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MEETING NOTICE

Marriage and Family Therapist Education Committee September 28, 2007

San Diego State University
Dede Alpert Center for Community Engagement
4283 El Cajon Boulevard
Suite #240
San Diego, CA 92105
(858) 829-1150

9:00 a.m. – 2:00 p.m.

- I. Introductions
- II. Review and Approval of March 9, 2007 Committee Meeting Minutes
- III. Review and Approval of June 15, 2007 Committee Meeting Minutes
- IV. Discussion of Draft Implementation Timelines for Curriculum Revisions
- V. Discussion of Draft Curriculum Relating to Addictions and Co-Occurring Disorders
- VI. Discussion of Competency Assessment in MFT Education Programs
- VII. Discussion of Draft Proposed Revisions to Curriculum Statutes
- VIII. Future Meeting Dates
- IX. Suggestions for Future Agenda Items
- X. Public Comment for Items Not on the Agenda

Public Comment on items of discussion will be taken during each item. Time limitations will be determined by the Chairperson. Items will be considered in the order listed. Times are approximate and subject to change. Action may be taken on any item listed on the Agenda.

THIS AGENDA AS WELL AS BOARD MEETING MINUTES CAN BE FOUND ON THE BOARD OF BEHAVIORAL SCIENCES WEBSITE AT www.bbs.ca.gov



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DRAFT MEETING MINUTES

Marriage and Family Therapist Education Committee

March 9, 2007
Golden Gate University
536 Mission Street
San Francisco, CA 94105

Committee Members Present:

Dr. Ian Russ, MFT, Committee and Board Chair
Donna DiGiorgio
Karen Pines

Staff Present:

Paul Riches, Executive Officer
Mona Maggio, Assistant Executive Officer
Justin Sotelo, Regulation Analyst

I. Introductions

The meeting was called to order at approximately 10:00 a.m. Dr. Russ thanked Golden Gate University for hosting the meeting. He then introduced the committee members and staff present. Audience members introduced themselves. Dr. Russ invited audience members to contact him with comments after the meeting, and encouraged everyone's participation.

Dr. Russ provided a review of the many issues that the Committee has looked at during its prior meetings. He invited people to contact him after the meeting if they have comments regarding any of those issues.

II. Review and Approval of July 21, 2006 Committee Meeting Minutes

The Committee concurred to approve the July 21, 2006 minutes of the MFT Education Committee.

III. Review and Approval of October 27, 2006 Committee Meeting Minutes

The Committee concurred to approve the October 27, 2006 minutes of the MFT Education Committee.

IV. Review and Approval of December 8, 2006 Committee Meeting Minutes

The Committee concurred to approve the December 8, 2006 minutes of the MFT Education Committee.

V. Presentation by Marianne Baptista, MFT on Training in Recovery Models

Dr. Russ welcomed Ms. Baptista who is the Training and Education Coordinator for the California Association of Social Rehabilitation Agencies (CASRA).

Ms. Baptista explained that she has worked in public mental health for over 20 years, primarily with adult populations and in nonprofit agencies. She has provided direct service and supervision to MFT and MSW students and interns. She recently provided training to Madera County regarding the Mental Health Services Act (MHSA) which gave her a new look at what people were coming into these jobs with, including an interesting group of consumers who were asked to come to the training prior to being hired for positions in a drop-in counseling center, as well as people who had been licensed for a number of years and people who had just graduated. Ms. Baptista also participated in the MFT DACUM process.

Ms. Baptista explained that she is going to present on more than just the recovery model because if you take away the jargon, everybody is on the same page. She stated her belief that she doesn't think there is anybody who doesn't believe that change is possible, and that it is possible for everyone - people can lead more satisfying lives. That is basically what the recovery model is all about, believing that recovery is possible, and holding that belief for somebody who cannot believe it for themselves.

She explained that the recovery model talks about being person-centered, which means helping people work on their goals and focusing on the quality of life, which MFTs in general are trained to do by helping people to better operate in their community or family. The recovery model engages the whole person, meaning it is a holistic approach. Ms. Baptista explained that she mainly learned how to be a therapist during her practicum and internship. She believes that is where people will learn the specific strategies to provide recovery-oriented services, more so than in the classroom.

Ms. Baptista explained that in general, MFT programs train people to work with clients who have insurance or that can pay. There are huge issues that come up when working with people who live in poverty. For example, she used to work with an agency who received funding through HUD to provide housing, and one of the requirements was that people had to be homeless. However, once people were placed, they were soon leaving. There was a lack of understanding that the culture of homeless is very powerful, there is a strong sense of community, and a lot of protection, and people are very drawn to that. They thought by just putting a roof over their head and having food available that the clients should be overjoyed. They weren't aware of the powerful pull to that community that people had developed. And those are the kinds of things that people can be taught. Another example is the person who calls their therapist to cancel an appointment saying they can't go outside, there are people who are trying to kill them. Well that could be true, and doesn't necessarily mean that this person is delusional, depending where they live and the dangers in their environment.

Therapists need to be aware of the laws, benefits available, and the Americans with Disabilities Act. Therapists also need to be prepared to work with people who have serious mental illness. She described how a lot of people with serious mental illness have very complicated presentations, often with more than one diagnoses, and this is more than people in private practice are used to dealing with. Also the family dynamics and cultural issues are different. For example, how people describe the symptoms of

their mental illness varies widely, so it isn't just a matter of communication style or values around getting treatment, people can describe physical and emotional symptoms in different ways and you have to try to get a sense of what it is they're talking about.

Ms. Baptista explained that medication along with psychosocial intervention are now considered best practices for people with serious mental illness. She is aware that some people in private practice will not work with someone with a serious mental illness, and believes that this really undermines the profession. When people seek out therapy, there needs to be people in private practice who will work with this population.

She explained that the practitioner works as part of a team which can include family members and others in the community, a nurse, case manager, counselor at their residential treatment program and others. Together those people form the team that helps the client accomplish their goals. The client has to approve that all of those people are on their team, but it is very different than the model of the one hour therapy session. Therapists are often working in the community, so we often have a session with clients at a restaurant, in the car, at their home, or anywhere in the community. Services are scheduled as needed, and it can be a 15-minute appointment or session that ends up taking half of a day, based on the client's needs.

Recovery-oriented services presents a different therapeutic relationship, quite different from a private practice. The relationship with the client, while always ethical, can be personal. The client can know what the therapist did over the weekend, or what movie you saw. Both people get to know each other as human beings. She clarified that she is not talking about being friends with the client, but showing that the therapist is a human being. Boundaries are less defined because of the way the therapist works with the person. There may be social events where clients and staff interact. This makes maintaining boundaries very tricky because the therapist still has to maintain boundaries, but they move all the time. It requires a skilled supervisor to help people work through these things. We teach that therapists have to be intentional about the decisions they make about boundaries. We can't just say it's a dual relationship, so don't do it. The therapist has to look at what the client wants, what feels right to the therapist, are their clinical implications to what the client is asking for so that you might not want to do it. For example, there could be a female client who says to her male therapist that she is so depressed and she could use a hug. But if she has been sexually abused, that is probably not appropriate.

So the challenge is to determine what material can be incorporated into existing courses, to develop a fundamentals of public mental health course, and to look at internships in public mental health settings. The one change that would have the most effect would be to provide a facilitator from public mental health in practicum seminars. Ms. Baptista then offered to answer questions from the audience.

Janlee Wong from the National Association of Social Workers California (NASW) stated that the recovery model tends to be comprehensive, but funding is typically for minimal services. He asked how the recovery model would be able to do this integration when the government says no. Ms. Baptista responded that you have to be creative about how services are obtained for people, and that can be done by engaging the community. Often it may be the churches, or it may be housing resources. For example, there may be three clients who need housing and the therapist introduces them to each other and helps them find a place together. Also, it is

the MHSA-funded programs which are mandated to do the recovery model, so that funding is there, but hopefully that will spill over to other government programs.

Mary Riemersma from the California Association of Marriage and Family Therapists (CAMFT) asked what other kinds of things need to be done within the educational system other than a facilitator during practicum. Ms. Baptista stated that it could be addressed in a lot of foundational coursework. The issues of the methods, such as working as a team, the therapeutic relationship and boundaries are best addressed in a practicum seminar, and it needs to be done by someone who understands the reality of the public mental health system. Issues also need to be addressed in law and ethics courses, especially the differences in different settings. For example, many people do not understand that some dual relationships can be beneficial.

Dr. Russ stated that therapists all put clients together in group therapy, but if a therapist had a contract with a person for individual therapy and then started introducing them to others who are also in individual therapy and they also have that contract that implies that their therapy is private and confidential, then there might be a problem. When there are people in group therapy, that contract is different with a different set of goals. It needs to be explained in ethics classes that if you're working for a clinic, then there are different rules than private practice, that the contract is with the clinic.

Olivia Loewy from the American Association for Marital and Family Therapy, California Division (AAMFT-CA) commented that as far as she knows, most agencies do have paperwork and explanations when there is an intake process that designates the treatment model and what to expect. She addressed Ms. Baptista and stated that this is a paradigm shift in terms of what constitutes professionalism in those different settings. She likes the suggestion of having a public mental health representative in the practicum. Her own experience in a community mental health center when taking in students was that there were contracts and a formal relationship between the schools and the agency. But that was usually the end of it, there was a disconnect. She did not get visits from the schools to see how the students were doing, and maybe they could find a way to connect such as through the regional collaboratives.

Ms. Riemersma stated that she takes several calls every week from interns and trainees working in the public sector, and they very often say the director of their agency expects them to share confidential information, but they are concerned because their relationship is with the client. That is one tiny piece that needs to be conveyed early on, that when you work for an agency, the client is a client of that agency, and information is shared with virtually everybody in the agency.

Ms. Baptista responded that it goes even further than that, that the client actually owns the information, so if they want the therapist to share information, it is really up to them. Mr. Riches stated that it may be a small concept, but it is a concept with huge implications. It speaks to the underlying philosophy that you're not treating the diagnosis, you're treating the person, and that person has connections all over the community. There has been a certain amount of formalism in the traditional private practice model and people tend to reflexively follow the rule of thumb rather than being thoughtful and careful about boundaries and sharing information.

Ms. Baptista responded that it is much more complicated work, where you have to evaluate for each client what is appropriate. Dr. Russ stated that within the agency, the trainee still needs to understand that once you reach outside the agency to talk with

the private psychiatrist who is not a member of the agency that the law requires documentation, releases, etc. so the agency still needs the permission to do that.

Dr. Russ stated that as a therapist, he shares personal information from time to time, which makes him ask himself whether it was about the client, or something else. It does get into difficult areas and we need to help people understand that there are different levels of mistakes, and the group can help monitor that. People who work in isolation don't get that. Ms. Baptista responded that this client population has often been seen in many different therapy settings by the time they qualify for help in the public sector, and traditionally they have been treated in a way in which they are not much included in their treatment. When she does supervision, she advises clinicians not to do anything just because it felt right, they need to be strategic about whatever they do, including self-disclosure. Therapists should do it because they see in some way it will benefit the the client. One of the benefits of hiring consumers in mental health positions is that they can bring that sense of hope and that people can get better, and it is important for them to share some of those experiences. We are really looking at having a relationship with people to the extent that it is possible, as their equal. It is important is that the therapist is comfortable with disclosures, and to know their own personal limits. This therapeutic model is more personal.

Ms. Riemersma responded to Ms. Baptista regarding the use of creativity to resolve issues. She is not sure that this is one of those things that can be taught, but is limited in the education that people get. This may be due to the fear of legal and ethical limitations. People get fearful of doing things that are unusual or outside the norm because they don't feel they have the latitude because things are very structured.

An audience member stated that any good therapist is creative, and although they might not come out of school that way. Once therapists get over the fear that they might make a mistake, people grow in that direction. Dr. Russ stated that this is largely about being creative, but the elements must be learned and practiced a lot and as that happens creativity grows. The board is concerned about the minimum competency to enter the field, to know that the basics are there so that people can grow down the line.

VI. Presentation by Rusty Selix of California Council of Community Mental Health Agencies

Dr. Russ introduced Adrian Schilton, a Senior Policy Analyst with the California Council of Community Mental Health Agencies (CCMHA), a statewide trade association whose members are the primary providers of mental health and substance abuse services in California. Rusty Selix is their Executive Director, who was a co-author of Proposition 63. This is a follow-up presentation to one that was made to the board a couple of months ago in which he articulated some of the workforce challenges that the member agencies are having. We have been working with CAMFT and AAMFT, and have confirmed that there are plenty of people seeking work, but they don't have the training to be strong candidates. So in response to these challenges, their policy committee initiated a process to obtain information from their members, surveying the skills they need to be a strong candidate for public service.

The purpose of the survey was to list specific competencies and elicit opinions about MFT preparedness. She clarified that Council members are not in a position to recommend specific changes to MFT educational requirements. They received 26 agency responses to their survey, which represents 5,485 employees. Ms. Schilton then reviewed the results of the survey with the audience.

Ms. Schilton introduced Neil Sternberg from Victor Treatment Centers, one of their member agencies, to help articulate how these recommendations could help his and other agencies. Mr. Sternberg stated that his agency is one of the largest nonprofits in the state, serving over 3,000 clients per year in 11 different sites. They employ many MFTs and MFT Interns. He stated that Ms. Baptista already said nearly everything he was prepared to say. The supervisors he employs feel that most professional staff is unprepared for the work for the reasons that Ms. Baptista articulated. Additionally, his agency is having a very difficult time acquiring clinical supervisors. Another issue is that a majority of their staff works well with individuals but have difficulty working with families as a whole. They also have difficulty forming a therapeutic relationship, and have difficulty writing therapeutic plans and progress notes. The state does a lot of auditing, so they have had to get good at documentation, and are spending a tremendous amount of time doing it. If they could hire someone who knows how to do document well, they would be extremely valuable. Dr. Russ asked whether documentation is a skill that could be taught in a classroom. Mr. Sternberg responded that yes, he believes it could be done as there are fairly standard requirements that could be taught. Mr. Riches asked whether his agency provided training that he could share with the Committee. Mr. Sternberg said yes, but it would be great if a number of agencies would get together for that training. Additionally, a manual regarding documentation for the state is being created.

Ms. Riemersma stated that they have been led to believe that each agency requires different types of documentation. Mr. Sternberg responded that he believes that it is fairly consistent from one agency to another.

