family therapists must develop: conceptual, perceptual, executive, evaluative, and professional.

Following completion of the MFTCC 2004, AAMFT decided to support their implementation by creating a beta test group. This group consists of eight marriage and family therapy training programs that are using the MFTCC in their curricula. Members of the group received resources to help implement the MFTCC. One result has been the development of a framework for mapping the competencies. Significantly, the MFTCC are included in the Commission on Accreditation for Marriage and Family Education's *Standards for Accreditation*, which accredits master's, doctoral, and post-graduate degree clinical training programs in marriage and family therapy throughout the United States and Canada.[9]

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[9] Nelson, T. S., Chenail, R. J., Alexander, J. F., et. al. (Oct. 2007). The Development of Core Competencies for The Practice Of Marriage and Family Therapy. American Association for Marriage and Family Therapy. *Journal of Marital and Family Therapy.* Volume 33 Issue 4, Pages 417—438.

Health Leadership Competency Model

The National Center for Healthcare Leadership (NCHL) produced the Health Leadership Competency Model to serve as a basis for focusing training and development initiatives and to provide a template for selecting and developing leaders who can meet the challenges of the 21st century. The model provides a guide for reorienting human resource development to stimulate the capabilities that have the most impact on performance.

To implement the model, the NCHL and the Association of University Programs in Health Administration formed the Graduate Health Management Demonstration Project. The project assists university demonstration sites in initiating a comprehensive review of their curriculum and teaching and assessment methods, and developing a plan for ongoing improvement. This includes:

- developing and implementing a program-wide, competency-based curricula and assessment using the Health Leadership Competency Model;

- participating in outcomes evaluation using measures and methods specified by NCHL evaluators; and

- disseminating learning and best practices including teaching/learning materials, evaluation methods, and instrumentation.[10]

The first four demonstration sites—University of Michigan, University of Minnesota, Simmons College, and University of Washington—were supplemented by six additional sites in 2006. NCHL is planning further efforts to disseminate the model to the academic community.

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[10] The National Center for Healthcare Leadership. (2005). NCHL Health Leadership Competency Model™ Retrieved from: http://www.nchl.org/static.asp?path=2852,3238, November 23, 2009.

Case Studies—Competency Models in Behavioral Health

SECTION 3.1: Overview of case studies

The creation, validation, and implementation of competencies within the behavioral health field are at various stages of development depending on the discipline, settings, and target populations served. This section features case studies on competency development and implementation in three areas: prevention of substance use disorders, treatment of substance use disorders, and treatment of COD. The following is a brief description of each case study. For more details, please see each case study.

- **3.2: Introduction to the prevention case studies**—Prevention competencies are still emerging and not as uniformly applied across the country as in other areas of behavioral health. Nationally, 37 States and the District of Columbia have licensing or credentialing requirements for substance abuse prevention specialists, whereas 13 States have no such requirements for practitioners. The two case studies in this section provide background necessary to understand prevention competencies by highlighting two unusual approaches to the adaptation and implementation of the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (IC&RC/AODA) competencies.

- **3.3: State implementation of prevention competencies**—The State of South Carolina requires certification, or work toward certification, for prevention workers in agencies that receive State or Federal funding. However, the State experienced high staff turnover and resistance to training and certification from all sectors, and officials were concerned about the quality and professionalism of the prevention workforce. In 2008, the State developed a statewide, competency-based **Professional Development Plan** and **Prevention Training Menu** along with extensive recommendations for diffusing those competencies at the local, regional, and State levels.

- **3.4: Provider adaptation and implementation of prevention competencies**—Florida does not require any type of credentialing and licensing of prevention practitioners, and salaries are quite low in the field. Operation PAR (Operation Parent Awareness and Responsibility), a behavioral health provider in West Central Florida, adapted the IC&RC prevention competencies and used them to develop competency-based job descriptions, a model for supervision and performance reviews, and a model for professional development to improve the quality of their workforce and retain skilled employees.

- **3.5: Implementing core competencies in addiction counseling (TAP 21)**—The National Curriculum Committee of the Addiction Technology Transfer Center (ATTC) Network developed *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes for Professional Practice* (Technical

Assistance Publication [TAP] 21) to support efforts to improve the quality of treatment staff, their ability to implement evidence-based practices, and, ultimately, client outcomes. An updated edition was later produced under contract #270-04-7049. SAMHSA's Center for Substance Abuse Treatment published the Technical Assistance Publication and followed TAP 21 with a companion piece on core competencies for clinical supervisors of addictions counselors (TAP 21-A, *Competencies for Substance Abuse Treatment Clinical Supervisors*). This case study describes how NFATTC supported providers in Idaho, Oregon, and other States to move this powerful tool for quality improvement and enhanced clinical supervision off the shelf and into the hands of the treatment counselors it was designed to support.

- **3.6: Development and implementation of competencies in COD**—Although there are currently no national competencies certifying clinicians in treatment of COD, SAMHSA's Co-Occurring Center for Excellence (COCE) has outlined 12 overarching principles for working with persons with COD. Some principles guide systems of care, whereas others guide the work of individual providers. SAMHSA also published a Treatment Improvement Protocol (TIP) on COD: *Substance Abuse Treatment for Persons with Co-Occurring Disorders* (TIP 42), which presents some of the competencies that may be required for treatment staff. Additionally, SAMHSA has provided funding through the Co-Occurring State Incentive Grant (COSIG) program to improve screening and treatment of COD. This case study focuses on how two States, Connecticut and Vermont, successfully leveraged their COSIG grants to develop and implement competencies based on the COCE principles and TIP 42, and to bring those competencies to a wide variety of clinicians, case managers, and peer counselors across a broad spectrum of treatment settings and social service agencies.

SECTION 3.2: Introduction to the prevention case studies

The development of prevention competencies is emerging. As a result, policies that use competencies to develop licensing or credentialing standards for mental health and substance use disorder treatment providers differ dramatically in the prevention field. The IC&RC/AODA offers competency standards that define successful performance in the prevention setting through a process of role delineation and job analysis aimed at helping the prevention practitioner to succeed at "critical work functions" or tasks in the prevention arena.

Thirty-seven States and the District of Columbia have established core competency–based Certified Prevention Specialist (CPS) programs based on the IC&RC/AODA competencies that allow States to credential and standardize at least one prevention job function level. Further:

- Nine of these States have additional competency-based certification for at least a second rung in their prevention career ladders (a certification that is above the CPS level);

- Twelve of these States have an additional competency-based entry-level certification for a prevention position (a certification that is an entry-level position or internship with lower functioning standards than a CPS); and

- One State's credentialing program uses its own State standards rather than the IC&RC standards and testing.

Many in the prevention field believe that the development of competencies and standards for individual professionals is necessary to professionalize the field and implement evidenced-based practices and program standards nationally. SAMHSA's Center for Substance Abuse Prevention (CSAP) formed a Prevention Core Competencies Workgroup in 2007 and in 2011 developed substance abuse prevention core competencies and definitions; the next phase of this process will be to develop the list of KSAs to complete the prevention core competencies.

The prevention competency model incorporates domains supporting CSAP's Strategic Prevention Framework (SPF). CSAP promotes a structured, community-based approach to substance abuse prevention through the Strategic Prevention Framework (SPF).[11] The SPF approach provides information and tools that can be used by States and communities to build an effective and sustainable prevention infrastructure. The SPF aims to promote youth development, reduce risk-taking behaviors, build assets and resilience, and prevent problem behaviors across the individual's life span. SPF uses a five-step process to achieve these goals.

Representatives within the prevention field will review the draft model. These include National Prevention Network (NPN) regions and national organizations such as National Association of State Drug Abuse Directors (NASADAD), Community Anti-Drug Coalitions of America (CADCA), and the Centers for the Application of Prevention Technology (CAPT), along with select local community coalitions and local prevention practitioners.

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[11]CADCA developed the Core Competencies that Facilitate Implementation of the SAMHSA's Strategic Prevention Framework that focuses on the competencies of prevention coalitions and may be useful in developing competencies for individual staff members.

SECTION 3.3: Prevention competency case study—South Carolina

**South Carolina's workforce turnover focuses
State prevention plan to enhance competency diffusion**

Surveys of the South Carolina prevention workforce conducted in 2005 and 2006 documented that employees had become increasingly frustrated at the lack of salary and professional advancement opportunities, leading to undesirable turnover rates within the prevention profession. With an estimated turnover cost of $20,282 each time a prevention specialist leaves to find another job, the State sought to improve retention and provide avenues for professional advancement.

South Carolina developed a first draft of a prevention workforce development plan with the help of a consultant assigned by CSAP, members of the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS), the South Carolina Association of Prevention Professionals and Advocates (SCAPPA), and prevention staff representatives in the State. The initial plan focused primarily on increasing the availability and quality of prevention training to ensure that prevention professionals would be better prepared to meet the rigorous standards of the State certification processes. The State has already implemented some recommendations from this first plan by:

- offering the national Substance Abuse Prevention Specialist Training (SAPST) curriculum;

- hosting an annual State prevention conference; and

- reclassifying trainings topics into categories: State-required trainings that must be completed within 1 year of hire; functional knowledge and skills-related training that must be completed within 2 years of hire; and certification-related trainings that must be completed within 3 years of hire and before taking the certification exam.

With the help of another CSAP-provided consultant, the State drafted a second, more comprehensive plan in 2008 to address other prevention workforce challenges, including frustration due to the lack of respect and support the prevention field receives and the lack of recognition given to individuals after successfully completing certification. Other key decisions were to:

- increase pre-certification support to enhance preparedness;
- expand the prevention career ladder; and
- diffuse competencies more effectively through an expanded training menu.

South Carolina's competency standards

The SCAPPA Certification Board, the organization that issues State prevention certification, and the IC&RC/AODA designed the State prevention competency standards. These standards, which define successful performance in the prevention setting, use knowledge and skills identified by the IC&RC through role delineation and job analysis. Competency achievement is tested through written and oral examinations, supervised work/mentoring, and evidence of education and training in designated core areas. This process helps the prevention specialist to successfully perform "critical work functions" or tasks in the prevention arena.

SCAPPA currently has specified the level of KSAs required for success in the prevention workplace within two levels: Certified Prevention Professional and Certified Senior Prevention Professional. DAODAS requires certification, or work towards certification, for prevention workers in agencies that receive State or Federal funding. The requirement covers 33 local and regional alcohol and drug abuse authorities serving the 46 counties of the State. Otherwise, certification is voluntary.

South Carolina Prevention Workforce Development Plan

Behavioral Health Services Association (BHSA)/DAODAS Prevention Subcommittee authored the proposed South Carolina Prevention Workforce Development Plan, with initial input and feedback from State prevention providers. Two competency tools resulted:

- A Professional Development Plan
- The South Carolina Prevention Training Menu

The Professional Development Plan is an online prevention competency survey that includes questions for self-rating and provides individualized results to respondents. Based on the answers given to 89 questions, the survey results outline individual strengths and weaknesses in prevention core competence (knowledge and skills) and highlights areas needing improvement. The survey also helps the individual prepare for the certification process because survey ratings correspond to the core areas used by SCAPPA for the entry-level Certified Prevention Professional exam.

Personalized results can be shared with supervisors and included in performance evaluations. For those who work in an agency with no prevention-specific guidance or under a supervisor who does not have a prevention background, the State has recommended that the employee receive professional development assistance through a contractual relationship with a Certified Prevention Supervisor from a nearby agency.

The Professional Development Plan has implications beyond the personal level. The State cross-references survey results with geographic patterns to address areas of strengths and weaknesses within local, regional, or State sectors. This information can guide education and training programs to offer training in competencies for which individuals have not tested well or by adjusting subject offerings in different locations. On the local level, provider agencies can redirect training resources supporting attendance for their prevention specialists in greatest need of education on specific topics.

By encouraging new prevention specialists to identify strengths and weaknesses and rapidly providing directed training in these areas, South Carolina hopes to engage newcomers and retain their involvement in prevention, thereby reducing turnover. Recognizing that not all entry-level employees will automatically possess the KSAs to perform all prevention functions, the State also has recommended prevention "privileging," a multilevel process by which an organization determines that employees are qualified to provide specific prevention services based on uniformly applied criteria. This process may relieve anxiety and frustration for prevention newcomers while they work through their Professional Development Plans.

More experienced prevention specialists will benefit from the Professional Development Plan in light of another State recommendation, a three-tiered system of prevention classification. A tiered system creates a career path within prevention, especially valuable in light of survey data that underscored the need to retain prevention workers in their first 5 years, a point at which many preventionists have invested enough in the field to stay much longer.

South Carolina Prevention Training Menu

The personalized results from the Professional Development Plan can be used to prioritize professional development and improve areas of weakness through parallel trainings offered within the Prevention Training Menu. The South Carolina Prevention Training Menu is divided into three tracks—Basic, Advanced, and Elective—within which there are 48 courses (20 basic, 15 advanced and 13 elective). Each course receives a priority code and classification within one of three ratings:

- ***State required***—Mandated either by DAODAS for receiving prevention funding or by other State agencies for working with clients. To be completed within 1 year of hire.

- ***Functional knowledge and skills***—To be completed within 2 years of hire for basic-track participants or as needed for job requirements or professional growth and development.

- ***Direct certification requirement***—Denotes those courses that contain information that will appear on the certification tests. To be completed within 3 years of hire and before taking the certification test for basic-track participants or as needed for job requirements or professional growth and development.

In addition to priority classifications, the Prevention Training Menu supplies the course name, course description and intended outcomes, instructors, corresponding domain (competencies and skills set covered within the course curricula), geographic location of the course, date and time, and fee information.

Novice preventionists can target those trainings that cover core competencies or pre-requisites. Many of the trainings are offered multiple times and have approval from SCAPPA such as Prevention Ethics, Prevention Certification Work Study Training, and KIT (Knowledge-based Information Technology), which centers around systems to monitor and measure impact and performance outcomes and provides knowledge for improved decision making.

At the heart of the basic track is the Substance Abuse Prevention Specialist Training (SAPST), an intensive, unified 5-day course available at very low cost. Developed by CSAP's National CAPT System, this training has demonstrated effectiveness in preparing prevention specialists to practice effective prevention and also to develop an understanding of key concepts of prevention science and how they interrelate. The course has been valuable both as an orientation to substance abuse prevention and as a booster for veteran professionals in need of updating their knowledge and skills. Local individuals have already been trained as trainers to conduct the South Carolina courses through support from DAODAS.

More experienced prevention professionals select menu offerings that match their professional development needs. Course selections include Prevention Evaluation 201, Change Management, and Supervision Techniques. Elective tracks include such courses as Exploring the Roles, Responsibilities, and Expectations of an Accountable Nonprofit Board; Cultural Competency; and Community Assessment. Elective track courses also concentrate on subject matter in line with needs of specific consumer populations, including courses such as Gang Awareness, Relationships, Sexuality and Recovery, and Strategic Approaches to Address the Culture of College Drinking. The State hopes that the advanced and elective tracks will help maintain long-term commitment from experienced prevention staff.

The Prevention Training Menu encourages diversity within training partners and regional network involvement. Potential training partners on the provider and regional level can be engaged to offer

trainings in the line with their staff's professional development needs. The training consortium will use the menu to ensure that trainings are available at regular intervals and locations.

Competency diffusion recommendations

The proposed South Carolina Prevention Workforce Development Plan makes recommendations at the local, regional, and State levels. Nine recommendations apply to local/county agency leaders, of which five relate to competency diffusion. Competency-based local recommendations include:

- Implement a three-tiered Prevention Specialist Certification system to create opportunities for advancement in prevention;

- Ensure all non-certified prevention professionals have supervision from an experienced prevention professional;

- Institute periodic self-assessment of prevention staff to guide professional development;

- Institute a system of prevention privileging; and

- Research all available study aides to assist prevention specialists in passing the SCAPPA certification exam.

The draft plan also includes three recommendations for the State system and five recommendations for the service regions.

Follow-up and next steps for South Carolina

The proposed South Carolina Prevention Workforce Development Plan was initiated with direct input and feedback from the field after 3 years of work. Local prevention staff have reviewed the components and overall report on multiple occasions, and local providers have confirmed that these recommendations and tools reflect their concerns and that their implementation would help the field. These recommendations promise a more supportive work environment for prevention professionals that should lead to increased job satisfaction, greater productivity and effectiveness, and reduced turnover, with considerable savings in local replacement costs.

Although there is currently no earmarked implementation funding, a 2008 survey held early in the confirmation process identified that up to 30 percent of county-level providers have already implemented some of the recommendations. All 33 local alcohol and drug abuse authorities serving South Carolina's 46 counties have given their approval to the plan in 2009. DAODAS continues to gain feedback from each county at mid-year and year-end to determine which of the currently proposed recommendations were implemented or scheduled to be implemented and to identify what resources would expedite adoption of each recommendation. The State is planning quarterly meetings to discuss possible supports necessary for implementation and to identify lines of funding.

SECTION 3.4: Prevention competency case study—Florida

Florida Prevention Provider Implements Prevention Competencies

Operation PAR has served West Central Florida for almost four decades. It began as a volunteer-run organization to help those struggling with drug addiction; it has grown into a multi-service, nonprofit organization employing 425 people and serving more than 13,000 individuals annually. Its substance abuse prevention division is particularly strong, with more than 30 staff and an annual budget of more than a half million dollars. Services include information dissemination, education, alternative activities, identification, and referral services through student and employee assistance programs, as well as coalition building and environmental strategies.

Despite the strength of its prevention program, Operation PAR experienced difficulty with recruitment and retention. According to the agency's assessment:

- Staff members who worked in schools left the agency—and sometimes the field of prevention altogether—to take jobs with these schools.

- Salaries for prevention staff in Florida are low, both in comparison to other States and to the overall substance abuse treatment field.

- Although the State has a credentialing program for prevention workers, it is not mandatory, which gives employees little incentive to study for or take the credentialing exam.

As a result of these factors, staff and potential hires did not view prevention as a field with a clear career ladder. Operation PAR's senior management, with the support of direct service supervisors, assumed the task of lifting expectations and rewards for their workforce by focusing on applying core competencies. Using Florida's voluntary guidelines as a starting point, Operation PAR adopted a comprehensive training program for its prevention workers.

As defined by the State of Florida, competencies are used in the voluntary certification process for prevention professionals:

- The **Certified Prevention Professional (CPP)** credential is for those who possess advanced prevention-related competency. A CPP can provide services across the spectrum of targeted behaviors, including but not limited to addictions, delinquency, teen pregnancy, suicide, and dropout prevention.

- The **Certified Prevention Specialist (CPS)** credential is the entry-level prevention certification. The CPS is also the reciprocal credential for those coming into Florida through IC&RC/AODA.

In addition to developing job descriptions based on Florida's core competencies and conducting supervision and performance reviews based on the same competencies, Operation PAR developed the Individual Career Enhancement and Development (ICED), a tool to make it easier and more appealing for prevention workers to pursue credentialing.

Individual Career Enhancement and Development (ICED)

ICED's development has allowed Operation PAR to assess the needs of the workforce and to empower their employees to be partners with the agency in terms of their professional development. Under its model, the agency provides:

- educational and professional opportunities with reimbursement;
- access to myriad professional development opportunities; and
- a career development plan, timetables for success, and monetary incentives.

Additionally, each participant is fully aware of positions that are and will be available to him or her as they progress, along with the increased compensation that may accompany those jobs. This has created a career ladder/lattice that provides prevention staff with encouragement about their future at Operation PAR. Operation PAR is certified to offer continuing education units for all their training events. Trainings use a variety of formats, including:

- training provided in-house by Operation PAR staff;

- collaboration with higher education, including Eckerd College (St. Petersburg, FL);

- standardized training using materials from the National Institute on Drug Abuse (NIDA), the Florida Alcohol and Drug Abuse Association (FADA), and the Florida Certification Board;

- online suicide prevention training; and

- self-guided study, using a manual available at each Operation PAR location, together with a post-test.

Because the training menu is informed by the ICED tool, prevention employees are ensured access to comprehensive prevention education. Additionally, the tool helps to identify areas in which a staff member might be particularly in need of training. Among the many topics covered are Motivational Interviewing, Cognitive-Behavioral Therapy, and Dealing with Problem Behaviors.

For example, one of the competency areas is Prevention Strategies, which includes prevention strategies, methods, programs, and signs of addiction. This is a key component to developing successful Prevention Specialists. This competency is introduced early in the development process and leads staff to an understanding of the evidence-based models utilized at Operation PAR.

Anecdotal improvements from competency-based strategies

Operation PAR reports that following these efforts, prevention staff members understand prevention better than before. Although this sounds basic, understanding is an essential component for prevention activities to have a positive impact. Core competencies have helped to focus all employees, direct service, supervisory, and program development teams on what needs to happen and how to implement approaches.

Supervisors and senior staff report that the focus on core competencies has increased motivation for employees to improve their knowledge base and skills. Using the ICED as a guide, staff members eagerly seek out training that will move them forward in the organization and the field.

Operation PAR took on a significant philosophical change in its focus on core competencies. Developing a more dedicated and skilled workforce has ultimately improved the quality and effectiveness of services. The agency increased motivation to improve service delivery at all levels. Finally, by having a larger number of staff with CPP and CPS credentials, a clear program to support professional development has made Operation PAR more competitive as the agency seeks out funding opportunities.

Facilitating factors: What worked?

Operation PAR attributes success to strong leadership and the value placed on teamwork to get the job done. CEO/President Nancy Hamilton leads by example and has established continuous improvement as a standard and a value throughout the organization. Operation PAR also has a strong leadership team that moved the process forward. With a large and diverse number of individuals supporting and advising on the initiative, moving toward a focus on core competencies was never a "sidebar" project. Additionally, Operation PAR developed a timeline and monitoring methods to keep this project as a priority within an agency managing an already full agenda.

Motivating program supervisors was particularly important. Administrator of Prevention Services Daphne Miller has a great gift of pulling people together and moving them along. This kind of consensus building meant that the mandate did not only come from above; the desire to improve was also held by every level of worker within the organization. Operation PAR had a prevention team dedicated to improvement.

Barriers to implementation

Operation PAR reported that one of the greatest challenges in applying core competencies throughout the workforce was lack of resources. They were unable to find published guidelines, examples, and dialog about how to make these core competencies "real." Operation PAR had to rely on resources from other fields, including the substance abuse treatment field, to help them concretize these principles. Now, the ICED tool serves as a clear path for implementing core competencies within the agency.

Next steps

Operation PAR has dedicated great resources to pursuing core competencies in prevention programs. To better embed these competencies into the prevention programs and to extend this focus to the agency's other programs, Operation PAR is trying to develop more examples of applied learning. The competencies must appear in the context of "real-life scenarios" to enable more concrete learning. In addition, Operation PAR recognizes the need to formally evaluate the effects of its focus on core competencies. The agency has plans to measure retention rates and follow the employee career paths within the organization to assess the project's effects.

SECTION 3.5: Core competencies in treatment of substance use disorders

Using TAP 21 to Improve Clinical Supervision for Addiction Counselors

As treatment providers across the Nation struggle to recruit and retain addiction counselors, particularly people of racial and ethnic backgrounds similar to those of their clients and people in recovery, ensuring staff competencies is particularly crucial. As John Porter[12] of NFATTC states, "The workforce shortage is incredible in every State: There aren't people out there who are qualified or willing to work in the field. You have to hire people and train them up, rather than hire the people you want."

NFATTC has developed a model that helps clinical supervisors ensure that addiction counselors have the competencies they need. It is designed to be implemented through a three-stage training and technical assistance (TA) package available through NFATTC or other consultants.

The model:

- includes materials for addiction counselors and clinical supervisors;

- simplifies self-evaluation and evaluation of counselors' competencies;

- outlines specific activities, such as ongoing evaluation and the development of learning plans, that become a part of regular clinical supervision;

- includes methods for building support for enhanced supervision at all levels of the organization;

- has been implemented in rural, small-urban, and large-urban settings; and

- has resulted in improved staff retention and client engagement.

The model is based upon the 123 competencies of *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes for Professional Practice*, published by CSAT as TAP 21,[13]

Making TAP 21 accessible

TAP 21 provides an excellent platform for clinical supervision of addiction counselors. It identifies 123 competencies and outlines needed KSAs. Also available is a companion piece, TAP 21-A: *Competencies for Substance Abuse Treatment Clinical Supervisors*. TAP 21 is widely used by many higher education programs, licensing and credentialing agencies (both State and private professional organizations), and training and TA organizations such as the ATTCs. However, many of the thousands of addiction counselors in the United

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[12] Porter is a technology transfer specialist on staff of NFATTC and also offers consultation through his own company, Pegasus Training & Consulting, which is based in Wilsonville, OR.

[13] Center for Substance Abuse Treatment. (2006). *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice.* Technical Assistance Publication (TAP) Series 21, HHS Publication No. (SMA) 06-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration.

States might not have ever seen a copy of TAP 21. If they have seen it, the 123 competencies and hundreds of KSAs might be somewhat overwhelming to them, their supervisors, and agency administrators.

NFATTC has made the material more accessible by creating simplified checklists for evaluation and self-evaluation based on the 123 competencies. The implementation materials also include training manuals and learning plans to help counselors improve their skills in each competency, and methods for clinical supervisors to put it all together. But for the methods to work, agency policy must support their use.

Training and TA

To help agencies adopt its model of clinical supervision, NFATTC offers ongoing training and TA in three stages:

- an initial 2-day training;
- a follow-up session 3 to 6 months later; and
- monthly TA visits for approximately 6 to 9 months.

Because Porter or another consultant provides the training and monthly TA on site, there are no travel costs for staff or additional time away from the treatment program. Cost is determined by the number of supervisors and counselors, and the consultant's travel expenses. The cost in the Northwestern United States is approximately $10,000 to $12,000 per agency for all the training and monthly TA over a 6- to 9-month period.

Self-evaluation, evaluation, and learning plans

After the initial training, the counselor completes some or all of NFATTC's performance evaluation rating forms as a means of self-evaluation. Some agencies choose to focus on one or two performance areas or to focus on the areas most closely aligned with a particular job description. Based on the counselor's self-evaluation, the clinical supervisor discusses areas of challenge and strength with the counselor. The supervisor then observes the counselor in those areas and provides feedback regarding the counselor's performance. The supervisor might say, "You ranked yourself as a 4 in this area, but from my observation, you have performed at a level 3 according to these criteria. Let's create a plan to get you to a 4." This kind of discussion and detailed feedback for the counselor creates a starting point for improvement

From this discussion, the counselor and clinical supervisor develop a professional development plan that includes a detailed timeline of activities such as observing other professionals, reading materials, or completing training. For example, a new or mid-level counselor who needs to improve skills in conducting groups might observe a might observe a senior counselor two to three times, with an assignment to write about what was learned. At regular supervision meetings, the supervisor and counselor discuss progress on the plan.

When the counselor successfully completes the initial professional development plan, there is a celebration to mark the success and then the counselor meets with the supervisor to develop the next PDP to continue the performance the performance improvement process. The supervisor might ask the counselor to identify the specific KSA for which she or he wants to be observed. On the other hand, the supervisor might identify areas needing work. For example, if health management organizations (HMOs) regularly ask a

counselor to clarify treatment plans, the supervisor can work with the counselor to improve KSAs related to treatment planning.

No counselor is exempt from any of the KSAs; however, when the clinical supervisor documents that the counselor has reached a certain level of proficiency with that item, they move on to another one. Ideally, a periodic reassessment can ensure that skills stay strong and knowledge is current. This model allows for continuing performance improvement.

Professional development for clinical supervisors

Porter has found that the clinical supervisors need someone to act as a mentor, coach, or guide to hold them accountable to certain expectations during the process of improving their own skills. Porter now incorporates the competencies for clinical supervisors found in TAP 21-A into all of the trainings and technical assistance he offers. He asks clinical supervisors to use TAP 21-A as a self-evaluation tool, creating a parallel process for their supervision of counselors using TAP 21.

Porter also asks supervisors each month to list their goals for the coming month, and then asks what they have been able to accomplish in the implementation process during the previous month. He models this process with them as an example of what they should be doing with their supervisees, and what the counselors should be doing with their clients.

Human resources policies

To fully embrace the competencies, an agency should incorporate them into their human resources policies. Although the goal is to increase staff competencies to improve the agency and the counselor's own career development, the process can link to corrective action plans that ultimately may lead to terminating an employee. Porter has found that some agencies are reluctant to terminate counselors because employees are so hard to replace, with managers hoping that a mediocre counselor can make great strides. Some will, but some will not. Under NFATTC's model, supervisors make it clear to the counselors that they are expected to meet the competencies to improve their performance and secure their job. The model supports the development of corrective action plans, which acts as a logical and fair "paper trail" that might be needed to support administrative action which might lead to termination of employment if improvement is not attained.

The agency may want to write or rewrite counselor's job descriptions based on competencies. New hires should reflect these new policies, with recruitment advertisements based on those competencies to identify appropriate candidates. Porter suggests that agencies observe the performance of a job candidate before hiring by asking the candidate to conduct a group—known as "job try-out," or "work simulation." A clinical supervisor uses an observation sheet based on the TAP 21 Rating Forms to rate the candidate's performance. This activity also provides a realistic job preview for the candidate.

Implementation sites

So far, the NFATTC model of clinical supervision has been tested in rural, small-urban, and large-urban settings. It is in statewide use in Idaho and at selected agencies in Oregon and Washington:

- CODA in Portland, OR, was the first place NFATTC implemented the model. At the time of implementation CODA had 5 sites and 13 programs with 1,000 clients at any given time.

- Idaho's Single State Agency (SSA) is the Bureau of Substance Use Disorders (BSUD) in the Department of Health and Welfare (DHW). Because of Idaho's rural demographics—1.4 million people spanning 82,700 square miles, with approximately 16 people per square mile—most policies are implemented on a statewide basis. BSUD/DHW hired Business Psychology Associates (BPA), an Idaho consulting firm, to train nearly 350 clinical supervisors in the State, with support from Porter. BPA also provides TA to these programs.

- With statewide training and TA, agencies across Idaho such as Road to Recovery (RTR), based in Pocatello, have adopted the NFATTC model. RTR has 42 employees and serves approximately 400 clients per year. RTR operates a diverse set of programs that include one inside a prison and a number of clinics that are open part-time with many part-time staff.

Meeting implementation challenges

There are, of course, some challenges to implementing addiction counseling competencies through an improved clinical supervision model. Change can be uncomfortable, and Porter warns agency executive directors, senior staff, boards, and supervisors that at first they will see a ripple effect and then usually a "tsunami" of changes in agency culture: The process lays bare the level of knowledge and skills—or lack thereof—for each counselor and clinical supervisor and exposes the agency's infrastructure. Implementing the model of enhanced clinical supervision will require making a firm commitment to change, finding time for supervision to take place, and arranging the supervision.

Commitment is critical

Making the commitment to enhanced clinical supervision is a huge challenge for many providers. Program managers and senior managers need to understand the importance of improved clinical supervision and counselor quality and their link to improved employee retention and productivity. Many providers have weathered so much change—in terms of staff turnover, workforce shortages, reimbursement policies, attitudinal shifts, and changes in funding sources—that asking them to make a long-term commitment to changing their clinical supervision is a huge challenge.

Change teams

NFATTC built into its model a mechanism for facilitating change. A change team—described in *The Change Book*,[14] published by the National ATTC—can help the agency strategize about the implementation and weather the storm of change. The team should include all of the clinical supervisors involved in the process and can also include a senior manager or program manager as well as one or more counselors.

When multiple agencies are involved, an executive change team coordinates activities. BSUD/DHW and BPA created an executive change team for the State to develop guiding policies and procedures. Ideally, a change team with its own leader should be in place at each agency. However, because many of Idaho's

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[14] Addiction Technology Transfer Center National Office. (2004). *The Change Book: A blueprint for technology transfer,* 2nd ed. Kansas City, MO: Author.

provider agencies are small and could not support a change team within the agency, BSUD/DHW and BPA also developed a clinical change team, consisting of clinical staff across the State, to assist each agency in implementing the model and reporting any barriers to the executive change team.

Support from the top

Commitment to change must take place at the top level. CODA's Deputy Executive Director Margaret Thiele credits the successful implementation of the NFATTC model to the executive director's firm commitment, including his support "with funding, with time, with philosophical statements to the staff about how we do our work, and how the model is applicable in both mental health and substance abuse."

In Idaho, State policy reinforced the implementation of the model by using both incentives and requirements. As incentives, BSUD/DHW offered free training for clinical supervisors working for 55 treatment contractors in more than 125 treatment sites, free mentoring and support of those supervisors as they begin to implement this program, and free materials such as a training manual, TAP 21 and TAP 21-A, *The Change Book*, learning plans, and rating forms.

The State agency also made adoption of the clinical supervision model a requirement for receiving State funds. State regulations require that clinical supervisors must participate in the initial 2-day training within 6 months of starting their job and that all SUD treatment counselors receive at least 1 hour of clinical supervision per month. BSUD/DHW does not require follow-up training or ongoing TA, but many providers request these services.

Support at all levels

Successful implementation also requires support at other levels of the organization. At RTR, there was quite a bit of resistance at first. Executive Director Liz Lovell had the unenviable task of explaining to her staff that they were required by their funders to do it, and that they needed to embrace the effort to improve clinical practice within the agency. "It's hard, when you are experienced, being told what to do," she explained, and some clinical staff left the agency because of this change.

However, after 3 years of enhanced clinical supervision, it gained acceptance. "When you start to see the response from the counselors, and see the better way that clinical supervision is being done, and when you see the counselors' skills going up, you really grab onto it," Lovell observed. She added, "As new employees come into the agency, they do not have the resistance, and some of them actually appreciate it."

At CODA, Thiele said, "Clinical supervisors and counselors both really feel like they were getting some attention and focus on building their skills. Counselors and supervisors have felt excitement about good outcomes." She suggests assembling a team of people—"super users"—who are particularly interested in the model and can provide support to clinical supervisors in implementing the changes. She also noted that ongoing TA can build support.

Staff time

Staff time is another major barrier. When Porter goes into an agency to talk with a CEO, he says, "Someone will have to give up time somewhere. It takes time to do this well." Treatment providers generally cannot bill for their supervision time, despite its critical link to providing quality treatment and implementation of

evidence-based practices. Enhanced clinical supervision takes even more time from billable services. Clinical supervisors frequently have other responsibilities, such as administrative tasks and their own clients.

Enhanced clinical supervision often requires exceeding State standards. Most States do not mandate a number of hours for clinical supervision; if there is a mandate, it is minimal, such as 1 hour per month in Idaho. Porter and others note that a MA-level clinician with 20 years of experience might not need more than 1 hour each month, but that those newer to the field or who have less academic training may need 1 hour each week or more.

Denise Leavitt, formerly of BPA,[15] described the policy that was used to develop this statewide program. "We started out thinking that [the State] would reimburse providers for clinical supervision, but there was no 'new' money to pay for this service," she explained. BPA polled providers, who overwhelmingly said they would prefer to keep the money in treatment and would provide the additional supervision without reimbursement, seeing it as a cost of doing business within this particular system. However, the provider community is still interested in pursuing additional reimbursement costs for enhanced clinical supervision.

Finding an hour for a clinical supervisor and treatment counselor to meet is difficult enough, but arranging for a face-to-face meeting in a rural setting can present additional challenges. BSUD/DHW Behavioral Health Program Specialist John Kirsch noted that in the frontier State of Idaho, the vast distance between sites can prevent a clinical supervisor from easily observing a counselor. "When one site is 125 miles away from another site it can get very expensive," he said. For agencies like RTR, with multiple sites, including sites open only part-time, enhanced supervision adds to the existing challenge of running a treatment program in a rural area.

Even agencies in large urban areas face challenges in coordinating supervision time. Like many agencies, CODA has a diverse client population, numerous treatment programs, and multiple sites. Of the staff of 150, half are involved in providing clinical treatment, and 13 are clinical supervisors.

Fortunately, improving technology has made managing supervision at multiple sites somewhat easier. In fact, to reduce supervision costs to individual agencies, Idaho is considering funding technologies (such as Webcams or audio monitoring) that will facilitate clinical observation and meetings.