Mr. Wong asked whether the goal of these notes were for practice or for billing. Mr. Sternberg responded that it is a valuable clinical tool, which then results in good notes for billing. Mr. Wong asked whether the audits are done by auditors or practitioners. Mr. Steinberg responded that most auditors are practitioners. Mr. Sternberg clarified that documentation is a fairly small piece, but he is just giving it as an example of one of the skills that is needed.

Ms. Roye asked Mr. Sternberg to talk about the other challenges that his agency is facing in terms of clinician preparedness. Mr. Sternberg responded that probably one of the largest issues is having the therapist understand the importance of the whole family, to convince therapists that to get the best outcome, the family must be involved. It can be very uncomfortable and anxiety-producing to work with challenging families. It is the hardest part of the work, and most of the therapists would prefer to work with the individual.

Dr. Russ asked whether MFTs have this same problem. Mr. Sternberg responded that if you asked his clinical supervisors, they would say that MSWs are better prepared than MFTs to work with families given the population of severely mentally ill that his agency serves. This is the case with both interns and licensees. Mr. Riches stated that applicants often struggle to get their required 500 hours in providing group or family therapy. Mr. Sternberg stated that there is often a lack of practical experience in this area.

Ms. Riemersma explained that much of the time MFT interns are working in the schools, with kids, but they are not able to provide services to families. This is also the case in private practice. Those opportunities are few and far between. Mr. Sternberg stated that there is a cultural bias that the reason a child is having a problem is

because of the family; therefore therapists want to only treat the child. It is very difficult changing the belief system to the recovery model, bringing everybody together to serve the client. He believes that this happens during training in school, which is frequently based on a medical model for the individual.

Dr. Russ asked the schools to respond. An audience member stated that their curriculum supports working with families, so she was surprised to hear that. Dr. Russ asked whether this represents the experience of the CCMHA. Ms. Schilton responded yes, it does. Dr. Russ asked whether this conversation could be put out to all of their members to get some feedback, as this is pretty powerful, and a big challenge to their identity as family therapists.

An audience member stated that at least 50% of her students are placed in a community mental health setting. It is her experience that many of her students do get some family work, but it is difficult, and a lot of families don't come in. There is a family systems approach even if you are working with an individual.

An audience member asked whether the students are unprepared, or do they just not want to work with families. Mr. Sternberg said that it is not clear. Dr. Russ stated that the family approach is best for issues like substance abuse and sexual abuse.

Ms. Baptista stated that public mental health clients can have incredibly complicated presentations. She guessed that when people get their experience, unless they work with that population, they aren't getting that experience of working with really disabled families. That is probably the main factor, that they don't have that experience, and these families probably way more complicated than an intern would be given anyway.

Ms. DiGiorgio stated she is hearing that there is a huge disconnect. Students are getting the education, but they are not getting the experience in family systems. Dr. Russ stated there may possibly be a bigger disconnect, where the schools are thinking they are providing the right education, and the students leave feeling that they didn't get it. Ms. Riemersma stated that people can only learn something if they have the chance to apply it.

An audience member stated that we are asking people to work with severely dysfunctional and mentally ill people, and if people are saying they aren't ready for it, they are probably right. This information has to be learned in both the classroom and out in the field. They are being trained how to approach families in the school setting, but there is no mentorship in the practicum, so people are unprepared.

Ms. Loewy stated that people are trained in family or systems therapy, and when you work with adult populations in those settings, there are often no families. We need to learn to deal with the larger scope and train people to work with the whole system.

Mr. Wong stated that he is bothered by what looks like pathologizing of families, if you approach families no matter what is going on with them using the recovery model, it is not impossible or hopeless, families can be brought back into some semblance of recovery, but there has to be the right approach.

Mr. Riches stated he feels there is a mentorship gap. The toolbox is being provided, but there is not an infrastructure out there to learn from someone who is experienced performing the therapy.

Mr. Sternberg stated that their clinical supervisors in general frequently express that MSWs are better prepared than the MFTs. He doesn't know what the differences are in the curriculum and has no evidence to support it, but that is the feedback they are getting. Mr. Sternberg admitted that agencies are part of the problem, they don't have a mentorship program and don't provide enough training. It is not an easy problem to solve.

Ms. Riemersma asked the MSWs are getting in school that helps them to be better prepared. An audience member stated that they get case management and resources. Ms. Riemersma clarified that she meant related to family therapy. Mr. Sternberg explained that if you are doing a lot of case management, you are bringing a lot of people together, so that may be a component. Mr. Riches clarified that what he is hearing in the discussion is the mindset exhibited on the part of the interns - the acquisition of some of those skills affects how you think about problems.

Dr. Russ stated there would be two more of meetings of the Committee, so he asked the community to discuss this, possibly through the Internet and professional newsletters, and ask people to respond because it is a big issue. He thanked the presenters and complimented them on the report, and expressed his hope that the schools would make use of this important information.

VII. Discussion of Draft Revisions to Curriculum Statutes

Dr. Russ stated that the draft represents the progression of the thinking by the Committee, and puts it out to the public in a concrete way. He emphasized that it is a concept draft which reflects feedback from conversations during these meetings that will eventually result in legislation at the end of the process. Dr. Russ and Mr. Riches pointed out the changes since the last concept draft.

Ms. Riemersma suggested that if terms like recovery and resilience are going to be included, maybe a brief definition of those terms should be included. She also suggested there be an emphasis on severe mental illness because a lot of schools believe that MFTs cannot treat severe mental illness. She also suggested adding to systems of care "for the severely mentally ill."

Mr. Riches asked whether the draft is getting closer to what should be captured in terms of involving consumers in MFT education. Dr. Russ suggested adding their experience in the treatment of mental illness, or in the systems of mental health, as opposed to just their experience of mental illness.

Ms. Loewy stated her belief that bringing consumers or agency staff in as teachers and instructors would enrich the educational experience in relation to public mental health. An audience member stated that she would add family members to that also. Another audience member stated that they bring in family members to their agency to give talks, and that can be very powerful. Dr. Russ stated that the other side of it is the impact that severe mental illness has on the family, even at lower levels such as severe ADHD. We have to understand the reciprocal quality that illness has on families and communities including isolation and humiliation.

Mr. Wong stated that he sees that recovery is included in the concept draft, but does not see that methods and service delivery using the recovery model have been included.

Dr. Russ stated that we have to add specific coursework in documentation of diagnosis, planning and progress, and that the progress will be measured in certain ways, so that it really is clear. This will eventually translate into the board sending out inquiries to schools regarding where and how these are taught within the curriculum.

Mr. Riches stated that there are several implicit bargains in this draft. We have heard and are respectful of the fact that an enormous amount of material is being taught within the required 48 units, and a great many are no longer 48 unit programs, so we respect that schools will have to be teaching a lot of new content. There is an enormous amount of flexibility being given in this draft. There are virtually no specific unit or hour requirements. Its basically for the schools to figure out, which will create difficulties with specific organizations who have worked to require specific content with a specific number of units. If schools want this flexibility, they need to be prepared to fight for it with us.

Ms. Riemersma asked what has not been included in the draft from current law. Mr. Riches stated that none of the content requirements have been removed, except for specific unit requirements. An educator remarked that this seems very sensible.

Ms. Riemersma stated as an example, that it was a particular legislator's interest that a specific number of hours in aging and long-term care be required, and she asked if we expect to run into any difficulty. Mr. Riches responded yes, that is what he was referring to, and that we are prepared to go there, but people need to stand together with us if it is going to work. Ms. Riemersma responded that she likes the flexibility and believes it should be less objectionable to some of the schools because it gives the educators discretion.

Dr. Russ stated this also goes along with the direction of AAMFT in looking at schools as competent in terms of competency issues for accreditation. Ms. Loewy responded that schools are designing curriculum in relation to competencies, and the MFT licensing examination backs that up. People will be getting what they need because they will need to pass the test. It seems a much more respectful way to set this up.

Mr. Riches asked if we need to look at adding units and in the past people have said no, but given that we are adding new competencies in public mental health, these could be offered as an extension program, not necessarily as credit level courses. An educator responded that she would like to require everything. Another educator stated that it would be easier on students who are getting financial aid to require everything. Another educator stated it would make more sense to require it so that it could be integrated into courses, which makes it more meaningful instead of learning things here and there. An educator from Sonoma State asked that extension courses remain an option because budgetary limitations to hire faculty are so severe, and they may not have the faculty available to teach it in-house.

Dr. Russ said he is hearing that 48 units may not be enough to cover everything, so should units be added or do require the topic but not the units. And if we do it that way, does it diminish accountability.

An educator stated that if something is required in their degree program, it sets a tone for the philosophy of their curriculum. If we don't include it as part of the program, students won't understand it as a shift in the philosophy of treatment.

Ms. DiGiorgio asked if some of the proposed new content could be integrated into existing coursework. Several audience members responded that it would be a challenge.

Dr. Russ stated that he is hearing that this draft really is covering largely what the curriculum needs to cover, and that some people feel it is clear that this additional content cannot be covered in 48 units, or within the existing units for their program.

Dr. Benjamin Caldwell responded that Alliant already has a 50-unit program, and he would rather see the content be required as part of the program because it is a fundamental shift taking place. It is a struggle any time they think about adding units because graduate school is expensive, each unit costs \$900, so it becomes an access issue as more units are added.

Dr. Russ stated that we are in the process of trying to figure out how to get people from a variety of cultures to pursue this as a career and now we are talking about increasing the cost of programs.

Mr. Wong stated that it sounds like there is a need to increase the number of units because material would be added. Mr. Riemersma asked Mr. Wong how many units are required for social work programs. Mr. Wong responded that 60 units are required. Ms. Riemersma stated that this is interesting because social work schools are attracting a more diverse student body even with the higher number of units. Dr. Russ stated that the licensed professional counselor proponents that they would require 60 units after several years.

Mr. Riches stated that it is hard to envision not needing to add material, and that discussion is done, we are adding significant material. He stated that there are three choices. The first option is to add content up front as part of the degree program within existing units. The second, in response to state schools who have a tough time changing content, is an alternative delivery mechanism. The third option is to rebalance the existing curriculum by adding some content and taking some away, which would be difficult.

Dr. Russ stated that he has reviewed the content requirements many times and cannot find anything that can or should be removed.

An audience member stated that when you have a program that is already at 60 units, which is the maximum the system will allow, it will have to be rebalanced.

Dr. Russ encouraged people to tell other faculty about the proposed changes and where they stand, and that it will affect the students, the teaching, and the schools. He asked them to have discussions, because it is very important that people be aware and on board with the changes.

VIII. Future Meeting Dates

The following dates were suggested for future meetings:

Friday, June 15, 2007 in Sacramento;

Friday, September 28, 2007 with the location to be announced.

XI. Suggestions for Future Agenda Items

Ms. Schilton requested a follow-up regarding the school's response to CCMHA's survey. Dr. Russ stated there is a listserv where this could be put out and the responses would be forwarded. Ms. Riemersma stated that CAMFT has a listserv for the schools and it is not being used, so it is ready to go if needed. Additionally, several of the consortia have already been given the survey's results.

The meeting was adjourned at approximately 12:38 p.m.

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MEETING MINUTES

DRAFT

Marriage and Family Therapist Education Committee

June 15, 2007

10:00 a.m. – 3:00 p.m.

University of Phoenix

Gateway Oaks Learning Center

2860 Gateway Oaks Drive, Room 101

Sacramento, CA 95833

MEMBERS PRESENT

Dr. Ian Russ, MFT, Committee Chair, Board Chair
Gordonna DiGiorgio, Public Member
Karen Pines, Board Volunteer

MEMBERS ABSENT

None

STAFF PRESENT

Paul Riches, Executive Officer
Mona Maggio, Assistant Executive Officer
Christy Berger, Legislation Analyst
Christina Kitamura, Administrative Assistant

GUEST LIST

On File

I. Introductions

Dr. Ian Russ, Committee Chair, called the meeting to order at 10:07 a.m. Audience members and staff introduced themselves. Committee members introduced themselves in place of roll, and a quorum was established.

II. Review and Approval of March 9, 2007 Committee Meeting Minutes

Dr. Russ postponed the approval of the March 9, 2007 meeting minutes for the next Committee meeting.

III. Discussion with Clients and Family Members Regarding Therapy Experiences

Consumers of therapy and their family members were invited to provide their input and to discuss their experiences with therapy. Their names were obtained from the California Mental Health Planning Council as part of their expert pool of consumers and family members.

One of the core values of the Mental Health Services Act (MHSA) is to “increase consumer and family member involvement in policy, program development, and employment in service delivery and behavioral health administration.” The MHSA requires that California develop an education and training plan for future and current mental health professionals that includes consumers, in order to allow the integration of the consumer perspective into education and training programs.

Dr. Russ asked the guests to discuss their experiences when encountering professionals. The questions that Dr. Russ asked were:

- Did you feel that the professionals were trained?
- Did they know the issues?
- Did they know the community?
- Were they able to be helpful? If so, how did that work? If not, what can be done better?
- What was helpful?

Marilyn Hillerman of Elk Grove shared that she has a daughter who is bipolar and a father who has schizophrenia. When she discovered that her daughter was bipolar, she immediately sought counseling for herself. Finding therapists that specialize in bipolar disorders was difficult. She did not know where to go to seek a therapist. A helpful resource was a support group, Depression Bipolar Support Alliance (BBSA). BBSA had all the resources that she and her daughter needed. Ms. Hillerman stated that the Mental Health Association was another helpful resource. The therapist suggested to Ms. Hillerman to educate herself by visiting Stanford and UC Davis, and to attend lectures to get an understanding. The most important thing for Ms. Hillerman was finding the right therapist.

Dave Schroeder of North Highlands shared his experiences. He had been in and out of therapy since he was a child. He was not diagnosed until later in his adult years. In all of his therapy, no one understood his life. No one looked at him as a person in a holistic manner. No one could help him understand why he could not deal with life in the same manner that other people could, how to live with his diagnosis, and what skills he needed to live with his diagnosis. He joined a support group which was very helpful. Mr. Schroeder stated that schools do not put a face to those who are suffering. Students should meet people with mental illnesses. The reality of what people with mental illnesses experience is missing from the curriculum. Mental health illnesses are not consistent from generation to generation and from culture to culture.