Results

Although Idaho has had enhanced clinical supervision in place only since 2005, those involved in the project anecdotally report improved employee retention and performance. Porter explains, "People seem to stay longer when they have a mentor, a teacher and a clinical supervisor whom they can trust and respect." Lovell believes that implementing NFATTC's model has improved clinical supervision, motivational interviewing, and the implementation of best practices.

Overall, the culture in Idaho has changed so that "clinical supervision is the expectation, not just another piece of paper or requirement that has to be done to get treatment dollars," Leavitt says. As an example, she said that early in 2008 she spoke with a staff person at a provider agency who asked her for feedback on a new job description and job advertisement to ensure that they would hire only staff who met the

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[15] Denise Leavitt is now a Treatment Program Manager for the Utah Division of Substance Abuse and Mental Health.

requirements of a clinical supervisor. Additionally, the clinical supervision trainings (held at least every 6 months across Idaho) have increased the exchange of information and collaboration between clinical supervisors in different agencies across the State. In fact, a group of providers who met during a training session has continued to meet, offering peer support and discussing solutions for implementing the model in rural and frontier settings.

BPA is working on a process evaluation to document their first review of clinical supervision charts, so as to identify gaps in the system and quantify the level of implementation across the State. The next step will be a formal evaluation of client outcomes. Such evaluations are already taking place at CODA. When fidelity to the clinical supervision model is strong, staff retention is good. CODA has also seen a strong correlation in staff retention and client engagement as well; when one is off, the other is sure to follow.

At CODA, the positive results seem to be linked to Porter's ongoing monthly TA. For a 6- to 8-month period, he was not focusing on clinical supervision because CODA management wanted him to work on other topics. However, the agency began to see an increase in turnover and decrease in skills, and management realized they needed to focus more on clinical supervision. Thiele believes that the clinical supervisors "need a relationship with someone they trust to guide them through the process."

Since CODA started using this model, they have implemented a number of other quality improvement programs. As a result, they have seen client satisfaction improve from admission to discharge, and improved client outcomes. However, Thiele noted, "clinical supervision is the brainpower behind the implementation of all of our services, whether it's case management or motivational interviewing. It is the foundational piece of our service model. The other stuff is the 'icing on the cake' in the sense that evidence-based practices can't be implemented unless our supervisors are really at the top of their game. It's critical."

SECTION 3.6: DEVELOPING COMPETENCIES FOR TREATING CO-OCCURRING DISORDERS

COD Competencies in Connecticut and Vermont

SAMHSA identifies COD[16] among 11 priority program areas developed to ensure that treatment addresses the elements that individuals with substance use and mental health disorders need to live a full, rewarding life in the community. However, lack of integration in the provider system at the local, regional, and State levels presents a significant challenge to identifying and treating COD. SAMHSA created the Co-Occuring State Incentive Grant (COSIG) to provide funding to the States to develop or enhance infrastructure and increase capacity to provide accessible, effective, comprehensive, coordinated/integrated, and evidence-based treatment services to people with COD. So far, 18 States and the District of Columbia have received COSIG funding.

Although there are currently no national competencies certifying clinicians in COD treatment, SAMHSA's COCE[17] has outlined 12 overarching principles for working with persons experiencing COD, covering both systems of care and individual providers. In addition, SAMHSA has published a Treatment Improvement Protocol (TIP) 42, *Substance Abuse Treatment for Persons with Co-Occurring Disorders*, which includes some of the competencies that may be required for treatment staff.

To progress from policy statements to treatment system transformation, States need a workforce with the knowledge, skills, and relationships to promote healing and recovery for people with COD. Two New England States, Connecticut and Vermont, have successfully leveraged their COSIG grants to develop and implement strategies to bring COD competencies to clinicians, case managers, and peer counselors across a broad spectrum of treatment settings and social service agencies.

The States differ in many ways, with demographics among the most notable. Connecticut has an extensive State-run network of treatment facilities, in addition to a large contracted provider network, to serve its mix of racially and linguistically diverse urban and suburban communities. Vermont relies almost exclusively on small nonprofit provider systems to serve its predominantly small-town/rural, mostly white population.

However, both share a vision of promoting recovery and integrating care across disciplines and services. They have been able to effect broad systems change by building on past successes, strengthening and expanding their networks of stakeholders, and fostering leadership and commitment at both grassroots and executive levels. These activities helped create a "tipping point" by bringing together all of the factors needed to rapidly increase the pace and speed of innovation. This case study will look at how these States designed and implemented their workforce development programs to get to the tipping point and beyond—and the challenges they currently face in maintaining and sustaining their momentum.

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[16] COSIG uses the definition of co-occurring disorders developed by the consensus panel convened to draft SAMHSA's Treatment Improvement Protocol (TIP) 42 *Substance Abuse Treatment for Persons with Co-Occurring Disorders*. People with co-occurring substance abuse and mental health disorders are "…individuals who have at least one psychiatric disorder as well as an alcohol or drug disorder."

[17] The Co-Occurring Center for Excellence (COCE), launched by SAMHSA in September 2003, was the first national resource for the field of co-occurring disorders (COD). Although COCE concluded in March 2009, the Web site remains an available resource at: http://www.samhsa.gov/co-occurring/.

Why implement co-occurring competencies?

Too often, States attempt to make policy changes that fail to have significant or lasting effects. Malcolm Gladwell,[18] who popularized the tipping point concept, identifies three factors necessary to tip the balance from isolated to "epidemic" change. Translated into State policy development language, Gladwell's model requires circumstances ripe for change, a memorable change message with wide impact, and a relatively small number of knowledgeable, persuasive, and connected individuals working together toward a common goal.

The successes in Vermont and Connecticut reflect both the hard work of a number of committed people and the use of Gladwell's three effective strategies to bring about comprehensive systems transformation.

- ***The conditions and circumstances were ripe for the change.*** Both States' initiatives were influenced by the configurations of their respective mental health and/or addictions oversight agencies and the relationships between these agencies and other divisions, such as corrections, public health, and child/family services. In Vermont, the State legislature's interest in mental health/substance abuse parity also helped push the workforce development agenda forward. In addition, each State could draw on a store of relevant past experiences.

- ***There was a memorable change message that had a wide impact.*** "Recovery" is a concept that resonates strongly in both the mental health and addictions treatment worlds. The recovery message has empowered consumers to take back their lives, and has shattered the old paradigm of mental illness and substance use disorders as chronic, degenerative, and ultimately fatal diseases. Vermont and Connecticut have made recovery the core value and primary component of their workforce competencies.

- ***A relatively small number of knowledgeable, persuasive, and connected individuals worked in concert to bring about change.*** Both States had strong, well-identified leaders at the community level and in senior positions in State government, who enlisted experts to help craft processes leading to competencies built on evidence-based practices. Crucially, Vermont and Connecticut had decided independently to establish "breakthrough" improvement collaboratives comprising varied mental health, substance abuse, and primary care treatment settings to develop, test, and evaluate the effectiveness of the competency development process.

Connecticut

Connecticut has a single State agency, the Department of Mental Health and Addiction Services (DMHAS) with combined responsibility for addictions and mental health services. The State operates eight large treatment facilities, including two psychiatric hospitals, two inpatient addiction treatment facilities, and six local mental health authorities. DMHAS also funds another eight local mental health authorities and approximately 100 other mental health and addiction treatment providers, most of which are private nonprofit organizations. The Department received COSIG grant funds in 2005.

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[18] Gladwell, M. (2000). *The Tipping Point: How Little Things Can Make a Big Difference*. Boston: Little, Brown.

Connecticut COSIG director Julienne Giard reported that in 2006, DMHAS used the COSIG funds, in part, to begin to (1) create clearly articulated guidelines for enhanced COD services across mental health and addiction services, and (2) develop a set of competencies for people working in those services. The guidelines and set of competencies are based on the Integrated Dual Disorders Treatment (IDDT) and Dual Diagnosis Capability in Addiction Treatment (DDCAT)[19] fidelity scales developed by Dartmouth Medical School.

DMHAS consulted and involved providers in this project from the start, leading to broad buy-in for the resulting program guidelines and COD services competencies. The State assembled a formal workgroup in 2007, culling members from the front lines of mental health and addiction treatment services. Their goal was to develop a set of guidelines and competencies that would be responsive to the different professional levels and credentials in both the mental health and addiction services fields, and to creatively merge existing evidence-based practices from mental health services with those emerging in the addictions field.

Source materials for the workgroup included TIP 42 and IDDT guidelines to identify competencies and quantify them at basic, intermediate, and advanced staff levels. The end product was the COD Enhanced Guidelines and Competencies, followed in 2008 by the accompanying Co-Occurring Capable Program Guidelines created by a second, small workgroup of providers and DMHSA staff.

Implementation results

The Co-Occurring Enhanced Guidelines have been implemented with two levels of care to date: Intensive Outpatient Programs (IOPs) and two new Co-Occurring Enhanced Residential Treatment Programs. The State introduced a new level of care—COD enhanced IOP—through the Federally funded Access to Recovery (ATR) grant. The 16 IOP providers who met the new Co-Occurring Enhanced Program Guidelines and Competencies won certification for this level of care and earned a 25% rate increase.

DMHAS ultimately plans to introduce the Co-Occurring Enhanced Program Guidelines as a requirement to all DMHAS-funded contracts. In the meantime, there are already successes. Using a request for proposals (RFP) process based on the Co-Occurring Enhanced Program Guidelines, Connecticut launched 2 new 20-bed residential programs that were funded at a higher rate than other residential programs. In these programs, supervisors monitor and improve compliance with practice standards through on-site observation and chart review, site visits, and specially developed assessment tools.

Connecticut has already enacted multiple mechanisms to support mental health and addiction treatment providers to increase their capability with COD services:

- The State purchases training and consultation from Dartmouth Medical School regarding integrated treatment for mental health and addiction treatment providers.

- Connecticut's SSA provides further onsite training using outside consultants, a practice highly rated by State facility staff.

- The Department's Education and Training Catalog offers free COD workshops thrice annually.

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[19]The DDCAT is a nationally recognized fidelity instrument for measuring the essential program elements for co-occurring capable and co-occurring enhanced addiction treatment programs.

The State created Co-Occurring Practice Improvement Collaboratives to test knowledge and skill development strategies, and increase co-occurring capability of participating agencies.

In a relatively short time span, Connecticut's co-occurring program guidelines and competency workgroups achieved a significant transformation in both practice standards and staff competencies. Critical to this success was the comprehensive parallel inclusion of providers and other affected stakeholders on both the State and local levels to create an integrated system of care. The tandem top-down, bottom-up approach rapidly overcame the pockets of initial resistance (primarily among those programs offering only mental health or only addiction treatment services). The State also took full advantage of focus groups and in-service sessions to systematically identify and resolve specific issues and concerns through interdisciplinary and cross-position training.

Conditions and circumstances ripe for change

DMHAS and other State agencies in Connecticut have a long history of working to improve services for persons with COD. In 1993, DMHAS convened a statewide Dual Diagnosis Task Force to report on treatment services and issued a second report in 1997. In 2002, the Task Force outlined draft definitions for dual diagnosis capable programs in the substance abuse treatment system. Two years later, Connecticut participated in the National Policy Academy on COD. Of no small consequence, the Department has also been receiving training and consultation about integrated treatment for several years through partnerships with Dartmouth Medical School.

DMHAS has also been the driving force behind interagency partnerships. For example, DMHAS and the State Department of Correction (DOC) collaborated to use Federal Mental Health Transformation Grant funds to increase integration of primary care, mental health, and addiction services for State residents involved in the correction system. The existing connections between DMHAS, its fellow agencies, and State providers made it easier to establish a conceptual and policy framework to enhance programs and service structures. The Department's operational and fiscal oversight of a large component of the system of care also strengthened its ability to align fiscal resources and administrative policies in support of workforce competencies.

A memorable change message with wide impact

Connecticut's Commissioner of Mental Health and Addiction Services Thomas Kirk, Ph.D., described the Department's commitment to serving the dually diagnosed population in a statement on the DMHAS Web site:

> "[The Department's] single overarching goal … as a healthcare service agency, is promoting and achieving a quality-focused, culturally responsive, and recovery-oriented system of care. The full attainment of this goal is not possible if the service system design, delivery, and evaluation are not fully responsive to people with co-occurring mental health and substance use disorders. We must work to identify, overcome, and remove obstacles to delivering integrated services and improving outcomes for people working to recover from these illnesses."

Connecticut has long been committed to recovery, as exemplified by its being one of only six States to receive a 2005 Mental Health Transformation State Incentive Grant (TSIG) from SAMHSA. The concept of recovery has served as an umbrella for integrating services and improving outcomes for people with COD

by combining perspectives and recovery lessons from both the addictions and mental health fields. This commitment propelled the Workforce Development Group to establish core competencies for licensed clinicians, paraprofessionals providing case management, and peers offering support services to individuals with COD.

A small group of key stakeholders working in concert for change

Connecticut made an upfront commitment to a multi-year process for developing and implementing its competency initiative, utilizing its two COSIG-funded pilot sites and two COD practice improvement collaboratives (the first comprising the 8 State-operated facilities and the other 21 private, nonprofit mental health and addiction treatment organizations) in addition to two dedicated workgroups. This multifaceted approach allowed different types of providers to develop and implement integrated service delivery by offering financial incentives, training plus ongoing consultation, coaching, and implementation support.

Next steps: Broadening and sustaining systems change in Connecticut

Connecticut implemented standardized screening measures for addictions and mental health service providers throughout the State, effective July 1, 2007. State-operated providers and more than 20 mental health and addiction treatment providers in the collaboratives continue to measure on an ongoing basis their co-occurring capability, and use the results to continually update implementation plans. DMHAS plans to recruit additional agencies to expand the practice improvement collaboratives, and the Department is currently increasing data capacity to better track and manage COD services and recovery outcomes.

Connecticut continues to address issues regarding funding and licensing requirements across payers and programs. In addition, workforce recruitment, retention, and training continue to be areas of focus. Taken together, these factors create a favorable influence for the continued advancement and improvement of Connecticut's COD workforce competencies.

Vermont

The State of Vermont won a COSIG grant in 2006, and used the funds to combine all of its current and previous change efforts into the Vermont Integrated Services Initiative (VISI). According to VISI Director Paul Dragon, MSW, Vermont has adopted the COCE competency standards, and recently mandated a statewide performance improvement process. As a result, every program of care will become a co-occurring capable program within the context of its existing resources and scope of service, and all clinicians will become a co-occurring competent clinician within the context of their current level of licensure or training. To facilitate investment and collaboration between providers and State authorities required to fulfill this mandate, Vermont has adopted a TA approach that assumes a common commitment among all stakeholders to improve care for its citizens with COD.

The legislature authorized a Workforce Development Summer Study Committee in 2007, charged with investigating the best method for building COD competencies and determining whether a specialized credential or license would be helpful since there is no process or licensure in Vermont to measure or recognize COD competencies at this time. The workgroup, which had broad representation from associations, credentialing boards, academia, providers, peers, and State staff, recommended that the Vermont Agency of Human Services, (AHS), commit to developing basic COD competencies (non-clinical)

for all direct service staff employed by AHS and establishing basic clinical competencies for all staff working in mental health and/or substance abuse treatment settings rather than requiring a new co-occurring credential or license.

VISI has created an online, interactive COD curriculum for clinicians that is mandatory training for all appropriate AHS employees and recommended for all contracted providers. The competencies in the Vermont training are based on the nine principles developed by the SAMHSA Managed Care Initiative on COD:

1. Diagnosis is an expectation, not an exception.
2. Subtypes of dual diagnosis exist.
3. Empathetic, hopeful, integrated, continuous relationships exist between consumers and providers.
4. Case management and care is balanced with empathic detachment, consequences, and contingent learning.
5. Primary treatment is dually integrated.
6. A disease and recovery model exists with parallel phases of recovery and stages of change/stages of treatment.
7. Treatment is individualized.
8. Outcomes are flexible.
9. Comprehensive, continuous integrated systems of care.

To establish clinical competencies, VISI has partnered with with Kenneth Minkoff, M.D., and other experts in the field, including faculty from Dartmouth Medical School to conduct regional, local, and provider-specific competency trainings based on the Comprehensive, Continuous, Integrated System of Care (CCISC) developed by Minkoff & Cline (2004, 2005). A major session component is working with participants to determine how each program and clinician will utilize the training to foster change within their practices. Practice improvement has already been documented as a result of the training initiative. VISI uses a fidelity assessment tool administered annually to establish a baseline, then to measure and track improvements in serving people with COD on a regular basis. Comparing statistics from the first quarter of 2008 and the first quarter of 2007, VISI found that:

- Programs screened 59 percent of all clients for both mental health and substance use in 2008, versus 38 percent of all clients in 2007.

- Of clients screened, 58 percent were identified as having COD in 2008; in 2007, the figure was 36 percent.

- The programs treated 69 percent of the clients identified as having COD in 2008; in 2007, 63 percent of the clients received treatment.

VISI is incorporating the competencies outlined in SAMHSA's TIP 42 into the State clinical supervision process for mental health and substance abuse programs. Pilot sites incorporated the competencies and are monitoring and evaluating their use through training and supervision documentation, chart review, and the Co-occurring Disorders Educational Competency Assessment Tool (CODECAT). Based on recommendations and results thus far, VISI plans to include this process throughout the Vermont community mental health and addiction treatment system to ensure that the competencies are part of the skill set that all clinicians possess.

Conditions and circumstances ripe for change

The development of integrated, recovery-oriented, evidence-based treatment services for individuals with COD requires long-term responsiveness. Vermont is using its COSIG funds to make short- and long-ranging strategic enhancements to the mental health and substance use treatment infrastructure, initially by establishing VISI as the single entity responsible for coordinating, adding, and updating program capability, clinician competencies, and peer supports across the mental health and substance use treatment system. VISI is moving forward as part of a broader statewide commitment to treatment integration.

A memorable change message with wide impact

Paul Dragon recently summarized the vision and mission promoted by VISI:

> "Our vision is to build a client-centered, recovery-oriented system of care that is organized at every level to serve people and families with complex needs, particularly those with co-occurring mental health, substance use, and or/medical conditions...Our mission is to improve Vermont's capacity to provide integrated services to people with co-occurring mental health and substance use conditions. Vermont's COSIG initiative has translated that commitment into developing peer-led, community-based supports for people with co-occurring conditions."

Vermont's competency development initiative supports peer-run programs through projects such as Vermont Psychiatric Survivors, Friends of Recovery Vermont, Harm Reduction Coalition, Recovery Network, and Vermont Vet to Vet. VISI also has formed a peer consultation team to guide the development of supports for COD treatment and provided TA to peer-led COD support groups across the State. The State's network of peer-run recovery centers are now co-occurring capable and can meet the needs of consumers with dual diagnoses.

A small group of key stakeholders working in concert for change

Vermont established an improvement collaborative of providers from different service systems to improve comprehensive services for people with COD. Twelve providers were initially identified as collaborative members, including 10 designated community mental health agencies and 2 Federally Qualified Health Centers. The collaborative has expanded over time and now is composed of 26 agencies, including community mental health and addiction treatment providers, a primary care practice, drug court, residential program, and seven providers of services to the homeless. Each agency has designated teams responsible for planning and implementing the organizational changes.

Although the diversity of the collaborative fostered an interdisciplinary approach to the treatment of COD, it also posed a challenge for competency development. Primary care physicians and nurses, for example, generally were familiar with the motivational interviewing techniques needed for treating COD, but did not have extensive prior training in screening, assessment, or treatment of behavioral health conditions. Collaborative members responded by tailoring competency training approaches to the existing knowledge and skills of the providers, building on their strengths and identifying and providing assistance in areas needing further development. As a result of this training, the primary care practices in the collaborative are now systematically screening and providing brief interventions and therapy for clients with COD.

In fall 2008, the collaborative expanded to include three additional communities as it developed a systematic process to enable designated primary care practices as providers of screening and brief interventions and treatment for clients with COD. The collaborative planned to develop relationships with community mental health and substance use providers and offer them support to make smoother and more seamless referrals for long-term treatment of clients with dual diagnoses.

Next steps: Broadening and sustaining systems change in Vermont

Vermont Deputy Commissioner of Health for Substance Abuse Barbara Cimaglio sees the further integration of COD services across the State's human service agencies as a major priority. In Vermont's welfare-to-work programs, for example, opiate addiction and post-traumatic stress disorder are the fastest growing co-occurring problems among beneficiaries, and State and community treatment providers need training to address these needs. The Health Department has also identified programs for children, adolescents, and transition-aged youth as key opportunities for prevention and early intervention services targeting substance use, mental health, and COD.

Like Connecticut, Vermont has limited resources and often competing human service priorities. As a result, the State faces challenges in establishing a fully integrated set of practice guidelines and workforce competencies. Deputy Commissioner Cimaglio observed that the commitment of State, community, and peer leaders to maintaining the pace and scope of system transformation is the key to Vermont's current and future success.

CHAPTER 4:

Developing an Implementation Plan

SECTION 4.1: Stages of implementation

Competency-based programming can help ensure effective "technology transfer," the application of "scientific knowledge" such as evidenced-based practices and a variety of knowledge and skills for practical purposes in a particular field.

Behavioral health organizations rely on staff competencies to implement changes in programs, policies and practices designed to improve client outcomes, staff effectiveness, and productivity. Implementing competency-based hiring, supervision and training requires the same kind of careful planning that might be used in implementing any comprehensive initiative, from a total quality management process to a new electronic health record system.

Why plan for implementation? Because, as Dean Fixen and his colleagues at the National Implementation Research Network (NIRN) note, "thoughtful and effective implementation strategies at multiple levels are essential to any systematic attempt to use the products of science to improve the lives of children, families and adults."[20] NIRN's exhaustive synthesis of literature on implementation[21] describes three stages of implementation.[22]

- Paper implementation—When organizations put new policies and procedures in place to "record the theory of change," but the material to support the implementation of that change remains on a shelf.

- Process implementation—When there are new mission statements, new operating procedures, new forms, and new training (the "expressed or active theory of change"), but the organization does not integrate the new practices into the day-to-day practices of the organization.

- Performance implementation—When the process implementation is accompanied by "integrating the theory of change" so that it creates actual change in the organization, its systems, and its consumers.

NIRN finds that many organizations do not get beyond the "paper implementation" phase of adopting innovation; this failure is noted by others as well. "More often than not, the failure of organizations in our

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[20] Fixen, D.L., Naoom, S.F., Blase, K.A., Friedman, R.M. & Wallace, F. (2005). *Implementation Research: A Synthesis of the Literature.* Tampa, FL; University of South Florida, Louis de La Parte Florida Mental Health Institute, The National Implementation Research Network (FMI Publication #231). NOTE: NIRN has since moved to the Frank Porter Graham Child Development Institute at the University of North Carolina, Chapel Hill.

[21] Ibid.

[22] Hernandez, M., & Hodges, S. (2003). Building upon the theory of change for systems of care. *Journal of Emotional and Behavioral Disorders, 11*(1), 19-26.

field [behavioral health] to succeed is not a failure of strategy, but a failure of implementation," Joe Naughton-Travers writes in his article the "[Five Pillars of Management Competency](#)."[23]

Why a "change initiative" is needed

Disseminating information and providing training are not enough to fully implement changes into an agency, community, or State.[24, 25] As *The Change Book* notes, although training is an important aspect of transferring knowledge and skills, "brief flurries of training alone" will not create lasting change. Training may be part of all stages of implementation, but true technology transfer "involves creating a mechanism by which a desired change is accepted, incorporated and reinforced at all levels of an organization or system."[26] Further, "To produce behavior change, technology transfer strategies must not only develop the cognitive skills needed to implement a new treatment component, but may also have to induce or increase motivation for behavior change, reduce concerns about change generally, and/or about the innovation specifically, and explore organizational issues in adopting new strategies."[27]

NIRN's review of implementation comes to a similar conclusion:

"Information dissemination alone (research literature, mailings, promulgation of practice guidelines) is an ineffective implementation method, and training (no matter how well done) by itself is an ineffective implementation method. Although these have been two of the most widely used methods for attempting implementation of policies, programs, and practices, they repeatedly have been shown to be ineffective in human services, education, health, business, and manufacturing."[28]

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[23] Naughton-Travers, J. (2003, June). Five Pillars of Management Competency: Behavioral Health & Social Service Organizations Need Strong Managers in a Challenging Time. Open Minds. *The Behavioral Health & Social Service Industry Analyst,* 15:3, 2-4.
[24] Fixen, D.L., Naoom, S.F., Blase, K.A., Friedman, R.M. & Wallace, F. (2005).
[25] Addiction Technology Transfer Center National Office. (2004). *The Change Book: A blueprint for technology transfer,* 2nd ed. Kansas City, MO: Author.
[26] Ibid.
[27] Brown, B. S. (2000). From research to practice—The bridge is out and the water's rising. In J. A. Levy, R. C. Stephens, & D. C. McBride (Eds.), *Emergent issues in the field of drug abuse: Advances in medical sociology* (Vol. 7, pp. 345-365). Stanford, CT: JAI Press.
[28] Fixen, D.L., Naoom, S.F., Blase, K.A., Friedman, R.M. & Wallace, F. (2005). Page 94.

SECTION 4.2: How to develop a "change initiative"

Implementing a competency-based system often creates enormous change within an organization because it exposes the KSAs/attitudes of staff, managers, and executives. Sometimes the impetus for change comes from external sources (e.g., funding, certification, accreditation or licensing agencies) that either suggest or mandate use of competencies. Other times, there are internal processes that create urgency around a competency initiative (e.g., the Board of Directors or senior management wants to improve client outcomes or reduce employee turnover).

Regardless of the reason, behavioral health providers attempting to use competencies to improve staff quality should expect a variety of challenges they can overcome with careful planning.

Overview of planning for change

The following list of characteristics and features that can provide a foundation for a successful plan comes from *The Change Book*, and has been adapted for use in competency diffusion initiatives:

- **Relevant**—The competencies in question must have obvious, practical application.

- **Timely**—Recipients must acknowledge the need for competencies now or in the very near future, whether at the behest of external (e.g., government funders) or internal forces (e.g, agency human resources department).

- **Clear**—The language and process used to implement the competencies, and accompanying systems (e.g., job descriptions, clinical supervision forms, performance evaluations, etc.), must be easily understood by the target audience.

- **Credible**—The target audience must have confidence in the proponents/sources of the competencies.

- **Multifaceted**—Diffusing competencies within a behavioral health organization will require a variety of activities and formats suited to the various targets of change.

- **Continuous**—The new behavior of using competencies—for hiring, clinical supervision, training, and professional development—must be continually reinforced at all levels until it becomes the standard and then is maintained as such.

- **Bi-directional**—From the beginning of the change initiative, individuals targeted for change must be given opportunities to communicate directly with plan implementers. This should involve having a "change team" that includes line staff who will be affected by the competency initiative.

At the same time, the key players must possess certain characteristics to ensure success:

- **System administrators** must be knowledgeable and supportive of the proposed innovations.
- **Agency directors** must be willing to adapt their service designs to a new model.
- **Supervisors** must be skilled in implementing new practices.
- **Opinion leaders** must endorse the proposed system change.

- **Service providers** must possess the KSAs/attitudes consistent with the delivery of new practices.

The NIATx Model of Process Improvement[29] also provides guidance in developing change teams, (including descriptions of change leaders and others involved in the process) and recognizing and overcoming common barriers to change. It suggests five steps for implementing powerful organizational changes:

- *Understand and involve the customer.* In the case of competencies, these are primarily internal customers (staff at all levels and in all departments), but can include clients/patients who ultimately will benefit from improved competencies.

- *Fix key problems.* It is critical to focus on issues that "keep the CEO awake at night." For most behavioral health providers, this means employee turnover and meeting/surpassing goals for improved patient outcomes.

- *Pick a powerful change leader.* The vast body of literature on change management shows that "if you want to improve something, the person in charge of improving it must have power, prestige, and influence in the organization," This person needs a broad understanding of the impact that moving to a competency-based system will have on staff at all levels, from those who see clients to clinical supervisors and human resource departments. NIATx and others warn that the change leader must have adequate time dedicated to their role as a change leader.

- *Get ideas from outside the organization/field.* Get support for implementing innovations from other fields. See the Resource Section of this Guide to find organizations and fields that might be able to help.

- *Use rapid-cycle testing.* Pilot test any kind of change initiative, perhaps with one department or unit of an organization, before rolling it out to the entire organization, to identify any additional supports or changes necessary to help it work effectively. A "Plan, Do, Study, Act" (PDSA) cycle can quickly assess how changes are working. The staff members involved in the pilot will become opinion leaders who can positively influence adoption of these changes.

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[29] Retrieved from NIATx on November 12, 2009.

SECTION 4.3: Assessing organizational readiness for change

It is imperative to assess an organization's readiness for change to anticipate the cultural shifts and potential resistance that can occur in response to competency implementation. Trainer and TA provider John Porter, cited earlier in this Guide, has supported many addiction treatment providers as they implement competency-based clinical supervision programs. He suggests that not being ready—because of the lack of infrastructure, leadership support, or any number of variables—can lead to an ineffective implementation. Dwayne Simpson, a researcher focused on understanding "research to practice" efforts in behavioral health, notes that challenges with implementing changes in policies, programs and practices are often the result of organizational factors such as "leadership attitudes, staff resources, and organizational stress" more than any particular dissemination policy.[30]

Organizations should determine whether they can develop and support the policies and programs needed to make the implementation of competency models work effectively. Simpson and his colleague Donald Dansereau, both at the Institute of Behavioral Research (IBR) at Texas Christian University, say that the "institutional atmosphere" can be a "subtle but critical dynamic in the change process," and that the more complex the innovation the more critical these factors become.[31]

There are a variety of questions to help professionals assess their organization's readiness for change, as well as instruments designed specifically for behavioral health organizations.

Assessing organizational readiness

The Change Book identifies 12 elements of organizational readiness to address in planning for change. These include recognizing current activities that might lay the foundation for desired change, understanding organizational barriers and supports for implementing change, and identifying resources for the change initiative. Ultimately, an organization must have an understanding of what adoption of the proposed change will mean at all levels of the organization. For example, in several of the case studies contained in this Guide, provider organizations discovered that introduction of competencies for performance evaluation and clinical supervision meant earmarking dedicated time and funding for supervisor and staff training, reworking salary or other incentives for those who improved their competency, and terminating staff who were unable to meet competency requirements.

The *Toolkit: Implementation of Clinical Practice Guidelines* developed by the Registered Nurses Association of Ontario (RNAO) suggests that change teams assess the following elements to determine the environmental readiness for change and to establish a basis for planning:[32]

- *Structure*—The organizational infrastructure that determines decision-making processes, staffing practices, workload patterns, physical facilities, and resource availability.

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[30] Simpson, D. D. (2002). Organizational readiness for treatment innovations. *Research Summary: Focus on Organizational Change.* Institute of Behavioral Research, Texas Christian University. Special Issue, Sept. 2002. P 1.

[31] Simpson, D. D., & Brown, B. S. (Eds.). (2002). Special Issue: Transferring research to practice. *Journal of Substance Abuse Treatment*, *22*(4).

[32] Registered Nurses Association of Ontario (2002). Toolkit: Implementation of clinical practice guidelines. Toronto, Canada: Registered Nurses Association of Ontario. Many of these elements are quoted almost verbatim, which is allowed by the copyright on the RNAO document.

- ***Workplace culture***—How the organization believes things "should be done," what is important to focus on and allocate resources to and what the organization aspires to, and, importantly, how this is expressed on a day-to-day basis.

- ***Communication systems***—This includes both the formal and informal process that the organization has in place to exchange information, which can range from agency newsletters, emails, and bulletin boards to informal discussions that determine how information about change within the agency is disseminated.

- ***Leadership support***—This is the extent to which management (at all levels) and others with influence are prepared to enable changes in the system related to the implementation of competencies within the organization. Examples might include whether management wants to promote core competencies and whether there are influential champions within the organization who can become "super users" or early adopters.

- ***KSAs/attitudes of the potential target group***—This includes staff members' general views and belief systems concerning change, as well as their core competencies and general motivation toward adopting new ideas and practices. It may be influenced by whether staff have been successfully supported through past chance and whether it is easy to discuss change with staff in the agency. (See ***communication systems***, above).

- ***Resources***—This includes financial resources, as well as human or in-kind requirements necessary to achieve the objectives in the action plan. Examples include agency funding to provide training, mentoring or coaching to implement competencies, and perhaps more importantly, the agency's willingness and ability to provide the time to staff and supervisors necessary to implement this initiative.

- ***Interdisciplinary relationships***—This refers to the behaviors and types of interactions between and among various disciplines and staff within the agency involved in implementing competencies. For example, established addiction counseling competencies are designed to cut across all disciplines (paraprofessionals, mental health counselors, social workers, mental health counselors, psychologists, nurses, etc.) but it would be important to note the interactions between these groups before implementing an agency-wide program for all of them.

IBR developed the [Organizational Readiness for Change (ORC)](#) assessment tool to serve as a diagnostic tool for planning interventions to improve organizational functioning.[33] It includes scales from four major domains: motivation, resources, staff attributes, and climate. Parallel versions of the ORC are available for the program director (or clinical supervisor) and the counseling staff. It focuses on organizational traits that predict program change:[34]

- Motivation—Program needs, training needs, and pressures for change;
- Program resources—Offices, staffing, training, and equipment;
- Staff attributes—Growth, efficacy, influence, adaptability, and orientation; and
- Organizational climate—Mission, cohesion, autonomy, communication, stress, and change.

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[33] Lehman, W. E. K., Greener, J. M., & Simpson, D. D. (2002). Assessing organizational readiness for change. *Journal of Substance Abuse Treatment*, *22*(4), 197-209.
[34] Ibid.

IBR also has developed the ORC-SA, an alternate version of the ORC assessment adapted for use in social agencies that do not directly provide treatment services. Other surveys can be found on the IBR Web site.

CHAPTER 5:

Using Competencies in Certification, Licensing, and Credentialing

SECTION 5.1: The connections among competencies, certification, and credentialing

The use of competency standards in licensing and certification can be a powerful tool in incorporating competencies as a basis for training, professional development, career pathway development, and work performance. The behavioral health field, led especially by the substance use disorders discipline, has begun to explicitly link competency standards with these credentialing processes.

Credentials include the various methods used in the workplace to attest to the completion of education, training, or on-the job performance requirements. Credentials come in many forms including educational degrees, certifications, and licenses. Educational degrees are widely understood as the credential conferred by a college or university upon successful completion of a program of study. The terms *license* and *certification* are often used interchangeably, so the following definitions are provided to help clarify the terms.

The major distinction between a license and a certification is that a certification documents performance, whereas a license affords a "right to practice." The glossary of terms developed by the University of Rochester Medical Center defines **licensure** as "a process by which a governmental authority grants permission to an individual practitioner or healthcare organization to operate or to engage in an occupation or profession." **Certification** is defined as: "a process by which an authorized body, either a governmental or non-governmental organization, evaluates and recognizes either an individual or an organization as meeting pre-determined requirements."

For example, the National Association of Social Workers (NASW) notes that its "credential or specialty certification is a professional designation and does not take the place of a State license." This professional organization for social workers notes that NASW credentials and specialty certifications are used to *enhance* the State license, signifying that the social worker with the certification has additional training, experience, and supervision. In other disciplines within behavioral health, the ability to become licensed or credentialed is linked to graduation from an accredited educational institution that is acceptable both for licensure in most States, as well as national credentialing bodies.

Licensure

Current service providers and potential workers in the behavioral health field should be aware of licensing requirements since they apply to many behavioral health career fields. License requirements generally

include the education, certification, and work experiences that are required to legally work in an occupation. In many States, occupations such as Substance Abuse and Behavioral Disorder Counselors, Mental Health and Substance Abuse Social Workers, Mental Health Counselors, and Counselors, All Other require a license. The titles of the license, as well as the requirements to obtain a license, vary from State to State. To search for information about licensing requirements in a State, search the online Licensed Occupations directory found on the Career InfoNet Web site.