Sandra Sertyn of Sacramento shared her experience as a parent whose children received mental health services. She was motivated to enroll in an MFT program at Phoenix University because of the roadblocks she experienced. Ms. Sertyn stated that curriculum does not include the knowledge of the culture of the family. She struggled to understand her adopted daughter who has Fetal Alcohol Attachment Disorder, even though she educated herself. What helped was the “wrap around philosophy” and the idea of looking at families as a unit. Role-playing in school is not helpful because it did not expose the student to the real life people with the disorders. The practicum requirement is very important because it provides for exposure to the people attached to the disorders because there is a big difference between the textbooks and the people with the disorders.

Nancy Smith of Lathrop shared her family’s experiences. She has an adult son who was in therapy since the age of 12, resided in a small rural town, and could not afford services. Catholic Social Services offered marriage and family counseling which helped

through the school years up to high school. At that point, her son began self-medicating with drugs. The family sought another therapist through Catholic Social Services. Her son had a psychotic break at the age of 19, and was sent to county mental health services and was in the mental health unit for 2 weeks. He was diagnosed with bipolar disorder. Ms. Smith joined the National Alliance on Mental Illness (NAMI). NAMI and their support group were very helpful. After the mental health unit, her son went to a halfway house, and learned how to live again. He had a counselor at that point who helped him through the system and was a friend to him. It is important to have a therapist on the team with a caseworker and doctor. Five years later while in college, he had another episode and was diagnosed with schizoaffective disorder. After he was released from the hospital, he did not have the treatment that was needed; he only had a doctor as caseworker. Ms. Smith continued with support groups; however, her son did not have a therapist during this time. Later he found a therapist who helped with his mental illness and his drug problem. Prior to that, he was sent back and forth between mental health professionals and drug rehabilitation services, and that continued for years. After his third episode, he did not get much help. The county was cutting back on services, and he was put on medication. He would get a phone call to see how he was doing, but he was not doing well nor was he taking his medication, and became resistant to help. He got in trouble with the law and was taken to the county mental health services. They would not take him and said that he needed to go to jail. He went back and forth between prison and county mental health. He went to the mental health court which referred him to Atascadero State Hospital, where he received better treatment than through the county mental health system. She sought several counselors herself to get through this. Ms. Smith explained that it is important for treatments to be affordable and to feel there is a gain from treatment. Support groups along with the combination of caseworkers, doctors, and therapists are most helpful.

Warren Treacher of Davis shared his family's experiences. Mr. Treacher has a sister who was diagnosed with bipolar disorder when she was 19 years old. The only help they could get was when she was in a crisis, through 51/50. She understood the system very well, and was considered to be a pain to the hospitals because she would file grievances. She was declared 51/50 six times in two weeks in the same county, and would be kicked out. She never received help until she would be declared 52/50, and was admitted somewhere long enough for Mr. Treacher to write letters to the director explaining her history so they would keep her hospitalized. Another problem was that because she is an adult, Mr. Treacher could not talk to therapists unless his sister gave permission, which she usually would not do. Another problem was the disconnect between the medical and mental health professionals. She was in the hospital to have a hip replacement and had a manic episode while in the hospital. Mr. Treacher urged medical professionals to get her a psychological evaluation before they released her. The medical professionals ignored Mr. Treacher and released his sister without notifying the family. Twelve hours later, she was declared 51/50. She never received the required therapy for her hip replacement. Currently, she has not had a manic episode in four years because she has been depressed for four years. So she is not on the radar and therefore, is not getting help because she is not "a big issue." She has her regular appointments to get her medications, but does not get the help she needs. One another issue, Mr. Treacher and his wife went to a therapist to address both of their depression. The therapist spent the first 45 minutes describing legalities, privacy, and other issues. After the 5th session, they became discouraged and stopped going to therapy because the therapist was not listening to them.

Ms. Pines asked if it mattered if mental health professionals were licensed or not, and if so, if it mattered if they were a LCSW, MFT, or a psychologist.

Ms. Hillerman responded that it did not matter. What mattered was if the individual related with the client and the chemistry they had with the client. What was important is that the therapist believed in her daughter's recovery, and that played a significant role in her recovery because he believed in her when she was not able to believe in herself. It is important for the therapist to treat the whole individual, not just the disorder.

Mr. Schroeder responded that most individuals do not care about titles because they're looking for a person to help them accomplish what the individual cannot do for himself or herself. The feeling and connection that the professional makes with the individual is what matters.

Mr. Treacher responded that the professionals who have the most acronyms behind their name have the least amount of time to help the clients and their families. His sister usually gets the best help when she goes to jail.

Dr. Russ asked if the professionals in the system were (1) were caring, (2) were helpful to the families, (3) had a general knowledge of the issues.

Ms. Smith responded that none of counselors told her that her son had a mental illness until he was a young adult and entered a psychiatric hospital. It is important to recognize the symptoms and give an early diagnosis.

Mr. Schroeder responded that most of the people in the public sector are caring. There is a systematic problem in that there is a lack of resources, staffing, and money. Privacy laws are a systematic problem that creates barriers for families trying to get involved in the treatment. It is also a barrier to the therapist when they are trying to get necessary information to help treat the individual.

Ms. DiGiorgio asked how they found support groups and other resources.

Ms. Hillerman responded that the therapist had access to resources and referred her to the support groups.

Ms. Smith responded that the mental health system referred them to other resources.

Mr. Schroeder responded that when he ran away from the hospital, he met a person going through the same thing. This person invited him to a support group.

Ms. Sertyn found her resources through her own research; one example was as the Internet.

Mr. Treacher received recommendations through his friends and family.

Ms. Sertyn added that it is helpful to have collaborations and community resources, which is not stressed in her schooling.

Dr. Russ assured the clients and family members who shared their experiences that their voices are heard not only by the Committee, but also by the schools and the Department of Mental Health (DMH) in attendance, to inspire and create programs and education that is going to be effective. The Committee is taking this information and will decide what is going to be mandated so that people better serve in public service and in private practice, to inspire people to serve in rural areas and in areas where clients cannot afford services.

Mr. Schroeder stated that the best teaching tool would be for the schools to invite the consumers and family members to share their experiences with the students. He suggested curriculum to involve consumers and family members discussions.

Ms. Smith added that therapists are needed in the prison system because those who are suffering with mental illnesses are locked up in jails and prisons.

IV. Discussion of Increasing the Minimum Unit Requirement for Qualifying Degrees

Dr. Russ reported that the Committee is recommending that the MFT program be increased to a 60-unit program instead of 48 units. Less than a third of the schools surveyed are already at 60 units. Twenty percent (20%) of the schools are at 48 units. The Committee is looking for equivalent training amongst master level therapists in terms of preparation for the community. The MSW program is already a 60-unit program. The only way that the MFT can be considered an equivalent license and not a second-tier license is to have a 60-unit program. This would cause some difficulties on schools in terms of increasing curriculum and tuition. We need to maintain the integrity of MFTs in the mental health community. We would be doing a disservice to the community if we did not require a 60-unit program.

Dr. Ben Caldwell, Alliant International University, discussed this with five different schools. Three positions emerged from those discussions:

1. Support, regardless of the specific changes the Board makes to the curriculum. More units mean more opportunities.
2. Support, but “going along kicking and screaming” because of increases in tuition and difficulty in finding quality teachers.
3. Opposition, 60 units is an arbitrary number that is not adequately justified by the material either in the current licensure standards, in the curriculum standards, or in the proposed curriculum standards. The number of units required should be driven by the curriculum and then determining how many units are required for certain areas.

Art Sanchez, California State University (CSU) Chico, stated that CSU Chico takes in 18 students a year, which means they have only three practicums a year with six students in the practicum and one faculty member to teach. CSU Chico also has 12 prerequisites so it is essentially a 60-unit program. CSU Chico has difficulty requesting additional faculty members because their undergraduate programs drive the resources. Mr. Sanchez expressed that the curriculum does not stop at 48 units. It should extend through the 3000 hours and should be approached as the “whole package” and not just 48 units. He invites the idea of 60 units because it puts pressure on his administration to add more faculty; however, the administration is not committed to its MFT program, unless outside resources are available. The CSU system has to deal with funding and the number of faculty.

Dr. Russ asked if the larger programs at other state universities that have 60 unit programs are able to do so because they have a larger student body.

Mr. Sanchez stated that the only way they can require more units in order to get more students is if they refer their students out to other agencies to do the practicum. If they do that, they lose much of their training quality, such as live one-to-one supervision, videotaping, and two-way mirror supervision.

Dr. Caldwell replied that CSU Sacramento is able to have a 60-unit program because they are accredited by the Council for Accreditation of Counseling and Related Educational Programs (CACREP).

Dr. Duncan Wigg, Pepperdine University, stated they Pepperdine's MFT program is a 48-63 unit program. He asked if some of the important requirements that is proposed for the curriculum were better placed in the internship period, offering students the opportunity to develop specializations in specific settings. Dr. Wigg suggested some thought on considerations of the identity and definition of marriage and family therapist as set out in regulations now, particularly the emphasis on multi-culturalism and diversity. There is too much in specifics of the curriculum that is more individualistic, non-community based.

Sue Ellen Wise, JFK University School of Holistic Studies, stated that she is concerned about the mandated curriculum, but not so much about the number of units. She asked how the required curriculum will impact already imbedded specialization, and how it may dilute programs with unique specializations.

Ray Greenleaf, JFK University, stated that multi-cultural should be imbedded in the curriculum. Some of these issues are cross-curriculum. It makes sense to place psych testing into the Diagnosis and Assessment instead of a separate class.

Dr. Russ we're not going to eliminate any unit requirements. The idea is to move towards competencies rather than unit requirements. If the minimum unit requirement increases, the schools can figure out how to implement it. The knowledge that the Committee is requesting cannot be done in 48 units. There is a lot needed in the internships and the practicum. Some of the competencies are practicum competencies. Social workers have 60-unit programs and 3000 post-graduate hours. Licensed Professional Counselors (LPC) by the year 2013, are going to be required 60 units and 3000 hours. Dr. Russ expressed that he does not know how this is going to become a substandard license if it remains at 48 units and the rest is made up in internship.

Mary Riemersma, California Association of Marriage and Family Therapists (CAMFT), stated it has been over 20 years since the last change in education standards for the profession. In 20 years, the profession and the settings where the profession is working has changed. Schools are going to be kicking and screaming when the number of units are increased. Given what needs to be infused in the curriculum, the only thing that can be done is increase the number of units but give the schools greater educational discretion as to how they apply those units. What is lacking: how to treat co-occurring disorders, working with severely mentally ill, how to use community resources, and how to do collaborative treatment. Students need to understand these competencies, so they can build relationships with clients.

Dr. Olivia Lowey, American Association of Marriage and Family Therapy, (AAMFT) discussed the AAMFT unit requirements. The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) is 48 units and is competency-directed. COAMFTE does not have the 60-unit requirement but it does have the competencies that need to be met, and it is structured and designed to incorporate that.

Barry Lord, Southern California Seminary, stated that they are in the process of increasing the units to 60. To do this, they also require adding more faculty members.

V. Presentation on Draft Revisions to Curriculum Statutes by:

Dr. Russ introduced Warren Hayes, Chief of Department of Mental Health (DMH).

Mr. Hayes spoke on his position as Chief of Workforce, Education and Training for the public mental health system. He has been focused on getting funds towards education and training efforts. DMH is launching the Workforce, Education and Training component of the Mental Health Services Act (MHSA). The funds will be applied to stipend programs and loan repayment programs. DMH is happy to see the Board taking this direction and addressing the competencies.

Mr. Warren outlined the needs of the public mental health system:

1. The public wants to ensure that someone who is licensed have a solid theoretical background. Educators are responsible for that.
2. There needs to be more application of practicum to theory. Students need to learn the theory in the environment to find their place. The public mental health experience needs to be integrated in the academic experience.
3. The knowledge base or skill sets required to work in the public mental health system.
4. Page 2, Section 4980.37(c)(6) of concept draft for MFT curriculum – recommendation to expand “resources” and include competencies such as focus groups for those in recovery, housing, benefit plans, relationships and social environments, public mental health system and understanding what it is, and the discipline of collaborative networking.
5. Relationships between internships and practicum - Quality clinical supervision out of the educator’s control is difficult to find. There is a need to find good environments for students, and develop dialogue between the schools and the employers regarding settings in order to get quality supervision and to connect it directly to theory.

Dr. Russ stated that one criticism is the language used in referring to the “Recovery Model.” Some educational institutions are concerned that these are “passing terms” that are being tied to a language, not an idea.

Mr. Riches stated that it is the BBS responsibility to look at the profession every so many years, research what the profession is doing, and update the regulations as the profession evolves. The regulations need to evolve as the profession evolves.

Ms. Riemersma stated that she also had concerns with the term “recovery” and if it is a time-sensitive term. She suggested using a more generic term. She added in regard to the schools oversight, the intent of the law is that the schools have responsibility for the trainees’ experience. The schools must have an agreement with each of those work settings and are to provide oversight. Ms. Riemersma expressed that she is not sure if the schools are doing as much as they could in this area. For those who are post-degree, supervision requirements were increased by creating ratios to make ensure better oversight and more concentrated oversight. They are getting more supervision than they were once required to get. The downfall is that employers are not necessarily the responsible parties making sure that is happening, because employers may not be providing that supervision; the supervisees may be finding supervision on their own. These are problems that may not be solved because we don’t have control over those work settings.

Dr. Russ responded that Joan Walmsley, Board Vice Chair, is looking into those issues and is going bring forth proposals to the Board over the next one to two years.

Dr. Wigg asked if the Board has an operational definition of the recovery model concept. If so, he suggested that the proposed language should include that definition.

Mr. Hayes stated that the Substance Abuse Mental Health Services Administration (SAMHSA) has a definition for recovery. The definition is operational-based and speaks to choice, caring, and other concepts. DMH is hesitant in defining the concept in regulations because it is new in the mental health arena.

Mr. Riches stated that it's a balance between capturing a definition for the concept and allowing the profession to evolve under that concept. The question is how much do we want to embody the current understanding versus outlining the core concepts. There is a need for guidance and discussion that does not have to be statutory or regulatory. A forum can be created with the Board, educators, consumers and family members to open a discussion and determine, for our purposes, guidance on what this means.

Dr. Russ invited anyone who has an idea that should be reflected in the language or has language to offer, to share it with the Committee either at a meeting, through email, or through a phone call.

Dr. Caldwell will discuss this with his group and bring forth language suggestions.

VI. Discussion of Draft Revisions to Curriculum Statutes

Dr. Russ asked the audience to review the concept draft for MFT curriculum and provide feedback.

Ms. Riemersma requested that an effective date be considered for this document.

Dr. Russ stated that he would like to see implementing this in the year 2013 since that would be the year when the LPCs 60-unit curriculum will go into effect, if it passes, and it gives time for the schools to prepare.

Mr. Sanchez commented on Section 4980.37(c)(5) of the concept draft regarding cultural competency. He recommended substituting "cultural competency and sensibility" for "cultural competency sensitivity." He explained that "sensitivity" tends to objectify another. "Sensibility" is a marriage of sensitivity and the ability to act on knowledge.

Mr. Riches stated that the language and subject matter relating to substance abuse and addiction on Section 4980.37(c)(8) of the concept draft needs to be addressed. The science of substance treatment and addiction treatment has progressed in recent years. It would be helpful if anyone who has expertise in this area, could review this and make suggestions in this area.

Ms. Riemersma added that the area of co-occurring disorders also needs to be addressed.

Ms. Riemersma referred to 4980.37(c)(6) stating that the understanding of the effects of socio-economic status on behavior and treatment, and available resources are two separate ideas. She suggested that available resources should be a separate concept in the language.

Mr. Riches responded that resources are addressed in 4980.37(e).

Mr. Hayes agreed with Ms. Riemersma, recommending giving it a separate number under 4980.37(c). He also recommended that resources be included in practicum under 4980.37(c)(11).

Dr. Caldwell appreciates the flexibility given to the educators. He asked if this new curriculum is implemented, how it can be operationalized in terms of establishing to the Board that the schools have taught these skills.

Mr. Riches responded that the Board may need to revisit the program certification process. If the requirements are increased, this will put more responsibility on both the Board and the schools. It will be left to the schools to decide how to cover the material. The Board and schools will have work together so that the transcripts and the Board's requirements reconcile.

Dr. Caldwell stated that the schools struggle with the accrediting bodies as they move toward more an outcome-oriented and competency-based approach.

Mr. Riches stated that he spoke to the accrediting bodies and realizes that they are changing their approach. The Board has no interest in getting into the accreditation business, which is why the Board is outlining what the schools are accountable for and providing that flexibility.

VII. Future Meeting Dates

Mr. Riches reported that the next Committee meeting was scheduled on Friday, September 28th at CSU San Diego.

VIII. Suggestions for Future Agenda Items

Mr. Wong requested the discussion regarding the definition of recovery on the agenda.

Ms. Hillerman offered a definition for recovery: to promote concepts key to the recovery for individuals who have mental illness. Hope, personal empowerment, respect, social connections, self-responsibility, and self-determination: A plan for each consumer's individual needs.

The meeting adjourned at 3:00 p.m.

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To: MFT Education Committee
From: Christy Berger
Legislation Analyst
Date: September 21, 2007
Telephone: (916) 574-7847
Subject: Discussion of Draft Implementation Timelines for Curriculum Revisions

Background

The attached draft implementation timelines for the proposed Marriage and Family Therapist (MFT) curriculum revisions is intended as a starting point for discussion. These revisions, if approved by the Board, are expected to be carried in 2008 legislation. If it passes, the legislation would technically take effect on January 1, 2009. However, in order to give schools enough time to implement the changes, the legislation would need to contain dates that guide the implementation of the new requirements.

Discussion

Once the legislation passes, the Board plans to work intensively with the schools to implement the new requirements. Staff estimates that it would take schools about 2.5 years for this process to be completed. The proposed timeline reflects that schools would begin offering the new degree programs that meet the new requirements beginning in Fall of 2011. However, the law would not require schools to do this specifically. Instead, the proposal would require applicants for MFT intern registration or licensure who graduate on or after July 1, 2014 to meet the new educational requirements. This would provide a straightforward way for the Board's application evaluators to determine which applicants must meet the new requirements. This would require staff to evaluate applicants' educational qualifications under two different sets of requirements ("old" and "new").

So that staff will not have to do this indefinitely, the final component of the timeline is proposed to be a sunset of the "old" educational requirements. This means that the law pertaining to the "old" educational requirements would become legally inoperative as of a specific date. It would also mean that once the "old" requirements sunset, all applicants for MFT intern registration or licensure must meet the new educational requirements. The proposed sunset date for the "old" educational requirements is January 1, 2018 (nine years after the legislation passes).

For people who graduated prior to July 1, 2014 (under the "old" requirements) who are still gaining hours of experience or attempting to pass the licensing examinations, this provides at a minimum of 3.5 years to complete their hours and pass the examinations. People who are unable to complete their hours or pass the examinations by the sunset date would not be able to qualify for registration or licensure, and would have to return to school for a remediation program, as discussed in Agenda item VII. The time period proposed for completion of the remediation program is prior to January 1, 2023, five years past the sunset date.

Attachment

Draft Timeline

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DRAFT TIMELINE FOR PROPOSED CHANGES TO MFT EDUCATIONAL REQUIREMENTS

Date	Time from Passage of Legislation	Description
January 1, 2009	N/A	<i>Legislation takes effect</i>
January 1, 2009 to December 31, 2009	1 year	<i>BBS works with intensively with schools</i>
January 1, 2009 to July 31, 2011	2.5 years	<i>Schools work to implement new requirements</i>
August 1, 2011	2.5 years	<i>Degree programs starting now should meet new requirements</i>
*July 1, 2014	5.5 years	<i>Persons graduating on or after this date must meet new requirements</i>
*January 1, 2018	9 years	<i>“Old” educational requirements sunset</i>
*January 1, 2023	14 years	<i>Applicants may no longer apply with an “old” degree, remediation no longer permitted</i>

*Dates proposed to be included in legislation

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To: MFT Education Committee

Date: September 21, 2007

From: Christy Berger
Legislation Analyst

Telephone: (916) 574-7847

Subject: Discussion of Draft Curriculum Relating to Addictions and Co-Occurring Disorders

Existing statute requires applicants for licensure as a Marriage and Family Therapist (MFT) to have specific instruction in "alcoholism and other chemical substance dependency." (BPC § 4980.41(d)) The required course content for this area is specified in regulation. (16CCR§1810) As part of the draft MFT curriculum revisions, the statute is proposed to be updated to:

- Integrate the statute and regulation
- Reflect the broader area of addiction (both substances and behavioral)
- Include co-occurring mental health and substance use disorders (co-occurring disorders)

Behavioral addiction is starting to receive more recognition from the State of California, and the Department of Alcohol and Drug Programs is currently administering a program regarding gambling addiction. This draft proposal would include instruction in behavioral addiction not limited to gambling, those that are computer-related (i.e., internet, video games, etc.), shopping, sex, eating, and work.

The term "substance use disorder" is proposed to be included, as this reflects current terminology in the DSM-IV TR. Co-occurring disorders have also been included, as this population often does not receive appropriate coordinated or integrated treatment.

The first attachment consists of text that had been proposed at the prior meeting of the Committee, and indicates the changes that have been suggested since that time. The second attachment shows the current statute and regulation that govern the curriculum requirements in this area. Should the proposed curriculum requirements be passed, it would supersede any regulatory requirement.

Attachments

Draft Proposed Curriculum

Current Law

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DRAFT MFT CURRICULUM PROPOSAL
SUBSTANCE ABUSE, ADDICTIONS AND CO-OCCURRING DISORDERS

- (8) ~~Provide specific instruction in substance~~ Substance abuse, co-occurring disorders, and addiction which shall include each including all of the following areas.
- (A) ~~The definition of alcoholism and other chemical dependency, and evaluation of the affected person.~~ substance use disorders, co-occurring disorders and addiction.
 - (B) ~~Medical aspects of alcoholism and other chemical dependency~~ substance use disorders and co-occurring disorders.
 - (C) The effects of psychoactive drug use.
 - ~~(C)~~ (D) Current theories of the etiology of substance abuse and addiction.
 - ~~(D)~~ (E) The role of persons and systems that support or compound the substance abuse and addiction.
 - ~~(E)~~ (F) Major treatment approaches to alcoholism and chemical dependency identification, evaluation and treatment of substance use disorders, co-occurring disorders and addiction, including best practices.
 - ~~(F)~~ (G) Legal aspects of substance abuse.
 - ~~(G)~~ (H) Populations at risk with regard to substance abuse use disorders and co-occurring disorders.
 - ~~(H)~~ (I) Community resources offering screening, assessment, treatment and follow-up for the affected person and family.
 - ~~(I)~~ The process of referring affected persons.
 - (I) Recognition of substance use disorders, co-occurring disorders and addiction and appropriate referral.
 - (J) The prevention of substance abuse use disorders and addiction.
 - (K) For purposes of this paragraph, "addiction" is defined as a chronic pattern of behavior that continues despite the direct or indirect adverse consequences that result from engaging in the behavior. This includes, but is not limited to substances and behaviors including computer-related, shopping, gambling, sex, eating, and work.
 - (L) For purposes of this paragraph, "co-occurring disorders" is defined as a mental illness and substance abuse diagnosis occurring simultaneously in an individual.

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BUSINESS AND PROFESSIONS CODE § 4980.41(d)

For persons who began graduate study on or after January 1, 1986, a master's or doctor's degree qualifying for licensure shall include specific instruction in alcoholism and other chemical substance dependency as specified by regulation. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it shall be considered as part of the 48 semester or 72 quarter unit requirement contained in Section 4980.40.

16CCR§1810. ALCOHOLISM AND OTHER CHEMICAL SUBSTANCE DEPENDENCY TRAINING

(a) The instruction and training in alcoholism and other chemical substance dependency required by Sections 4980.41, 4980.80, 4980.90, 4996.2, and 4996.17 of the Code shall consist of not less than fifteen hours of classroom training or coursework and shall include each of the following areas:

- (1) The definition of alcoholism and other chemical dependency, and the evaluation of the abuser.
- (2) Medical aspects of alcoholism and other chemical dependency.
- (3) Current theories of the etiology of substance abuse.
- (4) The role of persons and systems that support or compound the abuse.
- (5) Major treatment approaches to alcoholism and chemical dependency.
- (6) Legal aspects of substance abuse.
- (7) Knowledge of certain populations at risk with regard to substance abuse.
- (8) Community resources offering assessment, treatment and follow-up for the abuser and family.
- (9) The process of referring affected persons.
- (10) Education concerning and prevention of substance abuse.

(b) For persons subject to Section 4980.41 (d) of the Code, the training or coursework shall be:

(1) Obtained from an educational institution or in an extension course offered by an institution that is either accredited by one or more of the entities specified in Section 1832 of these regulations or is approved by the Bureau for Private Postsecondary and Vocational Education pursuant to Sections 94900 and 94901 of the Education Code;

(c) For all others, the training or coursework shall be:

- (1) Obtained from the educational institutions identified in subsection (b) (1); or
- (2) Obtained from or sponsored by a local, county, state or federal governmental entity; or
- (3) Obtained from a licensed health facility; or
- (4) Obtained from a continuing education provider approved by the board.

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To: MFT Education Committee

Date: September 21, 2007

From: Paul Riches
Executive Officer

Telephone: (916) 574-7840

Subject: Competency Assessment in Marriage and Family Therapy Programs

Background

Thus far the committee has focused almost exclusively on the content of Marriage and Family Therapy (MFT) degree programs with little attention to how education is delivered or assessed. This has been intentional. The draft curriculum requirements have been written to provide educators extensive latitude to design a curriculum that includes the specified subject matter. Such latitude has the virtues of allowing innovation in curriculum design and allowing curriculum to evolve as the practice of marriage and family therapy changes over time.

However, there has been considerable interest nationwide (and across disciplines) in developing practice competencies and evaluating individuals based on those competencies. Examples of competency documents in the immediate mental health arena include efforts by the California Social Work Education Center (Cal SWEC) in mental health and child welfare and by the American Association of Marriage and Family Therapy (AAMFT). A copy of one of the Cal SWEC mental health competency documents and the AAMFT document is attached for your reference.

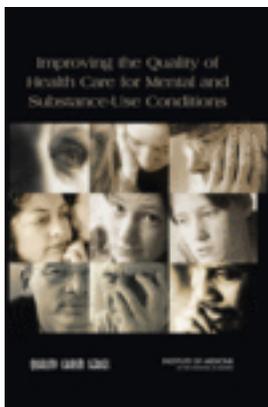
There has also been a drive from the United States Department of Education to include "outcome measures" in the university accreditation standards. The examples given are not exclusive by any measure but do reflect an increasing interest in requiring candidates to demonstrate the skills required to practice in any profession.

The issue of competency assessment in mental health education programs was highlighted specifically by the Institute of Medicine in [Improving the Quality of Health Care for Mental and Substance-Use Conditions \(2006\)](#). Attached to this memo is a chapter from that book addressing the mental health workforce. Also attached are articles by Michael Hoge and others discussing competency models for mental health professionals.

Question 1: To what extent do MFT education programs currently use competency assessment in their programs?

Question 2: Should the committee consider requiring MFT education programs to adopt/develop competency models for their students and include competency assessment in graduation requirements?

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Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series

Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders

ISBN: 0-309-65460-2, 528 pages, 6 x 9, (2006)

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Coordinating Care for Better Mental, Substance-Use, and General Health

Summary

Mental and substance-use problems and illnesses seldom occur in isolation. They frequently accompany each other, as well as a substantial number of general medical illnesses such as heart disease, cancers, diabetes, and neurological illnesses. Sometimes they masquerade as separate somatic problems. Consequently, mental, substance-use, and general health problems and illnesses are frequently intertwined, and coordination of all these types of health care is essential to improved health outcomes, especially for chronic illnesses. Moreover, mental and/or substance-use (M/SU) problems and illnesses frequently affect and are addressed by education, child welfare, and other human service systems. Improving the quality of M/SU health care—and general health care—depends upon the effective collaboration of all mental, substance-use, general health care, and other human service providers in coordinating the care of their patients.

However, these diverse providers often fail to detect and treat (or refer to other providers to treat) these co-occurring problems and also fail to collaborate in the care of these multiple health conditions—placing their patients' health and recovery in jeopardy. Collaboration by mental, substance-use, and general health care clinicians is especially difficult because of the multiple separations that characterize mental and substance-use health care: (1) the greater separation of mental and substance-use health care from general health care; (2) the separation of mental and substance-

use health care from each other; (3) society's reliance on the education, child welfare, and other non-health care sectors to secure M/SU services for many children and adults; and (4) the location of services needed by individuals with more-severe M/SU illnesses in public-sector programs apart from private-sector health care.