Certification

Unlike licenses, certifications generally are awarded following successful completion of an oral or written examination, or demonstration of observable on-the-job performance requirements. Certifications attest that the holder of the certification has acquired a level of knowledge, experience, or skill in an occupation or specific competency, and thus certifications tend to be more explicitly linked with competency standards. They are most often provided by national professional organizations, which usually have a certification branch or division.

Again, NASW is an example of such an organization. Through its Academy of Certified Social Workers, NASW offers three credentials and seven specialty certifications (five for Master's of Social Work and two for Bachelor's of Social Work). Similarly, the American Academy of Health Care Providers in the Addictive Disorders offers the Certified Addiction Specialist (CAS) certification to health care professionals working with clients who have addictive disorders. This occupational certification includes a requirement that applicants have a specified number of hours of training in competency areas that include basic counseling skills, assessments, interviewing, and diagnosis.

Credentialing of addiction counselors varies by State, and reciprocity for counselors moving from one State to another is available only if the two States rely on the same testing procedure. Currently, IC&RC and NAADAC, The Association for Addiction Professionals both provide examinations to determine the qualifications of those applying for addiction counselor certification.

The assessment company Brainbench offers a competency assessment and certification that is used widely across many behavioral health occupations: "Counseling Techniques." Brainbench's offering is an example of a skill certification. Successful performance on this test results in a certification verifying an individual's knowledge of specific counseling concepts. The certification implies competence in *counseling techniques*, but not in other core competencies required of a counselor.

Using competencies to enhance licensing and certification standards

In the 2007 publication *Applying the TAP 21 to Certification Standards & Other Addiction Treatment Workforce Improvement Initiatives*,[35] authors Pamela Baston and Pamela Waters suggest four main reasons to use a set of competencies to upgrade addiction certification or licensing standards, or for other workforce improvement initiatives:

1. ***Many individuals entering the workforce lack a common set of core competencies necessary to be an effective substance abuse treatment counselor because of the high turnover rates in the field.***
   "Organizations that accredit addiction training have an ethical, if not practical, responsibility to require

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[35] Published by the Southern Coast ATTC/Florida Certification Board.

adoption of teaching practices that have evidence of effectiveness." This also applies to the many pre-service and in-service training programs designed for mental health professionals at all levels, as well as for prevention practitioners.

2. ***Utilizing the most contemporary competencies improves treatment outcomes and is a necessary part of a good quality improvement agenda.*** Certification and licensing boards can incorporate tested competencies, KSAs/attitudes associated with positive treatment outcomes as part of an overall quality improvement strategy.

3. ***TAP 21 is the most current consensus document of its kind to present the KSAs/attitudes that are needed for achieving and practicing the addiction competencies.*** Because TAP 21 was developed through a process involving many national organizations, it is a very current set of addiction competencies with a widespread consensus, making it a powerful tool for certification.

4. ***Persons seeking recovery from addiction deserve the most competent treatment possible.*** By incorporating the high standards of these competencies in a certification or licensing process, the licensing/certification board positions its addiction treatment system to deliver treatment more competently.

Although Baston and Waters wrote about Florida's efforts to incorporate addiction counseling competencies into their State's certification of addiction counselors, many of these points are applicable to competencies in mental health or COD.

Definitions:

Certification—A process by which an authorized body, either a governmental or nongovernmental organization, evaluates and recognizes either an individual or an organization as meeting pre-determined requirements or criteria.

Licensure—A process by which a governmental authority grants permission to an individual practitioner or health care organization to operate or to engage in an occupation or profession.

Credentialing—An individual process, usually in written form that provides a basis of confidence and indicates evidence of authority in a given field. Credentials are the documents that constitute evidence of training, licensure, experience, and expertise of a practitioner. Evidence of licensure and certification are credentials.

SECTION 5.2: How are credentials used?

State and local service providers use credentials—such as evidence of licensure and certification—to ensure that the workforce possesses the necessary knowledge and skills to provide effective treatment for clients. They also use credentials to determine whether an employee's Scope of Practice or in-state privileges allow for third-party billing.

The following section provides examples of how States have used credentials to enhance the performance of staff in the delivery of behavioral health—in licensing, certification or both. (To locate information about occupational and skill certifications, use the Certification Finder tool on the Career InfoNet Web site.)

Mental Health Counselor

Mental health practitioners are credentialed in a variety of ways in different States. Most States require a Master's degree as the minimum qualification to qualify for a license as a Mental Health Counselor. In addition to the education requirements, State licensure frequently requires completion of an examination offered by The National Board for Certified Counselors. The National Clinical Mental Health Counseling Examination (NCMHCE) provides simulated cases that test complex problem-solving and decision-making skills based on explicit competencies. The Web site has a link to all State licensing boards that provides easy access to the State licensing agencies.

> *Case in Point*: The Minnesota Board of Behavioral Health and Therapy administers the licensure of Licensed Professional Counselor (LPC), Licensed Professional Clinical Counselor (LPCC), as well as Licensed Alcohol and Drug Counselor. Successful completion of the NCMHCE is one of the requirements for licensure. The licensing of workers in the mental health field protects the public and provides a standard of competent and ethical practice for the counselor.

Substance abuse treatment

Most States require a license for Alcohol, Chemical Dependency, Drug, or Substance Abuse Counselors. Frequently the license for the behavioral specialist engaged in substance or dependency counseling is associated with the occupations Mental Health and Substance Abuse Social Workers or Substance Abuse and Behavioral Disorder Counselors. State licensure requirements may require an applicant to hold a certification offered by a national association such as the International Certification & Reciprocity Consortium (IC&RC) or NAADAC, the Association for Addiction Professionals.[36] In other States, certification is voluntary.

The most widely used competencies in behavioral health—for licensure, certification and many other purposes—are the national Addiction Counseling Competencies identified and described in TAP 21 developed by SAMHSA.

> *Case in Point*: For example, the Florida Certification Board (FCB) used TAP 21 to standardize substance abuse counseling certification in the State and to elevate the field's level of professionalism. In 2003, FCB developed Scopes of Professional Practice based on TAP 21 for three

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[36] IC&RC includes 73 agencies representing more than 37,000 certified professionals internationally, while NAADAC has 10,000 members and 46 State affiliates.

levels of addiction certification. Expanded educational requirements detailed the content practitioners would require for certification, including specific hours in each transdisciplinary foundation and practice dimension. TAP 21 guided identification of professional standards—including 123 competencies and the knowledge, skills, and attitudes required to become proficient in each competency—essential for effectively counseling individuals with substance use disorders. As a result, continuing education providers are now required to detail the educational and training content of their programs on certificates in a way that matches these standards.

Case in Point: Georgia, one of the NAADAC test States, offers a voluntary certification at two levels for addictions counselors. The certification administered by the Georgia Addictions Counselors' Association was developed to promote high standards for those involved in providing addictions counseling services. Although the certification is voluntary, numerous job openings for this position list the certification as a preferred qualification for job applicants.

Substance abuse prevention

The International Certification & Reciprocity Consortium (IC&RC) is one organization that sets the international standards of practice in addiction counseling, prevention, and clinical supervision. IC&RC offers the Prevention Specialist (PS) certification and a list of the State boards that offer reciprocity for this and other certifications awarded by IC&RC.

Case in Point: The Florida Certification Board offers three levels of certification for Addiction Prevention Specialist based on a combination of the IC&RC standards, TAP 21 and the NAADAC certification standards. (See a case study about a Florida provider using Florida's prevention competencies in Chapter 3 of this Guide.)

Developing a credential for behavioral health

Some professionals from across the many disciplines in behavioral health would like to see a credential based on core competencies that may be the same throughout treatment of mental health, substance abuse and COD. At this time the credentials for mental health counselors, substance addiction treatment professionals, and prevention specialists are administered by separate professional trade organizations. The knowledge and skills required for workers in these occupations have many similarities.

However, the use of assessments and the resulting certification credential for occupations in the behavioral health area differ widely. In an article comparing State requirements for training substance abuse and mental health counselors, researchers note that the data on minimum State requirements "suggest that training as a Mental Health Counselor is primarily structured through formal education, whereas training as a substance abuse counselor resembles an apprenticeship model…. and generally require[s] more hours of supervised experience and continuing education, but fewer hours of formal coursework and practicum courses, and a lower level of education."[37]

Those who would like to see a behavioral health credential note that the development of core competencies needed for workers in the behavioral health field would be the foundation necessary to support the development of a credential in behavioral health. Such a credential would support a more

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[37] Kerwin, M. E., Walker-Smith, K., Kirby, K.C. (2006). Comparative analysis of State requirements for the training of substance abuse and mental health counselors. *Journal of Substance Abuse Treatment* 30. pp 173-181.

effective delivery of service to those in need of services, since the disorders and symptoms in the client population frequently do not break out into the separate specialties for which workers are trained. At this time there is no national effort to do so; however, several States have moved to a more comprehensive approach to credentialing behavioral health workers.

Case in Point: Before 2003, there were two separate divisions within the Alaska Department of Health and Human Services delivering mental health and addiction services. In July 2003, several agencies were merged to become the Division of Behavioral Health (DBH). As the result of a merger it became apparent that there is a need to develop a credentialing system that represents and supports an integrated "behavioral health" workforce for Alaskan treatment agencies. The division has undertaken a project to develop a set of core competencies and a credentialing system that will allow behavioral health care agencies in Alaska to hire and retain the most effective workforce possible.

CHAPTER 6:

Using Competencies in Human Resources

Identifying and implementing core competencies can help provider organizations recruit, hire, and retain staff by articulating the specific KSAs required for success in behavioral health careers. Through a process of assessment and credentialing, both the employee and employer can gain a better understanding of a worker's competence and areas in which staff development would enhance performance. The competencies required for an occupation within the behavioral health family (or career ladder) form the foundation for the development of assessment instruments, credentials, and the curricula that teach the required competencies.

SECTION 6.1: Using competencies to develop a career ladder/lattice

Development of core competencies facilitates development of career ladders and lattices in that field. Traditional career ladders have been occupational structures that encourage and reward competent employee performance within an organization. Employees move up the rungs by demonstrating successful performance and/or obtaining education and training that prepare them for the next level. Industry-based career ladders open up entry-level jobs and provide an incentive for individuals to enter a field and develop their skills for upward mobility.

Career *ladders* help employees plan for upward mobility in their careers, even if they start in an entry-level job. A career *lattice* recognizes that opportunities include career paths that move a job seeker or employee laterally or upward between industries or positions. A career lattice path requires varied amounts of continuing education and/or training in order to transfer into a related job in another industry.

Career ladders and lattices have many benefits for individuals, employers, and industries. Some benefits are:

- **Employee retention**—Career ladders illustrate potential for advancement, which serves as an incentive for employees to stay with organizations. Employers save on costly turnover, recruitment, and training expenses.

- **Performance incentive**—The opportunity for advancement motivates employees to produce and perform well on the job and to acquire new knowledge and skills.

- **Succession planning**—Career ladders enable organizations to plan for and develop the skills, knowledge, and abilities they need in their current and future workforces.

- **Boost to small agencies**—Regional industry-based career ladder strategies allow the cost of developing and maintaining career ladders and training to be spread among provider agencies and participants. This makes career ladder programs more affordable for small and medium-sized employers.

- **Career development programs**—The graphic representation of career ladders provides an easily understood tool to assist career counselors and individuals in career planning and decision-making.[38]

Career ladders in related fields

Career ladders/lattices are being developed in the health care and behavioral health industries, to cope with workforce shortages and to improve quality. This is especially true in the field of nursing, which faces severe shortages much like the field of behavioral health. (To learn more about career ladders in the health care field see Explore Health Careers.org.)

For example, the Council for Adult and Experiential Learning developed the Nursing Career Lattice Program with a grant from the Department of Labor. [39] Designed to help address shortages in the nursing field, the program seeks to:

- Allow participants to earn while they learn in a competency-based apprenticeship.

- Recruit incumbent health care workers as an available and valuable source of experienced personnel.

- Respond to the critical need to increase the flow of candidates into nursing and to attract candidates who better mirror the patient population.

- Create a structure that enhances the likelihood new entrants will remain and increases their chances of success.

- Develop pilot Certified Nursing Assistants (CNAs) and Licensed Practical Nurses (LPNs) Apprenticeship programs to provide opportunities for new and incumbent workers to enter and advance in nursing careers.

- Link to national online nursing programs that provide opportunities for LPNs to earn an Associate's Degree in Nursing, sit for the National Council Licensure Examination, and become an RN in less than two years.

- Promote best practices in educational policy among health care providers.

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[38] State of California Employment Development Department. (May 2003). Careers Under Construction: Models for Developing Career Ladders. Retrieved on Oct. 23, 2009 from http://www.calmis.ca.gov/file/occmisc/careerladdersconstruction.pdf.
[39] Council for Adult and Experiential Learning. Nursing Career Lattice Program. Retrieved Oct. 23, 2009 from http://www.doleta.gov/OA/cael.cfm.

- Encourage careers in nursing and health care, particularly among demographic groups traditionally underrepresented within the industry.

- Create strong support networks for adult learners engaged in health care education.

- Link these efforts to the publicly supported Workforce Investment system.[40]

Lee Mental Health Care Center, Inc. (LMH) is a behavioral health care provider for Lee County, Florida. This organization has developed career lattices for its Non-Clinical/Support and Clinical employees.[41] LMH provides a number of services to help its employees move through the career lattice. For example:

- LMH will reimburse two classes per semester for undergraduate, graduate, and specialized/technical-training classes related to the employee positions or for career advancement at LMH.

- Eligible employees receive a discount towards the cost of tuition at Hodges University.

- Employees gain access to free Web-based training.

- LMH programs assist employees in attaining licensure.

- LMH employees receive annual performance evaluations and receive internal and external training in their fields.

Additional examples of health-related career ladder programs noted by explorehealthcareers.org include:[42]

- Asante Health Systems in Oregon partnered with nearby Rogue Community College to provide training and education to advance clerical workers into positions in health care informatics.

- American Indians serving as health technicians on the Navajo reservation can advance their careers through Learning Circles for Health Technicians.

- The Owensboro Medical Health System in Kentucky and a local community college provide online and work-based training for CNAs, pharmacy techs, clerks, patient care techs, and environmental techs to become associate degree registered nurses.

- The Baltimore Alliance for Careers in Healthcare (BACH) plans to train employees currently working in non-patient care departments to become nurse extenders.

See *Careers Under Construction: Models for Developing Career Ladders* for more examples of Health Care Career Ladders and models for their development.

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[40] U.S. Department of Labor, retrieved from http://www.doleta.gov/oa/brochure/CAELDOL_Nursing_Career_Lattice_Program.pdf on Oct. 23, 2009.

[41] Career Ladder Information—retrieved from Lee Mental Health Care Center, Inc. on Nov. 11, 2009.

[42] Retrieved from http://www.explorehealthcareers.org/en/Article.164.aspx on Nov. 9, 2011

SECTION 6.2: How to write a job description based on competencies

Finding qualified job candidates can be accomplished best by implementing a structured selection process.[43] The basis of control in the selection processes is the job description. Job descriptions serve several important purposes by:

- providing essential information for assigning the appropriate pay grade, job function, and/or title for the job;

- assisting in recruiting efforts for screening and interviewing; and

- identifying essential functions of the job so the incumbent has an understanding of the primary accountabilities, duties, and responsibilities expected.

Identifying the important competences that define the essential functions of a job provides the basis for more accurate job descriptions, which in turn can lead to better and more targeted hires. A competency-based job description has one significant feature that traditional job descriptions do not possess. In addition to listing duties assigned to a position, a competency-based job description also includes the skills and behaviors required to successfully perform these duties. This feature does the following:

- enables recruiters to fully describe job requirements;

- leads to lower turnover due to better matches between applicants and job;

- helps supervisors adequately explain areas for improvement using concrete examples of expectations during performance reviews; and

- shows employees what skill sets are required to advance within an organization.

Including competencies and a broader range of responsibilities in the job description benefits a number of human resource functions. For example, a competency-based job description can provide greater flexibility in assigning work to employees, allow multiple jobs that require similar competencies to be grouped within a single job family, and lengthen the life cycle of job descriptions.

Establishing competencies used in job descriptions

If competencies have not yet been identified for a job or family of jobs, a competency model or list of key competencies will need to be developed first. To develop criteria that are critical to effective job performance, organizations should conduct a competency analysis of job families (groups of related jobs). It generally is not necessary to identify competencies for each individual job title in an organization, for while specific tasks may vary, underlying competencies will be consistent. An effective way to promote buy-in and encourage employees to share a common language to describe work is to engage cross-functional, multi-level focus groups to develop the competency components.

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[43] See the *Recruitment and Retention Toolkit*.

These groups should compile detailed descriptions of the tasks required in various jobs, a process sometimes called "task analysis." Data collection methods that can be used include:

- **Job Observation**—Observe incumbents performing their jobs and record their activities; and

- **Interviews**—Conduct interviews with incumbents and managers; ask questions about key responsibilities, problems solved, interactions with others, and skills and abilities they feel are needed for success; record responses in detail.

Concise, factual statements of the tasks associated with jobs comprise the Principle Accountabilities/Major Responsibilities element of job descriptions (see below). Each task should start with an action verb that is specific in nature. When the key competencies and major duties have been identified, the information can be used to fill out the key areas of the job description.

Key elements in job descriptions

The key elements of a good competency-based job description include:

- **Job title**—A designation that indicates an individual's official position in an organization;

- **Scope/relevance of position**—How the position supports the company goals and objectives;

- **Reports to**—Reporting relationship within the organization; the position to which the hire reports;

- **Job summary**—One or two concise sentences summarizing the main purpose of the job;

- **Principal accountabilities/major responsibilities**—The primary work functions and responsibilities the job is expected to perform, as well as end results that are to be achieved;

- **Minimum/critical qualifications**—The standards—experience, education, and certification—that candidates must meet to be considered for the position;

- **Minimum/critical competencies**—Skills, knowledge, abilities, and behaviors required for the job (e.g., excellent teamwork skills, adaptability, and flexibility);

- **Preferred qualifications**—Qualifications in experience, education, and certification that are preferred but not essential;

- **Preferred competencies**—Skills, knowledge, abilities, and behaviors that are preferred but not essential; and

- **Other job-related duties as assigned**—Variations in task assignment may be necessary from time to time; including this statement precludes the need to modify the job description when variations occur.

The specific elements and format of competency-based job descriptions will vary by organization and specific organizational needs. However, the key is to include competencies that help distinguish between

average and superior job performance. Effective hiring systems use the competencies identified in the job description as the basis for developing interview questions, identifying appropriate selection tests, and making the final hiring decision. Ensuring that job descriptions are accurate enables developing selection criteria and making selection decisions that are in the best interests of individuals and organizations.

SECTION 6.3: Using competency models in supervision

One of the biggest challenges facing behavioral health providers is the need to focus on quality improvement and the implementation of evidenced-based practices that can enhance client outcomes. A key is effective pre-service training in higher education programs for clinicians and counselors, as well as enhanced on-going clinical supervision for clinicians and counselors at every level from recent graduates to those who have been in the field for many years.

As prevention and treatment providers across the Nation struggle to recruit and retain prevention specialists, clinicians and counselors, ensuring staff competencies is particularly crucial. The Annapolis Coalition called for the use of competency-based approaches to improve the behavioral health workforce,[44] yet the provision of effective supervision is a challenge in all areas of behavioral health, particularly clinical supervision. As John Porter of NFATTC noted, "There aren't enough people out there who are qualified or willing to work in the field or resources available to hire counselors qualified to do the work adequately. Agencies are hiring counselor and training them up, rather than hiring the qualified counselors they need." Where there is a shortage of candidates with appropriate credentials, employers must seek out those with appropriate competencies.

Mental health clinicians, addiction counselors, and those treating COD often have not received the training they need to be effective supervisors, inhibiting implementation of new evidence-based practices.[45] Not only is there little training in clinical supervision, but often, when it does occur, the training is not competency-based.[46]

Within the prevention field especially, competencies are not widely used for ongoing clinical supervision, nor is supervision typically even viewed as "clinical," although prevention specialists are providing direct services to clients.

The addiction treatment field "grew up without supervision. The first and even second generation did not get supervision…," notes David Powell, an author and trainer in clinical supervision of substance use disorders."[47] Michael Torch, who also provides clinical supervision and training in addiction counseling, echoes Powell's concerns: "building clear recognition for the need for clinical supervision is the biggest workforce challenge we have."[48]

Across the behavioral health field, experts in clinical supervision say that one of the most difficult aspects of competency-based clinical supervision is developing plans that actually make a difference in how staff work with clients.[49]

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[44] Hoge, M.A., Tondora, J., & Marrelli, A.F. (2005). The fundamentals of workforce competency: Implications for behavioral health. *Administration and Policy in Mental Health, 32*, 5, 509-531.

[45] Scott, K.J., Ingram, K.M., Vitanza, S.A., & Smith, N.G. (2000). Training in Supervision: A Survey of Current Practices. *The Counseling Psychologist*, 28, 3, 403-422.

[46] Falender, C. A., & Shafranske, E. P. (2004). *The practice of clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.

[47] Personal communication.

[48] Personal communication.

[49] Center for Substance Abuse Treatment. (2009). Clinical Supervision and Professional Development of the Substance Abuse Counselor. Treatment Improvement Protocol (TIP) Series 52. HHS Publication No. (SMA) 09-4435. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Why use competencies for supervision?

Effective competency-based clinical and administrative supervision can be a key factor in providing ongoing training and support to ensure the workforce meets the needs of programs and clients.

Competencies can be used to help both supervisors and their employees understand the KSAs in clinical and administrative domains required for effective job performance. Program managers and agency executives need to have a detailed understanding of what KSAs are required to implement a variety of evidence-based practices in their programs and whether their staff has those competencies individually or as a group.

It is important to understand the distinction between administrative supervision and clinical supervision when using competencies. Administrative supervision focuses mostly on the employee within the organization, while clinical supervision focuses on the supervisee's work with clients in prevention or behavioral health treatment programs.[50] Administrative (non-clinical) competencies are the KSAs that are needed to be successful in *all* jobs within an organization. These competencies detail how the employee should function effectively in the organization, the organizational accountability that is expected, and how a competent employee should work with colleagues. Administrative competencies and the supervision that supports them are focused on how the individual can contribute to maintaining and improving the quality of the entire program or organization and meeting organizational objectives. Most of the competency resources in this Guide focus on clinical competencies.

How to conduct performance reviews using competencies

Examples of the use of competencies in effective clinical supervision can be found in two of the case studies in this Guide (Chapter 3). The first describes how a behavioral health prevention and treatment agency in South Florida (Operation PAR) has used prevention competencies to improve the quality of their prevention practices, provide a career ladder for their prevention specialists, and support supervisors and employees in the performance evaluation process.

The second case study describes how a comprehensive set of addiction counseling competencies have been used to strengthen clinical supervision focused on counseling practices.[51] In several areas of the United States, particularly in the Northwest region, SUD treatment providers are using competency-based clinical supervision that supports the effective implementation of evidence-based practices designed to make a difference in client treatment outcomes. The case study describes one such instance: how NFATTC developed a model to help clinical supervisors ensure that addiction counselors have the competencies they need.

In both cases, agencies use a set of established clinical competencies to develop job descriptions, employee self-assessment forms, performance evaluation measures, and individualized learning and professional

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[50] Todd, C. & O'Connor, J. (2005). Clinical Supervision. In N. Skinner, A.M. Roche, J. O'Connor, Y. Pollard, C. Todd (Eds.), *Workforce Development TIPS (Theory Into Practice Strategies): A Resource Kit for the Alcohol and Other Drugs Field.* National Centre for Education and Training on Addiction (NCETA), Flinders University, Adelaide, Australia.

[51] Center for Substance Abuse Treatment. (2006). *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice.* Technical Assistance Publication (TAP) Series 21, HHS Publication No. (SMA) 06-4171. Rockville, MD: Substance Abuse and Mental Health Services Administration.

development plans. This kind of structured support for both supervisors and supervisees bases clinical supervision in established criteria for all employees.

Operation PAR's performance evaluation tool is based on competencies used in developing a job description for prevention specialists, as well in the development of individualized professional development plans.

The NFATTC clinical supervision model is based on the 123 competencies in TAP 21.[52] In this model, both the clinical supervisor and the counselor complete the Performance Assessment Rubrics, which is tied directly to the competencies. Based on the counselor's self-evaluation, the clinical supervisor discusses areas of challenge and strength with the counselor. The supervisor then observes the counselor in those areas and provides feedback regarding the counselor's performance. From this discussion, the counselor and clinical supervisor develop a learning plan, which includes a detailed timeline of activities such as observing other professionals, reading materials, or completing training.

The model allows for continual performance improvement. When the counselor successfully completes the initial learning plan, there is a celebration to mark the success and a second plan is developed to continue the performance improvement process.

Competency-based supervision linked to HR policies

John Porter, one of the key developers and trainers in the NFATTC model, notes that it is imperative for an agency to fully embrace the competencies by incorporating them into human resource policies. While the goal is to increase staff competencies to improve the agency and the counselor's own career development, the process can link to corrective action plans that ultimately could lead to terminating an employee.

Supervisors make it clear to counselors that they are expected to meet competencies in order to keep their jobs. The model supports the development of corrective action plans, which act as a logical and fair "paper trail" that can be used to support termination or other action.

Competency-based supervision requires agencies to write or re-write counselors' job descriptions that are based on competencies. Recruitment advertisements for new hires also must incorporate the competencies. Porter suggests that agencies observe the performance of job candidates prior to hiring by asking candidates to conduct group sessions observed by a hiring manager. This is known as a "job try-out," (or "work simulation") which allows an applicant's performance to be checked against the list of competencies in the job description.[53]

Effect on turnover and implementation of evidence-based practice

There is some evidence to suggest that effective clinical supervision is a key to reducing turnover in behavioral health. Studies suggest that effective clinical supervision can reduce emotional exhaustion among counselors and the rate at which they plan to leave jobs.[54] There is also research to show that when supervisors provide their supervisees with support in performing day-to-day tasks as well as instrumental

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[52] ibid.

[53] See the *Recruitment and Retention Toolkit*.

[54] Knudsen, H.K., Johnson, J.A., Roman, P. M. (2003). Retaining counseling staff at substance abuse treatment centers: Effects of management practices. *Journal of Substance Abuse Treatment, 24*, 129-135.

social support, job satisfaction of supervisees increases. [55] Research has also found that clinical supervision plays a "protective role" in counselor's reports of well-being, noting that the data showed correlations between the support and the positive effect on well-being that were large and highly significant.[56]

Other research shows that competency-based supervision may be a critical link in implementing evidence-based practices; Falender and Shafranske suggest that reliable and valid measurement tools are needed to support clinical supervisors as they conduct empirically based assessments on how well a particular intervention is implemented.[57] The Task Force charged by CSAT to develop the *Competencies for Substance Abuse Treatment Clinical Supervisors* noted that "quality supervision will become a major factor in determining the degree to which evidence-based practices are adopted in community settings."[58]

Reliability and validity in assessing competencies in behavioral health

Competencies typically are derived from job analyses and can be used to help develop many different human resource-related solutions, from individual job descriptions and performance appraisals, to organizational development plans, career ladders and lattices, or training and development strategies. When used to assess an individual's performance, the assessment's ultimate use will determine the extent to which it must be established as credible; i.e., if the assessment will be used for decisions such as graduation, certification or licensure, the assessment results must be proven to be reliable and valid.

The requirements for reliability and validity in assessments are based on the *Uniform Guidelines on Employee Selection Procedures* (published jointly by three Federal agencies, including the U.S. Department of Labor).

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[55] Stinglhamber, F. and Vandenberghe, C. (2003). Organizations and supervisors as sources of support and targets of commitment: A longitudinal study, *Journal of Organizational Behavior*, *24*, pp. 251–270.

[56] Knudsen, H.K., Johnson, J.A., Roman, P. M. (2003). Retaining counseling staff at substance abuse treatment centers: Effects of management practices. *Journal of Substance Abuse Treatment, 24*, 129-135.

[57] Falender, C. A., & Shafranske, E. P. (2004). *The practice of clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.

[58] Center for Substance Abuse Treatment. (2007). *Competencies for Substance Abuse Treatment Clinical Supervisors*. Technical Assistance Publication (TAP) Series 21-A (Rep. No. HHS Publication No. (SMA) 07-4243). Rockville, MD: Substance Abuse and Mental Health Services Administration.

SECTION 6.4: Example of a career ladder in treatment of SUDs

This section focuses on developing career ladders, specifically in the treatment of substance use disorders. Once a career ladder is established, treatment agencies can use this resource as part of their recruitment, training and evaluation processes and salary scales. When a profession develops a set of standardized core competencies it encourages more professional expertise and expectations. It is critically important to have a clear concept of the competencies required to work at the different levels in a career ladder in any field.

[NAADAC, The Association for Addiction Professionals](#) developed a career ladder to help other professionals accept addiction-focused professionals as credible and legitimate. The flow chart and subsequent charts provide a guide to help resolve issues where practitioners may be well educated but have little experience in the real world of counseling clients with substance use disorders, or have a wealth of experience without the education to round out the knowledge competencies required to perform clinical practice at a Bachelor's or Master's level.

Career ladders within an addiction treatment agency

The use of the career ladder with the core competencies is instrumental in the every day existence of a treatment agency. In the recruitment phase, a competency-based career ladder helps in developing job announcements that speak accurately about the skills, education and other requirements expected of a practitioner. At the agency level, it creates a standard to assess and develop personnel and permits employers to appropriately compensate addiction professionals. For individuals, this provides a continuum for SUD treatment professionals who see how their career could develop from the intern stage through to clinical supervision.

With a fully conceptualized and accepted career ladder and scope of practice, agency managers and administrators will be able to perform accurate evaluations based on the core competencies in counseling and measure the skill areas of the addiction professionals more specifically. A training plan for each individual within an agency can help maximize the potential of the addiction professional and supervisor. A clear set of standards makes the performance evaluation process more objective and measurable and provides clear direction regarding the types of training needed for employee development.

Each area of administration and supervision within an agency should be interested for specific reasons:

- **Executive directors and administrators** need to be concerned in order to chart clear guidelines regarding professional development, liability issues, and retention of personnel.

- **Individual addiction recovery counselors** need to know that they have a career with the potential for advancement and objective standards by which they can be evaluated.

- For **Human Resources professionals**, outlining core competencies along a career ladder helps to build more specific job descriptions that accurately describe required KSAs, and can serve as a focus for employee training, review and evaluation.

- The focus for **clinical supervisors** is ensuring their employees' competencies are developed and are appropriate for each position. This chart helps to delineate those competencies, allows a person to

assess where they fit on the career ladder and determine the educational expectations needed to fulfill employment expectations.

SECTION 6.5: Career Ladder for Professionals in Substance Abuse Treatment

To use core competencies in the development of skills for a professional at substance abuse treatment provider organization, an organization first must develop a career ladder based on existing laws, regulations, and validated competencies.

Entry Level
Substance Use Disorder Counselor-in-Training
(Outreach, Recovery House, Detox Tech, Intern,
Registered, Counselor-in-training)

Substance Use Disorder Professional—Level I
Certified, Registered or Licensed

Substance Use Disorder Professional—Level II
Clinical Supervisor/Manager/Administrator
Certified, Registered or Licensed

Substance Use Disorder Professional—Level III
Clinical Supervisor/Manager/Administrator
Certified, Registered or Licensed

CHAPTER 7:

Planning for Training and Professional Development

In addition to conducting an assessment of organizational readiness for change as suggested in Chapter 4, direct services staff who will use the competencies should assess themselves—in collaboration with supervisors and program managers—to determine the areas they need to focus on to improve their KSAs. There are a number of tools listed below.

Self-assessment tools to identify training needs

The Program Training Needs (PTN) survey developed by the Institute of Behavioral Research (IBR) focuses staff on important domains of program needs and related issues (e.g., facilities, resources, staff training needs and preferences, and barriers for innovation adoption decisions). IBR suggests that it is an efficient planning tool for programs beginning to explore organizational openness to innovations. It also provides an opportunity to consult staff about program needs and planning for treatment innovations, including the types of training needed.

Addiction Counseling Self-Efficacy Scale (ACSES).[59] According to a description of the tool, this scale assesses various aspects of addiction counselors' perceived self-efficacy for working with clients in the following skill areas: (a) specific addiction counseling; (b) assessment, treatment planning, and referrals; (c) COD; (c) group counseling; and (d) basic counseling.

Motivational Interviewing Assessment: Supervisory Tools for Enhancing Proficiency. Designed as part of the NIDA/SAMHSA Blending Initiative, this suite of empirically supported treatment products was designed to enhance treatment providers' motivational interviewing skills and provide tools to fortify the supervisor's ability to provide more structured, focused, and effective clinical supervision.

Competency Assessment Instrument (CAI) is a validated set of competencies and an instrument to measure them for direct service professionals working with people who have severe and persistent mental illness**.** The CAI, developed by Alexander Young M.D. and others,[60] measures 15 provider competencies that were viewed as central to recovery-oriented care. Each competency is measured with its own scale, which is made of a combination of three to five Likert items requesting a numerical response on a four- or five-point scale. Demographic questions assessing race/ethnicity, gender, education level, job title, job duties, and number of years in the mental health field are also included. CAI was developed with funding from the

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[59] Murdock, A., Wendler , J., Nilsson **(**2005). Addiction Counseling Self-Efficacy Scale (ACSES): development and initial validation*. Journal of Substance Abuse Treatment*, Volume 29, Issue 1, Pages 55—64.

[60] Young A.S., Forquer, S.L., Tran A., et al (2000). Identifying clinical competencies that support rehabilitation and empowerment in individuals with severe mental illness. Journal of Behavioral Health Services and Research. 27:321–333

Department of Veterans Affairs, Desert Pacific Healthcare Network—Mental Illness Research, Education & Clinical Center (MIRECC).

Co-occurring Disorders Educational Competency Assessment Tool (CODECAT) is a proprietary tool that provides an integrated framework to evaluate clinicians' training needs and a framework within which disorder-specific treatment can be understood and applied more effectively. CODECAT is a competency assessment and self-teaching tool that raises awareness of desired attitudes, values, knowledge, and skills; identifies the expected clinician core competencies associated with each principle; and provides a format for supervisory evaluation or clinician self-evaluation.

Performance Evaluation Rating Form was developed by NFATTC and can be used as a self-assessment instrument. It is based on *TAP 21: Addiction Counseling Competencies*.

American Association of Directors of Psychiatric Residency Training (AADPRT) offers a chart and links for residency training programs' competencies.

Developing learning/professional development plans

A key element in ensuring that competencies improve is the creation of an Individualized Professional Development Plan (IPDP), or Learning Plan, to support employees' professional development activities that are linked to competencies identified for improvement. In the Resource chapter of this Guide, readers can download a Learning Plan based on one created in Idaho for use by addiction counselors who have identified various areas they need to work on to achieve a high level of competency. This form can be easily adapted for mental health or co-occurring competencies.

CHAPTER 8:

Links and References

SECTION 8.1: Links

WEB RESOURCES FOR COMPETENCIES IN THE PREVENTION OF SUBSTANCE USE DISORDERS

- IC&RC/AODA has competency standards that define successful performance in the prevention setting. See the IC&RC Candidate Guide for the list of competencies within each prevention domain.

- What Health Professionals Should Know: Core Competencies for Effective Practice in Youth Violence Prevention. (2005). Lyndee Knox, Ph.D., Editor—Southern California Academic Center of Excellence on Youth Violence Prevention

- Community Anti-Drug Coalitions of America (CADCA) trains community anti-drug coalitions, in effective community problem-solving strategies, teaching them how to assess their local substance abuse-related problems and develop a comprehensive plan to address them.

WEB RESOURCES FOR COMPETENCIES IN THE TREATMENT OF SUBSTANCE USE DISORDERS

- IC&RC/AODA has competency standards that define successful performance in the addiction treatment setting.

- NAADAC, the Association for Addiction Professionals—The NAADAC Certification Commission operates as an independent body managing NAADAC's credentials and education. The NAADAC Certification Commission deals with test administration, fees, ethics and rules of procedure. Alexandria, VA.