This mass of disconnected care delivery arrangements requires numerous patient interactions with different providers, organizations, and government agencies. It also requires multiple provider "handoffs" of patients for different services and transmittal of information to and joint planning by all these providers, organizations, and agencies if coordination is to occur. Overcoming these separations also is made difficult because of legal and organizational prohibitions on clinicians' sharing information about mental and substance-use diagnoses, medications, and other features of clinical care, as well as a failure to implement effective structures and processes for linking the multiple clinicians and organizations caring for patients. To overcome these obstacles, the committee recommends that individual treatment providers create clinically effective linkages among mental, substance-use, and general health care and other human service agencies caring for these patients. Complementary actions are also needed from government agencies, purchasers, and accrediting bodies to promote the creation of these linkages.

To enable these actions, changes are needed as well to address the less-evolved infrastructure for using information technology, some unique features of the M/SU treatment workforce that also have implication for effective care coordination, and marketplace practices. Because these issues are of such consequence, they are addressed separately in Chapters 6, 7, and 8, respectively.

CARE COORDINATION AND RELATED PRACTICES DEFINED

Crossing the Quality Chasm notes that the multiple clinicians and health care organizations serving patients in the American health care system typically fail to coordinate their care. That report further states that the resulting gaps in care, miscommunication, and redundancy are sources of significant patient suffering (IOM, 2001).¹ The *Quality Chasm's* health care quality framework addresses the need for better care coordination in

¹In a subsequent report, produced at the request of the U.S. Department of Health and Human Services, the Institute of Medicine identified "care coordination" as one of 20 priority health care areas deserving of immediate attention by all participants in American health care (IOM, 2003a).

one of its ten rules and in another rule calls attention to the need for provider communication and collaboration to achieve this goal:

Cooperation among clinicians. Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

Shared knowledge and the free flow of information. Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information. (IOM, 2001:62)

These two rules highlight two prerequisites to coordination of care: communication and collaboration across providers and within and across institutions. *Communication* exists when each clinician or treatment provider caring for a patient shares needed treatment information with other clinicians and providers caring for the patient. Information can be shared verbally; manually in writing; or through information technology, such as a shared electronic health record. *Collaboration* is multidimensional and requires the aggregation of several behaviors, including the following:

- **A shared understanding of goals and roles**—Collaboration is enhanced by a shared understanding of an agreed-upon collective goal (Gittell et al., 2000) and clarity regarding each clinician’s role. Role confusion and role conflict are frequent barriers to interdisciplinary collaboration (Rice, 2000).
- **Effective communication**—Multiple studies have identified effective communication as a key feature of collaboration (Baggs and Schmitt, 1988; Knaus et al., 1986; Schmitt, 2001; Shortell et al., 1994). “Effective” is defined variously as frequent, timely, understandable, accurate, and satisfying (Gittell et al., 2000; Shortell et al., 1994).
- **Shared decision making**—In shared decision making, problems and strategies are openly discussed (Baggs and Schmitt, 1997; Baggs et al., 1999; Rice, 2000; Schmitt, 2001), and consensus is often used to arrive at a decision. Disagreements over treatment approaches and philosophies, roles and responsibilities, and ethical questions are common in health care settings. Positive ways of addressing these inevitable differences are identified as a key component of effective caregiver collaboration (Shortell et al., 1994).

It is important to note that, according to health services researchers, collaboration is not a dichotomous variable, simply present or absent. Rather, it is present to varying degrees (Schmitt, 2001).

Collaboration also is typically characterized by necessary precursors. Clinicians are more likely to collaborate when they perceive each other as having the knowledge necessary for good clinical care (Baggs and Schmitt, 1997). Mutual respect and trust are necessary precursors to collaboration as well (Baggs and Schmitt, 1988; Rice, 2000); personal respect and trust are intertwined with respect for and trust in clinical competence.

Care coordination is the outcome of effective collaboration. Coordinated care prevents drug–drug interactions and redundant care processes. It does not waste the patient’s time or the resources of the health care system. Moreover, it promotes accurate diagnosis and treatment because all providers receive relevant diagnostic and treatment information from all other providers caring for a patient.

Care integration is related to care coordination. As defined by experts in health care organization and management (Shortell et al., 2000), integration of care and services can be of three types:

- “*Clinical integration* is the extent to which patient care services are *coordinated* across people, functions, activities, and sites over time so as to maximize the value of services delivered to patients” (p. 129).
- *Physician (or clinician) integration* is the extent to which clinicians are economically linked to an organized delivery system, use its facilities and services, and actively participate in its planning, management and governance.
- *Functional integration* is “the extent to which key support functions and activities (such as financial management, strategic planning, human resources management, and information management) are coordinated across operating units so as to add the greatest overall value to the system” (p. 31). The most important of these functions and activities are human resources deployment strategies, information technologies, and continuous improvement processes.

Shortell et al.’s *clinical* integration corresponds to care coordination as addressed in the *Quality Chasm* report.

In the context of co-occurring mental and substance-use problems and illnesses, the Substance Abuse and Mental Health Services Administration (SAMHSA) similarly identifies three levels of integration (SAMHSA, undated):

- *Integrated treatment* refers to interactions *between clinicians* to address the individual needs of the client/patient, and consists of “any mechanism by which treatment interventions for co-occurring disorders are combined within the context of a primary treatment relationship or service setting” (p. 61).

- *Integrated program* refers to an organizational structure that ensures the provision of staff or linkages with other programs to address all of a client's needs.
- *Integrated systems* refers to an organizational structure that supports an array of programs for individuals with different needs through funding, credentialing/licensing, data collection/reporting, needs assessment, planning, and other system planning and operation functions.

SAMHSA's *integrated treatment* corresponds to Shortell et al.'s *clinical integration*; both appear to equate to *coordination of care* as used in the *Quality Chasm* report. In this report, we use the *Quality Chasm* terminology of *care coordination* and address the coordination of care at the level of the patient. We do not address issues surrounding the other levels of coordination or integration represented by Shortell et al.'s *clinician* and *functional integration* or SAMHSA's *integrated programs* and *systems*.

FAILED COORDINATION OF CARE FOR CO-OCCURRING CONDITIONS

Co-Occurring Mental, Substance-Use, and General Health Problems and Illnesses

Mental or substance-use problems and illnesses seldom occur in isolation. Approximately 15–43 percent of the time they occur together (Kessler et al., 1996; Kessler, 2004; Grant et al., 2004a,b; SAMHSA, 2004). They also accompany a wide variety of general medical conditions (Katon, 2003; Mertens et al., 2003), sometimes masquerade as separate somatic problems (Katon, 2003; Kroenke, 2003), and often go undetected (Kroenke et al., 2000; Saitz et al., 1997). As a result, individuals with M/SU problems and illnesses have a heightened need for coordinated care.

Co-Occurring Mental and Substance-Use Problems and Illnesses

The 1990–1992 National Comorbidity Survey well documented the high rates of co-occurring mental and substance use conditions, finding an estimated 42.7 percent of adults aged 15–54 with an alcohol or drug “disorder” also having a mental disorder, and 14.7 percent of those with a mental disorder also having an alcohol or drug disorder (Kessler et al., 1996; Kessler 2004). These findings are reaffirmed by more recent studies. According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA) 2001–2002 National Epidemiologic Survey on Alcohol and Related Conditions, 19.7 percent of the general adult (18 and older) U.S. population with any substance-use disorder is estimated to have at least one

co-occurring independent (non-substance-induced) mood disorder, and 17.7 percent to have at least one co-occurring independent anxiety disorder. Among respondents with a mood disorder, 20 percent had at least one substance-use disorder, as did 15 percent of those with an anxiety disorder. Rates of co-occurrence are higher among individuals who seek treatment for substance-use disorders; 40.7 percent, 33.4 percent, and 33.1 percent of those who sought treatment for an alcohol-use disorder had at least one independent mood disorder, anxiety disorder, or other drug use disorder, respectively. Among those seeking treatment for a drug-use disorder, 60.3 percent had at least one independent mood disorder, 42.6 percent at least one independent anxiety disorder, and 55.2 percent a comorbid alcohol-use disorder (Grant et al., 2004a).

Similar or higher rates of co-occurrence are found for other types of mental problems and illnesses (Grant et al., 2004b), as well as for serious mental illnesses generally. The 2003 National Survey on Drug Use and Health documented that among adults aged 18 and older not living in an institution or inpatient facility, an estimated 18 percent of those who had used illicit drugs in the past year also had a serious mental illness.² Over 21 percent of adults with substance “abuse” or dependence were estimated to have a serious mental illness, and 21.3 percent of adults with such an illness had been dependent on or “abused” alcohol or illicit drugs in the past year (SAMHSA, 2004).

One longitudinal study of patients in both mental health and drug treatment settings found that mental illnesses were as prevalent and serious among individuals treated in substance-use treatment facilities as among patients in mental health treatment facilities. Similarly, individuals served in mental health treatment facilities had substance-use illnesses at rates and severity comparable to those among individuals served in substance-use treatment facilities (Havassy et al., 2004).

Co-occurrence with General Health Conditions

M/SU problems and illnesses frequently accompany a substantial number of chronic general medical illnesses, such as diabetes, heart disease, neurologic illnesses, and cancers, sometimes masquerading as separate somatic problems (Katon, 2003). Approximately one in five patients hospitalized for a heart attack, for example, suffers from major depression, and evidence from multiple studies is “strikingly consistent” that post-heart attack depres-

²A serious mental illness was defined for this study as a diagnosable mental, behavioral, or emotional disorder that met criteria in the *Diagnostic and Statistical Manual*, fourth edition (DSM-IV) and resulted in functional impairment that substantially interfered with or limited one or more major life activities.

sion significantly increases one's risk for death: patients with depression are about three times more likely to die from a future attack or other heart problem (Bush et al., 2005:5). Depression and anxiety also are strongly associated with somatic symptoms such as headache, fatigue, dizziness, and pain, which are the leading cause of outpatient medical visits and often medically unexplained (Kroenke, 2003). They also are more often present in individuals with a number of medical conditions as yet not well understood, including chronic fatigue syndrome, fibromyalgia, irritable bowel syndrome, and nonulcer dyspepsia (Henningesen et al., 2003).

The converse also is true. Individuals with M/SU conditions often have increased prevalence of general medical conditions such as cardiovascular disease, high blood pressure, diabetes, arthritis, digestive disorders, and asthma (De Alba et al., 2004; Mertens et al., 2003; Miller et al., 2003; Sokol et al., 2004; Upshur, 2005). Persons with severe mental illnesses have much higher rates of HIV and hepatitis C than those found in the general population (Brunette et al., 2003; Rosenberg et al., 2001; Sullivan et al., 1999). Moreover, specific mental or substance-use diagnoses place individuals at higher risk for certain general medical conditions. For example, those in treatment for schizophrenia, depression, and bipolar illness are more likely than the general population to have asthma, chronic bronchitis, and emphysema (Sokol et al., 2004). Persons with anxiety disorders have higher rates of cardiac problems, hypertension, gastrointestinal problems, genitourinary disorders, and migraine (Harter et al., 2003). Individuals with schizophrenia are at increased risk for obesity, heart disease, diabetes, hyperlipidemia, hepatitis, and osteoporosis (American Diabetes Association et al., 2004; Goff et al., 2005; Green et al., 2003). And chronic heavy alcohol use is associated with liver disease, immune system disorders, cardiovascular diseases, and diabetes (Carlsson et al., 2000; Corrao et al., 2000; NIAAA, 2000).

Substance use, particularly injection drug use, carries a high risk of other serious illnesses. In a large cohort study of middle-class substance-using patients, the prevalence of hepatitis C was 27 percent in all substance users and 76 percent in injection drug users (Abraham et al., 1999). Injection drug use accounts for about 60 percent of new cases of hepatitis C (Alter, 1999) and remains the second most common risk behavior for acquisition of HIV in the United States (CDC, 2001). Evidence of past infection with hepatitis B also is common in injection drug users (Garfein, et al., 1996). Hepatitis C and coinfection with HIV and active hepatitis B are associated with more-severe liver disease (Zarski et al., 1998). Alcohol use is prevalent among HIV-infected patients (Conigliaro et al., 2003), and accelerates cognitive impairment in HIV-associated dementia complex (Fein et al., 1998; Tyor and Middaugh, 1999).

Given that patients with HIV infection are now living longer, the impact of comorbid conditions in these patients, including alcohol and drug-use

problems, has become increasingly important. Hepatitis C–related liver injury progresses more rapidly in both HIV coinfecting persons and alcohol users. Laboratory and preliminary clinical evidence indicates that both alcohol use and hepatitis C can negatively affect immunologic and clinical HIV outcomes. Furthermore, both alcohol and drug use may adversely affect the prescription and efficacy of and adherence to HIV medications (Moore et al., 2004; Palepu et al., 2003; Samet et al., 2004).

The co-occurrence of mental, substance-use, and general health problems and illnesses has important implications for the recovery of individuals with these illnesses. All of these conditions need to be detected and treated; however, this often does not happen, and even when it does, providers dealing with one condition often fail to detect and treat the co-occurring illness and to collaborate in the coordinated care of these patients.

Failure to Detect, Treat, and Collaborate in the Care of Co-Occurring Illnesses

Although detection of some common mental illnesses, such as depression, has increased over the past decade, general medical providers still too often fail to detect alcohol, drug, or mental problems and illnesses (Friedmann et al., 2000b; Miller et al., 2003; Saitz et al., 1997, 2002). In a nationally representative survey of general internal medicine physicians, family medicine physicians, obstetrician/gynecologists, and psychiatrists, for example, 12 percent reported that they did not usually ask their new patients whether they drank alcohol, and fewer than 20 percent used any formal screening tool to detect problems among those who did drink (Friedmann et al., 2000b). Moreover, evidence indicates that general medical providers often assume that the health complaints of patients with a prior psychiatric diagnosis are psychologically rather than medically based (Graber et al., 2000).