- SAMHSA's Co-Occurring Center for Excellence (COCE) was a 5-year project that ended in March 2009. The Web site is still active and houses valuable information about COD, including "Overarching Principles to Address the Needs of Persons With Co-Occurring Disorders."

- Iowa Toolbox Training, Prairielands ATTC *Toolbox Training: A Substance Abuse Educational Series for Helping Professionals* is a curriculum based on the SAMHSA TAP 21, *Addiction Counseling Competences* and was developed by PATTC in cooperation with treatment directors and supervisors. The Toolbox Training Series "bridges" the 12 Core Competencies to TAP 21 and the *NIDA Principles of Effective Drug Treatment*.

- The Northwest Frontier ATTC has many competency related resources.

- The Caribbean Basin and Hispanic Addiction Technology Transfer Center (CBHATTC) has TAP 21 in Spanish: *Competencias en Consejería de la Adicción: Conocimientos, Destrezas y Actitudes de la Práctica Profesional (TAP 21)*.

- NASW Standards for Social Work Practice with Clients with Substance Use Disorders.

- Core Competencies for Social Workers in Addressing the Needs of Children of Alcohol and Drug Dependent Parents. National Association for Children of Alcoholics (NACoA).

- *Essential Psychiatric, Mental Health and Substance Use Competencies for the Generalist Nurse* (Draft) provides the framework for educational preparation of generalist professional nurses who can provide appropriate and effective care for persons with mental illness, substance use disorders, and those at risk for these conditions. Draft for review by the American Academy of Nursing, International Society of Psychiatric Nursing, and the American Psychiatric Nurses Association.

- Core Competencies for Canada's Substance Abuse Professionals.

WEB RESOURCES FOR COMPETENCIES IN MENTAL HEALTH

- SAMHSA's Co-Occurring Center for Excellence (COCE) was a five-year project that ended in March 2009. The Web site is still active and houses valuable information about COD, including "Overarching Principles to Address the Needs of Persons With Co-Occurring Disorders."

- National Association of Social Workers has practice standards for 13 different areas of social work practice.

- Competency Assessment Instrument (CAI)—An Instrument to Assess Competencies of Providers Treating Severe Mental Illness—Mental Illness Research, Education & Clinical Center (MIRECC) VA Desert Pacific Healthcare Network

- American Association of Directors of Psychiatric Residency Training (AADPRT) has a chart and links for residency training programs' competencies.

- Behavioral Health Standards and Competencies. (June 1998) Center for Mental Health Policy & Services Research Department of Psychiatry University of Pennsylvania's (Penn) Medical Center.

- Certified Psychiatric Rehabilitation Practitioner(CPRP) credential is a test-based certification based on core competencies. Currently there are CPRPs with Ph.D.s to GEDs, occupational therapists to peer specialists, social workers to case workers. Only nationally recognized professional credential for psychiatric rehabilitation professionals.

- Marriage and Family Therapist Core Competencies. American Association for Marriage and Family Therapy.

- Psychiatric Mental Health NP Competencies: National Panel for Psychiatric Mental Health NP Competencies, (2003). *Psychiatric-mental health nurse practitioner competencies*. Washington, DC: National Organization of Nurse Practitioner Faculties.

- **Peer Training Specialists in Mental Health**—While there is not yet a national set of competencies for training peer specialists, these resources may be helpful:

  o The Georgia Certified Peer Specialist (CPS) Project Web site has job descriptions, trainings, a manual, and code of ethics (as well as information about Medicaid reimbursement in GA only) for mental health peer specialists.

  o The Depression and Bipolar Support Alliance (DBSA) is a patient-directed national organization that provides training for people living with mental illnesses to use their experiences to work with others as peer specialists.

- Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals developed by the Suicide Prevention Resource Center, which is supported by a cooperative agreement with the Substance Abuse and Mental Health Services Administration.

- From the UK: The Capable Practitioner—A framework and list of the practitioner capabilities required to implement The National Service Framework for Mental Health.

WEB RESOURCES FOR ORGANIZATIONAL ASSESSMENT AND CHANGE

- *The Change Book*—Published by the Addiction Technology Transfer Center (ATTC) Network, it is a guide to implementing research into practice. This step-by-step handbook includes the principles, steps, strategies and activities for achieving effective change. The Caribbean Basin and Hispanic Addiction Technology Transfer Center (CBHATTC) has a Spanish version.

- Network for the Improvement of Addiction Treatment (NIATx) mission to improve access to and retention in addiction treatment, while making process improvement part of the culture of managing and delivering treatment.

- National Implementation Research Network (NIRN), at the Frank Porter Graham Child Development Institute at the University of North Carolina, Chapel Hill. The mission of NIRN is to close the gap between science and service by improving the science and practice of implementation in relation to evidence-based programs and practices.

- The Institute of Behavioral Research (IBR) at Texas Christian University (TCU) has a variety of resources on assessing organizations in behavioral health. The TCU Organizational Readiness for Change (ORC) assessment focuses on organizational traits that predict program change. It includes scales from four major domains—motivation, resources, staff attributes, and climate. A companion to the ORC is the TCU Survey of Organizational Functioning (SOF), which includes the ORC as well as nine additional scales measuring job attitudes (e.g., burnout, satisfaction, and director leadership) and workplace practices.

- [The Community Tool Box](#) (CTB) is a very large global resource for free information on essential skills for building healthy communities. It was developed and maintained by the CTB Team at the Work Group for Community Health and Development at the University of Kansas.

- [COMPASS^{TM} (Comorbidity Program Audit and Self-Survey for Behavioral Health Services](#)) is a tool that can be used by behavioral health care systems to assess program competencies that reflect standards for Dual Diagnosis Capable mental health (DDC-MH) and substance abuse disorder (DDC-CD) services. The tool can be used by the system designers and also be used by individual programs that wish to evaluate their competencies when not part of a larger system change initiative. It must be purchased to be used.

CULTURAL COMPETENCY RESOURCES

- [Cultural Assessment Survey (CAS) Project](#)—Assessed the extent that a select group of State accredited, non-tribal substance abuse programs in South Dakota are integrating Dakota/Lakota/ Nakota (D/L/N) cultures and spirituality into their treatment regimes.

- [Wisconsin's Minority Counselor Training Institute](#)

- Standards for Cultural Competence in Social Work Practice—[National Association of Social Workers Practice Standards](#).

GENERAL COMPETENCY RESOURCES

- Competency Model Clearinghouse http://www.careeronestop.org/CompetencyModel/ or at O*NET http://online.onetcenter.org/

- Example of links between competencies and resources: http://www.csrees.usda.gov/nea/food/fsne/pdfs/coordinator_core_competency_resources.pdf

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APPENDIX A: Resource Materials

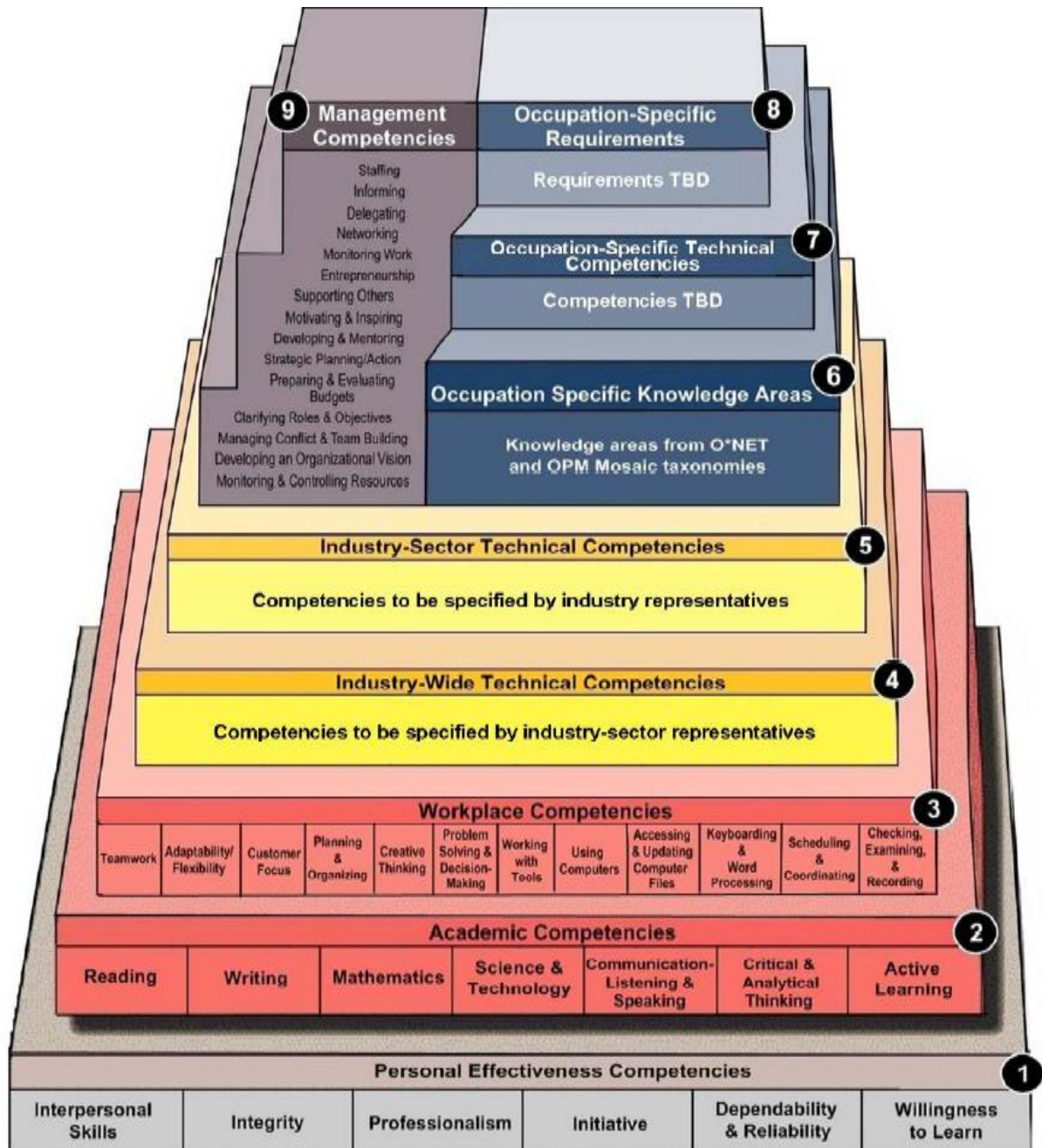<div style="border:1px solid black; text-align:center;">

RESOURCE MATERIALS:

A Provider's Guide:
How to Use
Core Competencies in Behavioral Health

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RESOURCE FOR SECTION 2.1: Sample Competency Model

Figure 1. A generic competency model, available at http://www.careeronestop.org/CompetencyModel/.

RESOURCE FOR SECTION 3.4: Florida prevention case study (A)

Job description for prevention specialist[61]

Name: _____

Program: Chemical Abuse Prevention Services (CAPS)   **Job Title:**   Prevention Specialist

Division: Operations   **Department:**   Prevention

GENERAL DESCRIPTION: Provides prevention skills and/or education to students. Responsibilities include: conducting group (per program guidelines); serving as resource for family members and school staff; recruitment and screening of potential students; timely and accurate completion of required documentation; collaboration and effective communication with PAR staff and other agencies.

RESPONSIBLE TO: Prevention Program Manager

RESPONSIBLE FOR: No staff

MINIMUM QUALIFICATIONS:

KNOWLEDGE, SKILLS AND ABILITIES:
-Knowledge of substance abuse, violence and other prevention strategies and principles
-Knowledge of culturally competent techniques and strategies
-Ability to assess and refer appropriately
-Ability to manage time and resources
-Ability to interact positively and effectively with students, staff, the community and other agencies
-Ability to document in a timely, accurate and quality manner in accordance with rules, regulations and agency standards
-Ability to use de-escalation skills with various student populations
-Ability to research and develop prevention activities/curriculum

EDUCATION AND EXPERIENCE:
-BA Degree from an accredited 4-year college in Social Work, Human Services or related Field or
Bachelor's Degree in another field plus minimum two years work experience with pediatric age and families
-Education and experience in prevention and education preferred

(A comparable amount of training, education, or experience may be substituted for the above minimum qualifications if regulation requirements for the position are met).

LICENSE, CERTIFICATIONS OR REGISTRATIONS:
-Current Florida driver's license
-Pass background check and fingerprinting as required by funders

ESSENTIAL PHYSICAL SKILLS:
-Ability to speak coherently
-Ability to write accurately and legibly
-Ability to move throughout program facilities
-Good vision and hearing

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[61] Developed by Operation PAR, Florida

ENVIRONMENTAL CONDITIONS:

     -Office
     -Community agencies
     -Schools

    Reasonable accommodation will be made for otherwise qualified individuals with a disability.

APPROVED SUPERVISOR: _____   **Date**_____

2ND LEVEL APPROVAL: _____   **Date**_____

EMPLOYEE SIGNATURE: _____   **Date**_____

Employees are evaluated and rated after first ninety days and then annually in June. The annual rating is a cumulative score based on the entire year's performance.

Initial competency evaluation
    N = Not competent
    C = Competent

Performance/Competency Rating scales for annual evaluation:

5 (95-100%) = <u>OUTSTANDING</u>—Performance and competency consistently exceeds the standard established. Demonstrates superior knowledge and application of skills. Exercises initiative, resourcefulness and provides a "model" for the standard. Conserves agency resources. Always acts in an ethical manner and adheres strictly to all Federal, State and local laws, rules and regulations. Demonstrates continuous professional development. Provides documentation of the highest quality.

4 (85-94%) = <u>EXCEEDS STANDARDS</u>—Performance and competency exceeds the standard. Performance is of high quality and is achieved on a consistent basis. Complies with all Federal, State and local laws, rules and regulations.

3 (75-84%) = <u>MEETS STANDARD</u>—Performance and competency meets the standard on a regular basis. Demonstrates a competent and dependable level of performance. Complies with all Federal, State and local laws, rules and regulations.

2 (65-74%) = <u>PARTIALLY MEETS STANDARD</u>—Improvement in skills and/or overall performance is required to achieve the expected performance level. Corrective action is required.

1 (< 65%) = <u>DOES NOT MEET STANDARD</u>—Performance and competency is below the established standard; substantial improvement is necessary. Corrective action is required to maintain employment.

RESOURCE FOR SECTION 3.4: Florida prevention case study (B)

Competency-based performance appraisal for a prevention specialist[62]

Name: _____   Date: _____

Review type (circle one):   Initial Competency Evaluation   Annual Performance Appraisal

ESSENTIAL JOB FUNCTIONS AND COMPETENCIES:

Student Supervision & Direction	Competency Level	Reviewer Comments
Establishes a helping relationship with the student characterized by warmth, respect, genuineness, concreteness and empathy.		
Set behavioral ground rules for participants and make consistent consequences when student's behavior is inappropriate for group or class.		
Carries out the actions necessary to form a group, including but not limited to: Recruiting and screening youth for appropriateness, notifying parents and teachers, scheduling groups, coordinating place and times with the school guidance counselor, and making referrals as necessary.		
Understands diverse cultures and incorporates the relevant needs of culturally diverse groups, as well as people with disabilities.		
Adapts strategies to the characteristics of the participants, including but not limited to, disability, gender, development level, culture, ethnicity and age.		
Average Section Score		

Documentation	Competency Level	Reviewer Comments
Completes all necessary paperwork within the allotted time frame.		
Protects student's rights to privacy and confidentiality, especially in relation to the communication of information with third parties.		
Prepares accurate outcome data such as post-test scores and evaluations in a timely manner.		
Understands contractual and program requirements for the provision of services and meets the standards set for units of service delivered and number of participants served.		
Average Section Score		

Screening and Referral	Competency Level	Reviewer Comments
Establishes rapport, including management of crisis situation and determination of need for additional professional assistance.		
Keeps school staff and supervisor informed of potential referrals. Seeks appropriate consultation from school personnel and supervisor.		
Knows about resources in the community in order to make referrals.		

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[62] Developed by Operation PAR, Florida

	Competency Level	Reviewer Comments
If staff is giving a referral, it's clear to the student why the referral is being suggested and they know how to access the referral.		
Average Section Score		

Age Specific Competencies	Competency Level	Reviewer Comments
Pediatric-Elementary -Has knowledge of growth and development -Defines and reinforces behavior limits -Keeps a safe environment -Presents lessons in a way that child understands -Obtains necessary information from parents -Observes child for signs of abuse and neglect -Explains the information or activity to the child in age-appropriate ways -Allows student participation and encourages verbalization, praises for appropriate behavior -Allows for cultural and/or religious beliefs		
Adult **-Addresses person with respect** -Provides for and maintains privacy -Obtains necessary information from person -Provides detailed information about referral, when necessary -Allows for cultural and/or religious beliefs -Provides information on community resources		
Average Section Score		

KNOWLEDGE, SKILLS, ABILITIES & COMPETENCIES:

Presentation Skills	Competency Level	Reviewer Comments
Appropriately provides Too Good for Drugs curriculum within group sessions.		
Appropriately provides Too Good for Violence curriculum within group sessions.		
Appropriately provides Kids Power curriculum within group sessions.		
Appropriately provides Motivational Enhancement and Cognitive Behavioral strategies within group sessions.		
Average Section Score		

Prevention Strategies	Competency Level	Reviewer Comments
Demonstrates knowledge of Prevention Strategies, including risk and protective factors and developmental assets.		
Knows current prevention methods, strategies and programs.		
Understands the signs and symptoms of addiction.		
Average Section Score		

Interpersonal Skills	Competency Level	Reviewer Comments
Demonstrates professional conduct with staff and consumers (school staff, students, and parents) in face-to face interaction.		
Demonstrates professionalism in corresponding with staff and		

consumers through email or other written communication.		
Uses approved de-escalation techniques when needed.		
Average Section Score		

Professional Growth	**Competency Level**	**Reviewer Comments**
Takes initiative in professional growth by: reading new resources, keeping updated on prevention trends, researching prevention topics, and attending trainings.		
Demonstrates ability to receive feedback on work performance and areas for growth.		
Average Section Score		

Workplace Standards	**Competency Level**	**Reviewer Comments**
Adheres to company time and attendance standards		
Meets dress code standards		
Adheres to ethical, professional and organizational standards		
Maintains a safe work environment		
Attends and participates in mandatory trainings and meetings		
Performs all duties in an ethical manner.		
Conserves agency resources		
Completes tasks within assigned timelines.		
Manages time effectively.		
Demonstrates knowledge of agency policy and procedures		
Performs other duties as assigned		
Average Section Score		

Annual Performance Appraisal Average of all Sections _____

APPROVED SUPERVISOR: _____ **Date**_____

2ND LEVEL APPROVAL: _____ **Date**_____

EMPLOYEE SIGNATURE: _____ **Date**_____

RESOURCE FOR SECTION 3.5: Learning Plan for TAP 21 (A)

Sample competency-based learning plan[63]

Counselor: _____ Supervisor: _____ Today's Date: _____

Professional Practice Dimension: _____

Competency to be addressed and page number from TAP 21:
_____

Strengths:

Challenges/Concerns:

Present level of proficiency from rating forms: 1 2 3 4 5		Level of Proficiency to be achieved with this learning plan: 1 2 3 4 5	Date of Completion of this plan
What is the issue: **What KSA will be addressed in the Leaning Plan?**	**The goal**: **What is to be accomplished**?	Activities necessary to achieve the goal **How will it be done?**	**Metrics Completion Date** **How will progress be measured? When?**
K:			
S:			
A:			

Additional comments:

Counselor Signature: _____   Supervisor Signature: _____

Date:

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[63] Developed by the NFATTC.