Similarly, mental health and substance-use treatment providers frequently do not screen, assess, or address co-occurring mental or substance-use conditions (Friedmann et al., 2000b) or co-occurring general medical health problems. In a survey of patients of one community mental health center, 45 percent of respondents reported that their mental health provider did not ask about general medical issues (Miller et al., 2003).

Evidence presented in Chapter 4 documents some of the failures of providers to treat co-occurring conditions. Other studies have added to the evidence that even when co-occurring M/SU conditions are known, they are not treated (Edlund et al., 2004; Friedmann et al., 2000b, 2001). The above-cited longitudinal study of patients with comorbid conditions at four public residential treatment facilities for seriously mentally ill patients and three residential treatment facilities for individuals with substance-use ill-

nesses found no listings of co-occurring problems or illnesses in patient charts despite the existence of significant comorbidity. “Patient charts in the public mental health system generally include a primary psychiatric disorder; co-occurring psychiatric or substance use disorders are not systematically included. Substance abuse treatment sites only documented substance use disorders” (Havassy et al., 2004:140). In the national survey of primary care providers and psychiatrists described above, 18 percent of physicians reported that they typically offered no intervention (including a referral) to their problem-drinking patients, in part because of misplaced concern about patients’ sensitivity on these issues (Friedmann et al., 2000b). Nearly the same proportion (15 percent) reported that they did not intervene when use of illicit drugs was detected (Friedmann et al., 2001). A 1997–1998 national survey found that among persons with probable co-occurring mental and substance-use disorders who received treatment for either condition, fewer than a third (28.6 percent) received treatment for the other (Watkins et al., 2001).

Additional evidence of the failure to coordinate care is found in the complaints of consumers of M/SU services. The President’s New Freedom Commission reported that consumers often feel overwhelmed and bewildered when they must access and integrate mental health care and related services across multiple, disconnected providers in the public and private sectors (New Freedom Commission on Mental Health, 2003).

These failures to detect and treat co-occurring conditions take place in a health care system that has historically and currently separates care for mental and substance-use problems and illnesses from each other and from general health care, to a greater extent than is the case for other specialty health care. Absent or poor linkages characterize these separate care delivery arrangements. Numerous demonstration projects and strategies have been developed to better link health care for general, mental, and substance-use health conditions and related services. These include The Robert Wood Johnson Foundation’s Depression in Primary Care: Linking Clinical and Systems Strategies Project (Upshur, 2005) and the MacArthur Foundation’s RESPECT—Depression Project (Dietrich et al., 2004).

NUMEROUS, DISCONNECTED CARE DELIVERY ARRANGEMENTS

“Every system is perfectly designed to achieve exactly the results it gets.”
(Berwick, 1998)

Organizations and providers offering treatment and services for mental, substance-use, and general health care conditions typically do so through separate care delivery arrangements:

- Arrangements for the delivery of health care for mental and substance-use conditions are typically separate from general health care (financially and organizationally more so than other specialty health care services).
- In spite of the frequent co-occurrence of M/SU problems and illnesses, the delivery of health care for these conditions also typically occurs through separate treatment providers and organizations.
- Some health care for mental and substance-use conditions and related services are delivered through governmental programs that are separate from private insurance—requiring coordination across public and private sectors of care.
- Non-health care sectors—education, child welfare, and juvenile and criminal justice systems—also separately arrange for M/SU services.

Traversing these separations is made difficult by a failure to put in place effective strategies for linking general, mental, and substance-use health care and the other human services systems that also deliver much-needed services for M/SU problems and illnesses; by a lack of agreement about which entity or entities should be held accountable for coordinating care; and by state and federal laws (and the policies and practices of some health care organizations) that limit information sharing across providers.³

Separation of M/SU Health Care from General Health Care

Although the proportion has been declining in recent years, two-thirds of Americans (64 percent in 2002) under the age of 65 receive health care through private insurance offered by their or their family member's employer (Fronstin, 2003). Over the past two decades, employers and other group purchasers of health care (e.g., state Medicaid agencies) have increasingly provided mental and substance-use health care benefits through health insurance plans that are separate administratively and financially from the plans through which individuals receive their general health care. These separate M/SU health plans are informally referred to as "carved out." In *payer* carve-outs, an employer or other payer offers prospective enrollees one or more health plans encompassing all of their covered health care except that for mental and substance-use conditions. Covered individuals are then enrolled in another health plan that includes a network of M/SU

³In addition, the less-evolved infrastructure for deploying information technology among mental health and substance-use treatment providers inhibits ease of coordination (see Chapter 6). Some of the unique features of the M/SU treatment workforce (e.g., the greater number of provider types, variation in their training and focus, and their greater location in solo or small group practices) that also contribute to this problem are addressed in Chapter 7.

providers chosen separately by the employer/payer. In *health plan* carve-outs, employees enroll in just one comprehensive health plan, and the administrators of that plan arrange internally to have M/SU health care provided and managed through a separate vendor. Estimates of the proportion of employees receiving M/SU health services through carve-out arrangements with managed behavioral health organizations (MBHOs) vary from 36 to 66 percent, reflecting differences in targeted survey respondents (e.g., employers, MBHOs, or employees) and what is being measured (e.g., carved-out services can include utilization review or case management only, or the provision of a full array of M/SU services) (Barry et al., 2003).

The MBHOs that provide these carve-out M/SU services arose in part in response to financial concerns. In the 1980s, employers' costs for behavioral health services were increasing at twice the rate of medical care overall and four times the rate of inflation. Evidence is clear that MBHOs have been successful in reducing these costs and also in achieving greater use of community-based care as opposed to institutionalization. They also have been credited with playing a role in keeping costs down in the face of broadened benefits, which has assisted in securing support for greater parity of mental health benefit coverage. Moreover, MBHOs have helped move clinicians from solo into group practices (Feldman, 2003), which, as discussed in Chapter 7, can facilitate quality improvement. Carve-out arrangements can nurture recognition and support for specialized knowledge of M/SU problems and illnesses and treatment expertise. They also can attenuate problems involving the adverse selection of individuals with M/SU illnesses in insurance plans (see Chapter 8).

In contrast to the clear evidence for the benefits described above, evidence for the effects of carve-out arrangements on quality of care is limited and mixed (Donohue and Frank, 2000; Grazier and Eselius, 1999; Hutchinson and Foster, 2003). However, models of safety and errors in health care suggest that whenever individuals are cared for by separate organizations, functional units, or providers, discontinuities in care can result unless the unavoidable gaps in care are anticipated, and strategies to bridge those gaps are implemented (Cook et al., 2000). A previous Institute of Medicine (IOM) report found that carved-out M/SU services "do not necessarily lead to poor coordination of care. . . . However the separation of primary care and behavioral health care systems brings risks to coordination and integration. . ." (IOM, 1997:116). The President's New Freedom Commission on Mental Health care deemed the separation between systems for mental and general health care so large as to constitute a "chasm" (New Freedom Commission on Mental Health, 2003).

Several factors could help account for problems with coordinating care in the presence of M/SU carve-outs. First, under carve-out arrangements, primary care physicians generally are not expected to treat (and may not

always be able to be reimbursed for treating) M/SU problems and illnesses (Feldman et al., 2005; Upshur, 2005). The employer or other purchaser of health insurance benefits for the individual has, by contract, specified that general health care is to be provided by one network of providers through a health plan covering that care, and M/SU care through a different health plan's network of specialty M/SU providers. This is different from the situation with other medical problems and illnesses. For example, when a patient seeks care for diabetes, asthma, allergies, heart problems, or other general medical conditions, the patient's primary care provider is allowed to treat these illnesses and can be reimbursed for those services. When the primary care provider and/or the patient decides that the problem requires the attention of a specialist, the provider makes a referral or the patient self-refers to a specialist. Use of a specialist comes about based generally on the primary care provider's and/or patient's judgment. In contrast, under M/SU carve-out arrangements, M/SU health care often is predetermined by the employer or other group purchaser to require the attention of a specialist and must therefore be provided by a second provider. As a result, one method of care coordination—care by the same provider—is not available to the patient. While not all primary care providers have the expertise and/or desire to treat M/SU illnesses (see Chapters 4 and 7), some do, and evidence indicates that many patients typically turn initially to their primary care provider for help with M/SU problems and illnesses (Mickus et al., 2000).

A second obstacle to care coordination is that information about the patient's health problem or illness, medications, and other treatments must now be shared across and meet the often differing privacy, confidentiality, and additional administrative requirements imposed by the different health plans. Consumers also are required to navigate the administrative requirements of both health plans.

Finally, as described in Chapter 4, the use of carve-outs poses difficulties for quality measurement and improvement—including measurement and improvement of coordination—in two ways. First, because primary care providers cannot always be reimbursed for M/SU health care, they sometimes provide the care but code the visit according to the patient's somatic complaint (for which the treatment they provide can be reimbursed) (Rost et al., 1994). This situation masks the true prevalence of M/SU illnesses in primary care and impedes quality measurement and improvement efforts. Moreover, the existence of two parallel health plans serving the patient creates some confusion about accountability for quality and coordination. For example, the National Committee for Quality Assurance's mental and substance-use quality measures (i.e., those contained in its Health Plan Employer Data and Information Set [HEDIS] measurement set) are required to be reported by comprehensive managed

care plans seeking accreditation, but not by MBHOs seeking accreditation.⁴ Also, as discussed later in this chapter, accreditation standards do not always make clear the responsibilities for care coordination when an individual is served by two health plans, such as a managed care plan providing general health care and an MBHO.

Separation of Health Services for Mental and Substance-Use Conditions from Each Other

The mental health and substance-use treatment systems evolved separately in the United States as a result of the different historical understandings of and responses to these illnesses described in Chapter 2. This separation became increasingly institutionalized with the evolution of three separate institutes of the National Institutes of Health (NIH) (the National Institute of Mental Health [NIMH] in 1949 and National Institute on Alcohol Abuse and Alcoholism [NIAAA] and the National Institute on Drug Abuse [NIDA] in 1974) and separate programming and funding divisions within SAMHSA. This separation at the federal policy level is frequently mirrored at the state level, where separate state mental health and substance-use agencies exist (although they are combined in some states).

The separation of service delivery that mirrors this separation of policy making and funding does not optimally serve individuals with co-occurring mental and substance-use illnesses. A congressionally mandated study of the prevention and treatment of co-occurring substance-use and mental conditions (SAMHSA, undated) found that the difficulties faced by individuals with these co-occurring conditions in receiving successful treatment and achieving recovery are due in part to the existence of these two separate service systems. The study notes: “Too often, when individuals with co-occurring disorders do enter specialty care, they are likely to bounce back and forth between the mental health and substance abuse services systems, receiving treatment for the co-occurring disorder serially, at best” (SAMHSA, undated:*i*). The study further states that this separation of public-sector substance-use and mental health service systems is accompanied by marked differences in “staffing resources, philosophy of treatment, funding sources, community political factors, regulations, prior training of staff, credentials of staff, treatment approaches, medical staff resources, assertive community outreach capabilities, and routine types of evaluations and testing procedures performed” (SAMHSA, undated:*v*). Of greatest concern, the study found that individuals with these co-occurring conditions also may be

⁴Personal communication, Philip Renner, MBA, Assistant Vice President for Quality Measurement, NCQA on March 22, 2005.

excluded from mental health programs because of their substance-use condition and from substance-use treatment programs because of their mental condition (SAMHSA, undated).

Frequent Need for Individuals with Severe Mental Illnesses to Receive Care Through a Separate Public-Sector Delivery System

Treatment for M/SU conditions also is unique in that state and local governments manage public-sector health care systems that are separate from the private-sector health care system for individuals with M/SU illnesses. Indeed, “behavioral disorders remain essentially the only set of health problems for which state and local governments finance and manage a specialty treatment system. [Although] public funds pay for a large portion of the costs of care for certain other disorders (such as Medicare financing of dialysis), and public services exist for a few rare disorders such as leprosy, . . . the public mental health system is the only substantial disorder-specific treatment system in existence today” (Hogan, 1999:106).

Because (as discussed in Chapter 3) individuals with M/SU illnesses face greater limitations in their insurance coverage than is the case with coverage for other illnesses, some individuals with M/SU illnesses who start receiving their care through private insurance must switch to public insurance (Medicaid or the State Children’s Health Insurance Program [SCHIP])⁵ or other publicly funded programs at the state and local levels when their private insurance is exhausted. Evidence indicates that these benefit limits most often are reached by individuals with some of the most severe mental illness diagnoses, including depression, bipolar disorder, and psychoses. There is also evidence that other serious diagnoses appearing in childhood, such as autism, are excluded from coverage under certain private health benefit plans (Peele et al., 2002). The lesser availability of health insurance for severe mental illnesses and for substance-use treatment also helps explain the involvement of other public sectors (i.e., child welfare and juvenile justice) in the delivery of mental health care (as described below).

The federal Substance Abuse Prevention and Treatment (SAPT) and Community Mental Health Services (CMHS) Block Grant programs provide funds to states help fill these gaps. SAPT and CMHS grants to states support the planning, delivery, and evaluation of M/SU treatment services. SAPT funds can be used for individuals regardless of the severity of their substance-use problem or illness, while CMHS grant funds may be used only for individuals with serious mental illnesses and children with “serious

⁵The Medicaid and SCHIP programs also deliver mental health services to individuals for whom these programs are the primary source of health insurance as a result of low income.

emotional disturbances” (SAMHSA, undated). Some of these funds also are given to county and other local government units to use in the planning and delivery of care. In a number of states, major responsibility for mental health services rests with local government, and the extent of coordination between state and local governments is variable.

In addition, public mental health hospitals play a key role in the care of forensic patients—those charged with crimes and being evaluated for competence to stand trial or assume criminal responsibility, or for other issues; those found incompetent to stand trial and being treated to restore competence; those found not guilty by reason of insanity and being treated; those referred for presentencing evaluation; and those sent from prison for hospital-based treatment. In some states, these and related categories account for more than half of all inpatient beds in public mental hospitals. A growing number of people in each of these categories are also being treated in the public (or equivalent community mental health clinic-based) outpatient system. To a considerable extent, this is a function that the public sector has always served. But as other functions have shrunk or been transferred to the private sector (e.g., acute care in many states), forensic functions have come to account for a larger percentage of the public system.