RESOURCE FOR SECTION 3.5: Learning Plan for TAP 21 (B)

Sample Competency-based Learning Plan[64]

Staff_____ Supervisor: _____ Today's Date_____

Professional Practice Dimension:_____

Competency to be addressed and page number from TAP 21: _____

KEY	
1 = Understands	Comprehends the tasks and functions of counseling
2 = Developing	Applies knowledge and skills inconsistently
3 = Competent	Consistent performance in routine situations
4 = Skilled	Effective counselor in most situations
5 = Master	Skillful in complex counseling situations

Present level of competency from the Rating Forms:

1	2	3	4	5
Understands	Developing	Competent	Skilled	Master

Proficiency level to be attained with this learning plan:

1	2	3	4	5
Understands	Developing	Competent	Skilled	Master

Strengths:

Challenges/Concerns:

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[64] Developed by John Porter, PEGASUS Training & Consulting (revised 04.08)

List the knowledge, skills and attitudes relevant to achieving the target competency:

Knowledge:

Skills:

Attitudes

Identify the specific performance expected from the counselor upon successful completion of plan:

What activities or tasks will be completed by the counselor to achieve the goal?

How will progress be evaluated? How will proficiency be demonstrated? When will this occur?

Supervisor Signature_____ Date_____

Counselor Signature _____ Date_____

UPDATE

Date of demonstration_____ Demonstration successful? _____Yes _____No

If "No," demonstration needs the following correction and follow-up demonstration rescheduled:

Supervisor Signature _____Date_____

Counselor Signature _____ Date_____

RESOURCE FOR SECTION 3.6: Core Competencies in Treating COD

**Connecticut Department of Mental Health and Addiction Services:
Competencies for Providing Services to Individuals
with Co-Occurring Mental Health and Substance Use Disorders[65]**

<u>**Basic:**</u>

1. Screen for mental health and substance use problems using standardized measures.

2. Form a preliminary impression of the nature of the presenting problems.

3. Use basic engagement skills.

- Including stabilization, outreach, assistance with practical needs, building the therapeutic alliance, *not* working on changing substance use behavior in early engagement stages.

- Able to use some basic motivational interviewing skills: asking open ended questions, making reflective listening statements, summarizing, and making statements of affirmation.

4. Use de-escalation skills when needed.

5. Knowledge of crisis management procedures.

- Know the behavior/physiological signs for intoxication and withdrawal from various substances, and the signs of risk to self or others.

- Follow the crisis management procedures if someone is intoxicated or in withdrawal from substances, and/or reporting suicidal ideation and/or homicidal ideation.

6. Knowledge of referral processes and uses them assertively when needed.

7. Coordinate care assertively when multiple providers are concurrently involved in care.

8. Display patience, persistence and optimism.

<u>**Intermediate: (In addition to the competencies listed above)**</u>

9. Conduct integrated assessments.

- Knowledgeable of the drug classes and mental health diagnostic categories used in the DSM IV.
- Determine severity of disorders.
- Knowledge of current street names of the various drugs.
- Assess stage of change for both disorders.
- Complete a functional assessment.
- Document mental health and substance use disorder diagnoses.

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[65]Developed by the Connecticut Department of Mental Health and Addiction Services, and revised February 2009**.**

10. Perform integrated and collaborative treatment (recovery) planning with a focus on shared decision making.

11. Conduct engagement, education, and treatment for both mental health and substance use disorders.

- Use more advanced motivational interviewing strategies: developing discrepancy (e.g., using the importance ruler, decisional balance, and exploring personal goals and values); rolling with resistance (e.g., reflection, shifting focus, personal control, reframing); and how to offer information and suggestions.

- Know the basic social learning theory concepts that underlie a Cognitive Behavioral Therapy (CBT) approach. Complete a functional analysis (behavior chain) and teach coping skills (e.g., rationale and guidelines, modeling, role plays, providing constructive feedback, and assisting consumers/individuals in recovery to practice exercises in their community).

- Able to modify counseling strategies for consumers/individuals in recovery with a severe mental illness.

12. Use stage-wise treatment methods.

- Use treatment strategies compatible with each stage of change for each disorder.

13. Understand the 12-steps used in AA/NA self-help groups, and assertively link people with co-occurring disorders to ones that are welcoming or specific to co-occurring disorders (e.g., Dual Recovery Anonymous).

Advanced: (In addition to both the basic and intermediate competencies)

14. Use integrated models of assessment, intervention and recovery.

- Understand group processes and facilitate groups (e.g., process groups, social skills groups, stage-wise groups, interactive psychoeducation groups).

15. Provide interventions for families and other supports.

- Work individually with families; facilitate a multi-family psychoeducation/support group.

16. Demonstrate an understanding of psychotropic medication.

17. Support quality improvement efforts, including a focus on incorporating new "best practices", resources, and tools in the provision of integrated services for people with co-occurring disorders.

This document available in PDF form at: Competencies for Providing Services to Individuals with Co-Occurring Mental Health and Substance Use Disorders (February 2009). Also available:

 Connecticut's Co-Occurring Capable Program Guidelines (February 2009)

 Connecticut's Co-Occurring Enhanced Program Guidelines (February 2009)

RESOURCE FOR SECTION 6.2: Sample Job Descriptions

Substance Use Disorder Treatment Counselor III

Company name:

Division:

Location:

Supervisor's title:

Position title: Level III or Clinical Supervisor

Type of Position: Level II Second Level Counselor

Full time: X   ***Part Time:***   ***Contract:***   ***Intern:***

Hours: 40 hours per week, 8 AM to 5 PM

General Description: This position requires the employee will manage and coordinate day to day client/patient related matters and to take responsibilities as clinical supervisor of counselors as they offer services to clients/patients assigned. The incumbent shall possess knowledge of screening, intake and assessment procedures, models, theories and methods of counseling, treatment planning and implementation of same, group and individual counseling, diagnosis of addictive disorders, documentation of client/patient records, referrals and case management, community resources, clinical evaluation, discharge and continuing care planning, ethical standards, legal issues, community and professional issues.

The incumbent is required to supervise interns and Level I, and Level II counselors, develop a clinical supervision and training plan for each staff member and conduct trainings in specific counselor skill develop areas and conduct community educational presentations.

Essential Job functions:
1. Conduct and review screening, intake and assessments
2. Document diagnoses of substance disorders
3. Complete treatment, discharge and continuing care planning
4. Conduct Individual and group counseling
5. Conduct educational sessions with clients and families
6. Act as case manager
7. Document as required in all client/patient files
8. Conduct clinical evaluations
9. Prepare and update list/s of community resources
10. Be aware of and adhere to a standard code of ethics
11. Conduct community educational sessions
12. Conduct staff trainings in areas of counselor skill development
13. Supervise interns and level I counselors as required
14. Sign off on all documents that are completed by non-licensed or certified staff

Work Experience: The incumbent shall evidence 3-5 years of work experience in substance use disorders or a related field.

Educational Requirements: A master's degree in substance use disorders or a related field.

Testing/Licensing requirements: Level III credential and or be licensed in substance use disorders or related field.

Medical reporting requirements: Evidence of Hepatitis A and B testing and TB test

Criminal background check requirement: Must be completed prior to hire

Sample Job Description: Substance Use Disorder Counselor II

Company name:

Division:

Location:

Supervisor's title:

Position title: *Substance Use Disorder Counselor II*

Type of Position: Level II Second Level Counselor

Full time: X   ***Part Time:***   ***Contract:***   ***Intern:***

Hours: 40 hours per week, 8 AM to 5 PM

General Description: This position requires the employee will coordinate and manage day to day client/patient related matters and to take responsibilities as primary counselor for all clients/patients assigned. The incumbent shall possess knowledge of screening, intake and assessment procedures, models, theories and methods of counseling, treatment planning and implementation of same, group and individual counseling, diagnosis of addictive disorders, documentation of client/patient records, referrals and case management, community resources, clinical evaluation, discharge and continuing care planning, ethical standards, legal issues, community and professional issues. The incumbent may also be required to supervise interns and Level I counselors, conduct training in specific counselor skill develop areas and conduct community educational presentations.

Essential job functions:
1. Conduct and review screening, intake and assessments
2. Document diagnostic symptoms of substance disorders
3. Complete treatment, discharge and continuing care planning
4. Conduct Individual and group counseling
5. Conduct educational sessions with clients and families
6. Act as case manager
7. Document as required in all client/patient files
8. Conduct clinical evaluations
9. Prepare and update list/s of community resources
10. Be aware of and adhere to a standard code of ethics
11. Conduct community educational sessions
12. Conduct staff trainings in areas of counselor skill development
13. Supervise interns and level I counselors as required

Work Experience: The incumbent shall evidence at least 3 years of work experience in substance use disorders or a related field.

Educational Requirements: A bachelor's degree in substance use disorders or a related field.

Testing/Licensing requirements: Level II credential

Medical reporting requirements: Evidence of Hepatitis A and B testing and TB test

Criminal background check requirement: Must be completed prior to hire

Sample Job Description: Substance Use Disorder Counselor I

Company name:

Division:

Location:

Supervisor's title:

Position title: *Substance Use Disorder Counselor I*

Type of Position: Level I or First level Counselor

Full time: X   ***Part Time:***   ***Contract:***   ***Intern:***

Hours: 40 hours per week, 8 AM to 5 PM

General Description: This position requires the employee to assist coordinate and manage day to day client/patient related matters and to take responsibilities as primary counselor for all clients/patients assigned. The incumbent shall possess knowledge of screening, intake and assessment procedures, models, theories and methods of counseling, treatment planning and implementation of same, group and individual counseling, diagnosis of addictive disorders, documentation of client/patient records, referrals and case management, community resources, clinical evaluation, discharge and continuing care planning, ethical standards, legal issues, community and professional issues.

Essential Job functions:
1. Conduct screening, intake and assessment
2. Document diagnostic symptoms of substance disorders
3. Complete treatment, discharge and continuing care planning
4. Conduct Individual and group counseling
5. Conduct educational sessions with clients and families
6. Act as case manager
7. Document as required in all client/patient files
8. Conduct clinical evaluations
9. Prepare and update list/s of community resources
10. Be aware of and adhere to a standard code of ethics

Work Experience: The incumbent shall evidence at least 2 years of work experience in substance use disorders or a related field.

Educational Requirements: A high school diploma or GED, with at least 2 years of education in substance use disorders.

Testing/Licensing requirements: Level I credential

Medical reporting requirements: Evidence of Hepatitis A and B testing and TB test

Criminal background check requirement: Must be completed prior to hire

Sample Job Description: Substance Use Disorder Counselor in Training

Company name:

Division:

Location:

Supervisor's title:

Position title: Substance Use Disorder Counselor in Training

Type of Position:

Full time: X   ***Part Time:***   ***Contract:***   ***Intern:***

Hours: 40 hours per week, 8 AM to 5 PM

General Description: This position requires the employee to assist with the day to day management and maintenance of client/patient related matters, to assist the primary counselor with duties assigned. The incumbent will obtain knowledge of screening and intake procedures, models, theories and methods of counseling, treatment planning, group and individual counseling, diagnosis of addictive disorders, legal issues, community and professional issues.

Essential Job functions:
1. Screening and intake
2. Assist with:
   a. treatment planning
   b. group and individual counseling
   c. case management
   d. education of clients and families
   e. preparation of continuing care plan

Work Experience: The incumbent shall demonstrate an internship or volunteer experience with an accredited college or university or treatment facility.

Educational Requirements: A high school diploma or GED

Testing/Licensing requirements: N/A

Medical reporting requirements: Evidence of Hepatitis A and B testing and TB test

Criminal background check requirement: Must be completed prior to hire

RESOURCE FOR SECTION 6.3: Learning Plan vs. Corrective Action Plan

Clinical Supervision Essentials[66]

The Differences between Learning Plans and Corrective Action Plans	
LEARNING PLAN	**CORRECTIVE ACTION PLAN**
Developmental in nature	Disciplinary in nature
Guiding	Authoritative
Process oriented	Immediate results oriented
Based in relationship	Based on procedure
Encouraging	Limit setting/Cautionary
Ongoing	Time limited
Coaching/Mentoring skills	'Counseling' skills

The Similarities between Learning Plans and Corrective Action Plans
1. Completed in a supervisory context
2. Both require employee engagement in learning
3. Focused on employee success and improved performance
4. Both require follow up and evaluation
5. Success of both require proficient communication and commitment

When to Move from a Learning Plan to a Corrective Action Plan
1. Violation of a 'Major Rule' or Code of Ethics
2. Ongoing performance problems, more significant the sooner

When to Involve Human Resources in Corrective Action
1. Anytime the supervisor needs clarification about the process
2. Anytime code of ethics is violated
3. After written warning proves ineffective

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[66]This was developed by CODA in Portland, OR as part of their clinical supervision program using TAP 21.

RESOURCE FOR SECTION 6.5: Career ladders in SUD counseling

Linking addiction counseling competencies and career ladders

The following chart and diagram of a career ladder reflect competency expectations demonstrated in the four levels of Transdisciplinary Foundation and the eight Practice Dimensions of the Technical Assistance Publication (TAP) Series 21.[67]

	SUD Professional in Training	SUD Professional First Level	SUD/ Clinical Supervisor/ Manager/ Administrator Second Level	SUD/ Clinical Supervisor/ Manager/ Administrator Third Level
1. Transdisciplinary Foundation I *Understanding Addiction*	Competencies 1-2	Competencies 1-3	Competencies 1-4	Competencies 1-4
2.Transdisciplinary Foundation II *Treatment Knowledge*	Competencies 5, 6 & 8 and progressive development with supervision and training	Competencies 5, 6 & 8	Competencies 5-8	Competencies 5-8
3.Transdisciplinary Foundation III *Application to Practice*	Competencies None at beginning internship-show progressive learning w/time	Competencies 9-17	Competencies 9-17	Competencies 9-17
4.Transdisciplinary Foundation IV *Professional Readiness*	Competencies Competencies None at beginning internship-show progressive learning w/time	Competencies 18-23	Competencies 18-23	Competencies 18-23
5. Practice Dimension 1 *Clinical Evaluation Element: Screening*	Competencies 24 & 27 with progressive development of other competencies with supervision	Competencies 24-32	Competencies 24-32	Competencies 24-32
6. Practice Dimension 1 *Clinical Evaluation Element: Assessment*	Competencies 33 & 35 with progressive development of other competencies with supervision	Competencies 33-36	Competencies 33-36	Competencies 33-36
7. Practice Dimension II *Treatment Planning*	Competencies 41 & 47 with progressive development of other competencies with supervision	Competencies 37—48	Competencies 37—48	Competencies 37—48
8. Practice Dimension III *Referral*	Competencies 53 with supervision	Competencies449 with supervision and 50—55	Competencies 49—55	Competencies 49—55

[67] Center for Substance Abuse Treatment. (2006). *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice.* Technical Assistance Publication (TAP) Series 21.

9. Practice Dimension IV *Service Coordination Implementing the Treatment Plan*	Competencies 59 with Supervision	Competencies 57 with supervision and 56, 58-61	Competencies 56—61	Competencies 56—61
10. Practice Dimension IV *Service Coordination Element: Consulting*	Competencies 63-66 with supervision and progressive development	Competencies 62—66	Competencies 662—66	Competencies 62—66
11. Practice Dimension IV *Service Coordination Element: Continuing Assessment & Treatment Planning*	Competencies 67, 68 & 73 with supervision and progressive development	Competencies 67—74	Competencies 67—74	Competencies 67—74
12. Practice Dimension V ***Counseling*** *Element: Individual Counseling*	Competencies 75-80 & 82-83 & 85 with supervision and progressive development	Competencies 75—85 and 87 with supervision on 86	Competencies 75—87	Competencies 75—87
13. Practice Dimension V ***Counseling*** *Element: Group Counseling*	Competencies None	Competencies 88—93	Competencies 88—93	Competencies 88—93
14. Practice Dimension V ***Counseling*** *Element: Counseling Families, Couples and Significant Others*	Competencies 94 with training and supervision	Competencies 94 & 95 96—98 with supervision	Competencies 94—98	Competencies 94—98
15. Practice Dimension VI *Client, Family & Community Education*	Competencies 99—107 with progressive training and supervision	Competencies 99—107	Competencies 99—107	Competencies 99—107
16. Practice Dimension VII *Documentation*	Competencies 108—110 with progressive training and supervision	Competencies 108—114	Competencies 108—114	Competencies 108—114
17. Practice Dimension VIII *Professional & Ethical Responsibilities*	Competencies 115—118, and 121—123 and 120 with progressive training and supervision	Competencies 115—188 and 120—123 119 with training and supervision	Competencies 115—123	Competencies 115—123

APPENDIX B: Acknowledgements

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