Involvement of Non-Health Care Sectors in M/SU Health Care

M/SU problems and illnesses often are detected (sometimes for the first time) by agencies or organizations that are not part of the traditional health care sector, such as schools, employers, or the welfare and justice systems. These organizations often refer, arrange for, support, monitor, and sometimes deliver M/SU health services. School mental health services and the child welfare and juvenile justice systems provide access to mental health services for the majority of children (DHHS, 1999). The criminal justice system also plays a role in securing M/SU services for some adults. In the private sector, employee assistance programs play a key role in the identification, referral, and provision of services to individuals with M/SU problems and illnesses. Moreover, many other publicly funded entities, such as housing programs, programs for individuals who are homeless, income maintenance programs, and employment programs, provide services that are essential to the recovery of many individuals with severe and chronic M/SU illnesses. The involvement of this array of human service providers generally not considered to be part of the health care sector necessitates additional levels of care coordination. This coordination must be effected despite the inevitable difficulties of working with multiple bureaucracies and in systems with differing priorities, knowledge bases, and practices.

Schools

Most children and adolescents who receive health care for mental conditions receive that care through their schools, not from primary medical or specialty mental health care providers (Kessler et al., 2001). The approaches used by schools to deliver M/SU health care services are highly variable, ranging from (1) class-room based, teacher-implemented programs; to (2) multifaceted, schoolwide programs that employ multiple strategies, such as modification of school policies, classroom management strategies, curriculum changes, and facilitation of parent–school communications; to (3) therapy provided to an individual student, group, or family; to (4) other strategies, such as parent training and education, case management, and consultation. Some of these approaches are prevention-oriented, while others are designed to treat individuals with identified psychopathology. Service modality, intensity, and duration also vary according to individual needs (Rones and Hoagwood, 2000). Some programs rely primarily or exclusively on school-supported mental health professionals (e.g., school social workers, guidance counselors, school nurses), while others have varying degrees of linkage with community mental health agencies and providers (e.g., clinical psychologists, social workers, psychiatrists) who either provide the mental health services exclusively in the school or partner with school staff. In some cases, mental health providers from the school and/or community work on-site in school-based health centers in partnership with primary care providers (Weist et al., 2005).

A review of research on such school-based mental health services published between 1985 and 1999 found that although evidence exists for the effectiveness of a subset of strong programs across a range of emotional and behavioral problems, most school-based programs have no evidence to support their impact, and no programs are targeted to specific clinical syndromes such as anxiety, attention deficit hyperactivity disorder (ADHD), and depression. This same study also found that precisely what is provided by schools under the rubric of mental health services is largely unknown, as is whether those services are effective (Rones and Hoagwood, 2000).

To learn more about school-based mental health services, SAMHSA and Abt Associates recently conducted a national survey aimed at providing information on mental health services delivered in U.S. public schools, including:

- The types of mental health problems/issues encountered most frequently in the school setting.
- The types of mental health services delivered, and models and arrangements for their delivery in public elementary, middle, and secondary schools.

- Barriers to the provision and coordination of mental health services in school settings.
- The numbers, availability, and qualifications of mental health staff in public schools.

The final report is to be released during fall 2005.⁶

Experts on school-based mental health services note that (1) schools should not be viewed as responsible for meeting all the mental health needs of their students (in some cases they are already overburdened with demands that should be addressed elsewhere); and (2) connections between school-based mental health services and substance-use treatment services are nonexistent or tenuous (Weist et al., 2005). These two factors, plus the need to coordinate M/SU services with general health care, impose responsibilities on school-based M/SU providers to collaborate with other specialty and general health care providers serving the student, and for the other specialty and general health care providers to do the same.

Child Welfare Services

Almost half (47.9 percent) of a nationally representative, random sample of children aged 2–14 who were investigated by child welfare services in 1999–2000 had a clinically significant need for mental health care (Burns et al., 2004). Even higher rates have been observed in children placed in foster care arrangements (Landsverk, 2005). This is not surprising given that the circumstances of children who are the subject of reports of maltreatment and investigated by child welfare services are characterized by the presence of known risk factors for the development of emotional and behavioral problems, including abuse, neglect, poverty, domestic violence, and parental substance abuse (Burns et al., 2004). Moreover, substantial rates of substance use among adolescents in child welfare have been detected (Aarons et al., 2001).

Ensuring the well-being of children is typically considered part of the mandate of child welfare services, and the children served by these agencies also have very high rates of use of mental health services. However, the first nationally representative study examining the well-being of children and families that came to the attention of child welfare services (the National Survey of Child and Adolescent Well-Being [NSCAW]) found that three of four youths in child welfare who met a stringent criterion of need did not receive mental health care within 12 months of a child abuse and neglect investigation (Landsverk, 2005). States have traditionally used Medicaid to provide medical, developmental, and mental health services to children in

⁶Personal communication, Judith L. Teich, ACSW, Health Policy Analyst. Center for Mental Health Services/SAMHSA on July 15 and October 10, 2005.

foster care;⁷ however, use of this resource requires that child welfare services first identify children in need of such services. Analysis of the NSCAW data found that although 94 percent of counties participating in the survey assessed all children entering foster care for physical health problems, only 47.8 percent had policies for assessing mental health problems (Leslie et al., 2003). Data from the NSCAW also indicate that underutilization of needed services can be alleviated when there is strong coordination between local child welfare and public mental health agencies (Hurlburt et al., 2004).

Justice Systems

Criminal justice system The proportion of U.S. citizens incarcerated has been increasing annually—from a rate of 601 persons in custody per 100,000 U.S. residents in 1995 to 715 persons in custody per 100,000 residents in 2003. As of mid-2003, the nation's prisons and jails⁸ held 2,078,570 persons—one in every 140 U.S. residents (Harrison and Karberg, 2004). Corrections facilities increasingly must attend to M/SU treatment because of this growth in the proportion of the U.S. population that is incarcerated and the requirement that prisons and jails provide treatment to inmates with medical needs (Haney and Specter, 2003).

A rigorous epidemiologic study of the prevalence of mental and substance-use illnesses in correctional settings has not been undertaken.⁹ According to the U.S. Bureau of Justice, however, approximately 16 percent of all persons in jails and state prisons reported having either a mental “condition” or an overnight stay in a psychiatric facility, as did 7 percent of those in federal prisons (Ditton, 1999). Consistent with the evidence in Chapter 3 indicating that those with mental illnesses are responsible for a small share of violence in society, this rate is not much higher than that among the U.S. population overall (13 percent of those over age 18 reported receiving mental health treatment in an inpatient or outpatient setting in 2003¹⁰) (SAMHSA, 2004). Also consistent with the evidence in

⁷Little information is available about the need for and use of mental health services for children whose families receive in-home services from the child welfare system (Landsverk, 2005).

⁸In general, prisons and jails differ by the inmates' length of sentence. Prisons hold those convicted of felonies and serving sentences longer than a year, while jails hold those awaiting adjudication, convicted of misdemeanors, and serving sentences of a year or less. Prisons are operated by the state; jails by counties and other localities (Wolff, 2004).

⁹A more rigorous epidemiologic study of the prevalence of mental and substance use illnesses in correctional settings, modeled on the prevalence studies of the general population in the United States (Kessler et al., 2001) and the correctional and general populations in the United Kingdom, has been called for (Wolff, 2004).

¹⁰This figure does not include treatment solely for substance use.

Chapter 3, substance use plays a larger role in incarceration. Over half of inmates in state prisons and local jails were under the influence of alcohol or other drugs at the time of their offense, as were 33 to 46 percent of federal prison inmates (Ditton, 1999). In an average year, moreover, approximately one-third of new admissions to prisons result from a violation of parole conditions, nearly 16 percent of which are for some type of drug-related violation, such as a positive test for drug use or possession of drugs (Hughes et al., 2001). Although the majority of prisons and jails screen, assess, and provide treatment for mental illnesses, far fewer prisoners receive treatment for their substance-use problems and illnesses. When they do, detoxification and self-help group/peer support counseling are most commonly provided (Wolff, 2004).

The police and courts also interact with systems providing treatment for M/SU illnesses as they exercise their judgment and license to divert individuals with such illnesses from criminal processing (Metzner, 2002). As discussed in Chapter 3, courts increasingly influence the receipt of treatment for M/SU illnesses through the use of specialty drug and mental health courts. Defendants in these courts have the option of treatment or incarceration. If they choose treatment, they may forgo criminal processing altogether, or undergo criminal processing but forgo sentencing. The court supervises compliance with treatment. Police also influence treatment; as the gatekeepers for the criminal justice process, they are charged with determining whether to “socialize, medicalize, or criminalize” the event. And probation and parole officers influence treatment in exercising their oversight over compliance with terms of probation and parole. All of these actors’ decisions are influenced by their personal understanding of these issues, the culture of their agency, and their localities’ enforcement policies and social norms (Wolff, 2004).

Appropriate decision making about diverting or prosecuting, exercising coercion into treatment in a way that preserves patient-centered care (see Chapter 3), and fulfilling the right of incarcerated persons to medical treatment requires policies and practices that reflect an understanding of M/SU problems and illnesses and their effective treatment, as well as knowledge of the availability of treatment in the local community. However, individual agents of the judicial system vary in their training on these issues, and the policies and practices of each locality vary according to local norms and the public’s beliefs about M/SU illnesses¹¹ (Wolff, 2004). As a result, coordination with specialty M/SU providers, organizations, and systems is essential to the development of evidence-based criminal justice policies and

¹¹Since the chief prosecutor in each jurisdiction is typically elected, the public’s perception of M/SU illnesses and dangerousness, for example (see Chapter 3), even if erroneous, may shape policies and practices (Wolff, 2004).

practices and to the delivery of effective care to individuals in the criminal justice system.

However, numerous and sizable obstacles to coordination between M/SU health care and criminal justice systems have been documented. Several actions that are consistent with the *Quality Chasm* framework for redesigning health care have been recommended to overcome these obstacles. These include using performance measures of the coordination between M/SU health care and criminal justice systems at the system, agency, program, and individual levels; providing combined, interdisciplinary training in collaboration and coordination for personnel from both types of agencies and programs; incentivizing coordination through promotion, salary, and budget decisions; providing education and decision support to prosecutors and judges; and using information systems to facilitate the communication of information essential to responding appropriately to each individual (Wolff, 2004).

Juvenile justice system Primary components of the juvenile justice system include intake, detention centers, probation services, secure residential facilities, and aftercare programs (Cocozza, 2004). Although research on the prevalence and nature of M/SU illnesses in juvenile justice systems is limited (Cocozza, 2004), between 60 and 75 percent of youths in these systems are estimated to have a diagnosable mental health “disorder” (Cocozza 2004; Teplin et al., 2002; Wierson et al., 1992), and 20 percent are conservatively estimated to have a severe mental illness (Cocozza and Skowrya, 2000). Rates of co-occurring substance-use illnesses also are high (Cocozza, 2004; Grisso, 2004).

Moreover, in a 2003 survey of all (698) secure juvenile detention facilities in the United States,¹² two-thirds of the facilities reported holding youths (prior to, after, or absent any pending adjudication) because they were awaiting community mental health services. Further, like youths who are not abused or neglected but are placed in child welfare solely to obtain mental health services (discussed in Chapter 1), children who are not guilty of any offence are similarly placed in local juvenile justice systems and incarcerated solely to obtain mental health services not otherwise available. Although no formal counting and tracking of such children takes place, juvenile justice officials in 33 counties in the 17 states with the largest populations of children under age 18 estimated that approximately 9,000 such children entered their juvenile justice systems under these circumstances in 2001. County juvenile justice officials’ estimates ranged from zero to 1,750, with a median of 140. Nationwide the number of children

¹²Response rate of 75 percent.

placed in juvenile justice systems is likely to be higher; 11 states reported to the Government Accountability Office (GAO) that they could not provide estimates even though they were aware that such placements occur (GAO, 2003).

Although the vast majority of juvenile justice facilities report providing some type of mental health service (Goldstrom et al., 2001), “numerous investigations suggest that many youth in the juvenile justice system do not receive needed mental health services and that available services are insufficient and inadequate.” Most existing programs have not been evaluated, and some of the most popular and widely implemented programs have no evidence to support them and may actually be harmful. Juvenile justice systems, however, lack the training, service, and expertise to respond more effectively (Cocozza, 2004). Because many youths are in juvenile justice systems for relatively minor, nonviolent offenses, there also is a growing sentiment that whenever possible, youths with serious mental illnesses should be diverted from those systems. However, the limited amount of research on the efficacy of juvenile diversion programs has yielded mixed results. To achieve appropriate diversion and the provision of evidence-based care to children and youths in juvenile justice, coordination is crucial: “Almost every study and report that has focused on youth with mental health disorders who come in contact with the juvenile justice system has arrived at the same conclusion—that collaboration between mental health and juvenile justice (and other systems such as child welfare and education as well) at every level and at every stage is critical to any progress. The problem cannot be solved by any single agency” (Cocozza, 2004:35).

Employee Assistance Programs

An increasing number of individuals are covered by employee assistance programs (EAPs). An estimated 66.5 million employees were enrolled in such programs in 2000—a 245 percent increase since 1994 and a 13 percent increase over the year before (Fox et al., 2000). EAPs offered by employers¹³ to their employees (and frequently employees’ family members) vary in structure, types and qualifications of personnel, scope and length of services provided, location, and relationship to health plans providing M/SU and general health care services to the same employees. Although EAPs began as occupational programs to address alcohol-related problems in the workplace, they now typically offer consultation with personnel in identifying and resolving other job performance issues, and pro-

¹³Other organizations, such as labor organizations, unions, and professional associations, also sponsor EAPs.

vide further assessment, referral, and follow-up services. Additional services offered include assistance to employees experiencing stressful events, wellness training, assistance with work/life issues, legal assistance, and financial services. EAPs sometimes have a formal relationship with the M/SU services offered by a health plan and/or serve as a required gateway to M/SU services (Masi et al., 2004). Thus, an EAP's caseload can include individuals with severe M/SU problems and illnesses (Masi, 2004). EAPs are distinct in that their services are typically brief (an average of six counseling sessions) and often are provided via telephone or the Internet by a provider in a different location—perhaps several states away—and with round-the-clock access (Masi, 2004).

Linkages with Community and Other Human Services Resources

Individuals with M/SU problems and illnesses sometimes require additional services from a variety of community resources, such as self-help and support programs for individuals with specific diseases, housing services, income maintenance programs, and employment services, that are essential to the recovery of many individuals with severe and chronic M/SU illnesses. Appendix C contains a description of an array of such support services provided by the Veterans Health Administration to veterans with severe M/SU illnesses.

Discharge planning units or similar staff within inpatient facilities, as well as case management staff within outpatient treatment settings or programs, must assess patients for the need for these services, establish referral arrangements, and coordinate the services with the human service agencies providing them. Such coordination of care across inpatient and outpatient providers is essential to ensure timely access to these services. When discharge planning or outpatient care fails to ensure speedy access to these services and continuity of care within the community, patients are at risk for failure to implement their treatment plans, homelessness, incarceration, or other adverse outcomes.

Unclear Accountability for Coordination

Because patients receive care from multiple providers and delivery systems, there often is an unclear point (or points) of accountability for patients' treatment outcomes. When organizations or providers are reimbursed separately for the services they provide, each may perceive no responsibility for the services delivered by others and, as a result, for any patient outcomes likely to be affected by those services. Unless providers' accountability for sharing information or collaborating with other providers is explicitly identified in their agreements with purchasers, they may reasonably

believe that those other providers have primary responsibility for initiating and maintaining ongoing communication and collaboration.

Moreover, the concept of collaboration has not been clearly defined (Schmitt, 2001). Thus, when providers do accept responsibility for collaborating with other providers, what constitutes “collaboration” is left to their own interpretation based on historical local practice patterns and limitations imposed by their current workload. This unclear accountability has been acknowledged and addressed in a conceptual model for coordinated care delivery developed by the National Association of State Mental Health Program Directors and the National Association of State Alcohol and Drug Abuse Directors. This model articulates a vision of coordinated care involving primary, mental health, substance-use, and other health and human service providers who share responsibility for delivering care to the full population in need of M/SU health care depending upon the predominance of medical, mental, or substance-use symptoms (SAMHSA, undated).

DIFFICULTIES IN INFORMATION SHARING

The sharing of patient information across providers treating the same patient so that care can be coordinated is widely acknowledged as necessary to effective and appropriate care. This need was acknowledged most recently in regulations governing the privacy of individually identifiable health information under the authority of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA’s implementing regulations generally permit health care organizations to release—without requiring patient consent—individually identifiable information (except psychotherapy notes) about the patient to another provider or organization for treatment purposes.¹⁴

However, the HIPAA regulations are superseded by other federal and state statutory and regulatory provisions that may make it difficult for different providers or treatment organizations to share information. First, HIPAA itself (Section 264 (c)(2)) requires that regulations promulgated to implement its privacy provisions not supersede any contrary provisions of state law that impose more stringent requirements, standards, or implementation specifications pertaining to patient privacy. Each of the 50 states (and the District of Columbia) has a number of statutes governing the confidentiality of medical records, and specifically governing aspects of mental health records. Many of these statutes are more stringent than the HIPAA requirements, and the variation among them is great (see Appendix B for a detailed discussion of federal and state laws regarding confidential-

¹⁴45 CFR Part 164, Subpart E, § 164.502.

ity and the release of health care information pertaining to mental and substance-use conditions).

Second, regulations implementing HIPAA also permit health care organizations to implement their own patient consent policies for the release of patient information to other treating providers.¹⁵ As a result, health care organizations may adopt even more stringent privacy protections that require participating providers to adhere to additional procedures before sharing patient information with other treatment providers or organizations.

Moreover, separate federal laws govern the release of information pertaining to an individual's treatment for drug or alcohol use. These laws do not permit sharing of records related to substance-use treatment or rehabilitation by organizations operated, regulated, or funded by the federal government without the patient's consent, except within a program or with an entity with administrative control over the program, between a program and organizations that provide support services such as billing and data processing, or in case of a "bona fide medical emergency." These federal laws are also superseded by any state laws that are more stringent (see Appendix B). The preamble to the HIPAA privacy regulations also recognizes the constraints of the substance-use confidentiality law and states that wherever one is more protective of privacy than the other, the more restrictive should govern (65 Fed. Reg. 82462, 82482–82483).

The bottom line is that clinicians providing treatment to individuals with M/SU illnesses must comply with multiple sets of rules governing the release of information: one prescribed federally and pertaining to information on treatment for alcohol or drug problems, state laws that pertain to information on health care for mental and substance-use conditions (depending upon whether they are more stringent than the federal rules), and other policies prescribed by the organization or multiple organizations under whose auspices patient care is provided.

STRUCTURES AND PROCESSES FOR COLLABORATION THAT CAN PROMOTE COORDINATED CARE

Because of the complexities described above, strategies to improve coordination of care need to be multidimensional (Gilbody et al., 2003; Pincus et al., 2003). A systematic review of studies of organizational and educational interventions to improve the management of depression in primary care settings found that initiatives with the most multidimensional approaches generally achieved positive results in their primary outcomes (Gilbody et al., 2003). Components of multidimensional strategies to im-

¹⁵45 CFR Part 164 Subpart E § 164.506(b).

prove care coordination that can be used by providers and health care organizations at the locus of care include (1) screening for co-occurring conditions; (2) making a formal determination to either treat, or refer for treatment of, co-occurring conditions; (3) implementing more effective mechanisms for linking providers of different services to enable joint planning and coordinated treatment; and (4) providing organizational supports for collaboration between clinicians on- and off-site. Purchasers and quality oversight organizations can create incentives for providers to employ these strategies through their funding and accountability mechanisms and by exercising leadership within their spheres of influence.

Health Care Provider and Organization Strategies

Screening

Because of the high rates of comorbidity described above—especially among those seeking treatment—screening to detect the presence of comorbid conditions is a necessary first step in care coordination. Screening enables a service provider to determine whether an individual with a substance-use problem or illness shows signs of a mental health problem or illness, and vice versa. If a potential problem is identified, a more detailed assessment is undertaken. Routine screening has been shown to improve rates of accurate mental health and substance-use diagnosis (Pignone et al., 2002; Williams et al., 2002).

The above-mentioned congressionally mandated study of the prevention and treatment of co-occurring substance-use and mental conditions (SAMHSA, undated) identified screening as critical to the successful treatment of comorbid conditions. Similarly, because of the high prevalence of emotional and behavioral problems among children served by child welfare services, screening has been recommended for children in the child welfare system overall (Burns et al., 2004) and especially for those placed in foster care (American Academy of Child & Adolescent Psychiatry and Child Welfare League of America, 2003). The U.S. Preventive Services Task Force also has recommended two types of screening in primary care settings:

- Screening for alcohol misuse by adults, including pregnant women, along with behavioral counseling interventions.
- Screening for depression in adults in clinical practices that have systems in place to ensure accurate diagnosis, effective treatment, and follow-up (AHRQ, 2002–2003).

The U.S. Preventive Services Task Force has not addressed the issue of screening for comorbid mental or substance-use conditions among indi-

viduals presenting with either condition. To facilitate the adoption of screening and treatment for comorbid mental and substance-use illnesses, the task force could include among its recommended guidelines screening for a co-occurring mental or substance-use problem at the time of an individual's initial presentation with either condition.

As discussed earlier, however, when screening is done, it often is not performed effectively (Friedmann et al., 2000b; Saitz et al., 2002). Effectiveness can be increased by use of any of a broad range of available and reliable instruments for screening for mental illnesses and co-occurring substance-use problems and illnesses (NIAAA, 2002; Pignone et al., 2002; Williams et al., 2002). An example is the Patient Health Questionnaire, a self-administered instrument designed to screen for depression, anxiety disorders, alcohol abuse, and somatiform and eating disorders in primary care (Spitzer et al., 1999). Other very brief, single-question screens have been evaluated for use in screening for alcohol-use problems (Canagasaby and Vinson, 2005). NIAAA has developed a single question (one for men and one for women) for screening for alcohol-use problems in primary care and other settings (NIAAA, 2005).

Anticipation of Comorbidity and Formal Determination to Treat or Refer

Again because of the high prevalence of co-occurring conditions, especially among individuals seeking treatment, the congressionally mandated study of the prevention and treatment of co-occurring substance-use and mental conditions (SAMHSA, undated) stated that individuals with co-occurring disorders should be the expectation, not the exception, in the substance-use and mental health treatment systems. SAMHSA and others have concluded that substance-use treatment providers should expect and be prepared to treat patients with mental illnesses, and similarly that mental health care providers should be prepared to treat patients with substantial past and current drug problems (Havassy et al., 2004; SAMHSA, undated). In its report to Congress, SAMHSA stated that one of the principles for effective treatment of co-occurring disorders is that “any door is the right door”; that is, people with co-occurring disorders should be able to receive or be referred to appropriate services whenever they enter any agency for mental health or substance-use treatment.

This same principle is applicable to general health problems and illnesses as well. A review of innovative state practices for treating comorbid M/SU conditions found that agency staff *expected* their clients to present with co-occurring general health problems. They screened and assessed for related conditions, including HIV/AIDS, physical and sexual abuse, brain disorders, and physical disabilities. Staff were cross-trained in both mental health and substance-use disciplines (although they did not work outside of

their primary discipline) (NASMHPD and NASADAD, 2002). The congressionally mandated study also stated that with training and other supports, primary care settings can undertake diagnosis and treatment of these inter-related disorders (SAMHSA, undated). Alternatively, use of a systematic approach to referral to and consultation with a mental health specialist is often used in model programs for better care (Pincus et al., 2003).

Linking Mechanisms to Foster Collaborative Planning and Treatment

As discussed at the beginning of this chapter, the simple sharing of information, by itself, is insufficient to achieve care coordination. Care coordination is the result of collaboration, which exists when the sharing of information is accompanied by joint determination of treatment plans and goals for recovery, as well as the ongoing communication of changes in patient status and modification of treatment plans. Such collaboration requires structures and processes that enable, support, and promote it (IOM, 2004a).

Not surprisingly, available evidence indicates that referrals alone do not lead to collaboration or coordinated care (Friedmann et al., 2000a). Stronger approaches are needed to establish effective linkages among primary care, specialty mental health and substance-use treatment services, and other care systems that are involved in the delivery of M/SU treatment. These stronger linkage mechanisms vary in form and are theorized to exist along a continuum of efficacy. The extremes range from the ad hoc purchase of services from separate providers to on-site programs (see Figure 5-1) (D'Aunno, 1997; Friedmann et al., 2000a). Linkage mechanisms toward the right of the continuum are theorized to be stronger because they lower barriers or causes of "friction" (e.g., problems in identifying willing providers, clients' personal disorganization, and lack of transportation¹⁶) that prevent patients from receiving services.

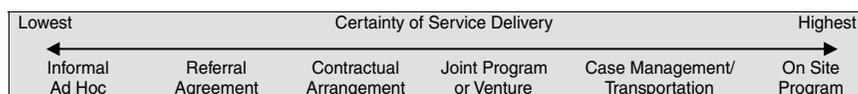


FIGURE 5-1 The continuum of linkage mechanisms.

SOURCE: Friedmann et al., 2000a. Reprinted, with permission, from Health Services Research, June 2000. Copyright 2000 by the Health Research and Educational Trust.

Approaches whose effectiveness in securing collaboration has some conceptual and/or empirical support include collocation and clinical integration of services, use of a shared patient record, case (or care) manage-

¹⁶These are in addition to the problems in insurance coverage discussed in Chapter 3.

ment, and formal agreements with external providers. Evidence to date also indicates that some of these approaches are more effective than others. Moreover, their successful implementation requires leadership within an organization, facilitating structures and processes within treatment settings, and often redesigned professional roles and training in these new roles.

Collocation and clinical integration of services Physical proximity of would-be collaborators facilitates collaboration (IOM, 2004a). This point is exemplified by the multiple studies of mental or substance-use health care showing that same-site delivery of both types of care or primary care is more effective in identifying comorbid conditions (Weisner et al., 2001), effectively links clients to the collocated services (Druss et al., 2001; Samet et al., 2001), and can improve treatment outcomes (Untzner et al., 2001; Weisner et al., 2001). In a 1995 study of a nationally representative sample of all outpatient drug-use treatment units, same-site delivery of services was more effective than formal arrangements with external providers, referral agreements, or case management in ensuring that patients would utilize necessary services (a first step in collaborative care) (Friedmann et al., 2000a). For these reasons, the collocation of multiple services (mental, substance-use, and/or general health) at the same site is a frequently cited feature of many care collaboration programs. The congressionally mandated study of prevention and treatment of co-occurring substance-use and mental conditions (SAMHSA, undated) highlighted “integrated treatment” as an evidence-based approach for co-occurring disorders, defined, in part, as services delivered “in one setting.” The report noted that such integrated treatment programs can take place in either the mental or substance-use treatment setting, but require that treatment and service for both conditions be delivered by appropriately trained staff “within the same setting.”

Others have noted the benefits of integrating behavioral health specialists into primary settings, as well as the reciprocal strategy of including primary care providers at locations that deliver care to individuals with severe mental and substance-use illnesses. This type of collocation facilitates patient follow-through on a referrals, allows for face-to-face verbal communication in addition to or as an alternative to communicating in writing, and allows for informal sharing of the views of different disciplines and easy exchange of expertise (Pincus, 2003).

Such opportunities for face-to-face communication are important because multiple studies identify effective communication as a key feature of collaboration (Baggs and Schmitt, 1988; Knaus et al., 1986; Schmitt, 2001; Shortell et al., 1994). “Effective” communication is described as frequent and timely (Gittell et al., 2000; Shortell et al., 1994),¹⁷ and is characterized

¹⁷As well as accurate, understandable, and satisfying.

by discussion with contributions by all parties, active listening, openness, a willingness to consider other ideas and ask for opinions, questioning (Baggs and Schmitt, 1997; Shortell et al., 1994), and the free flow of information among participants. This type of communication is less easily achieved through electronic, mail, and telephone communications. Nonetheless, when physical integration of services is not feasible, other efforts to promote effective collaboration (i.e., communication between providers by indirect means such as shared patient records or use of a case manager) may yield benefits.

Shared patient records Coordination of care provided by different providers can also be facilitated by shared patient records and documentation practices that promote interdisciplinary information exchange. Electronic health records (EHRs) are supported as an important mechanism for sharing such information and have been highlighted as one of the essential components of the developing National Health Information Infrastructure (NHII). EHRs allow (1) the longitudinal collection of electronic information pertaining to an individual's health and health care; (2) immediate electronic access—by authorized users only—to person- and population-level information; (3) provision of knowledge and decision support to enhance the quality, safety, and efficiency of patient care; and (4) support for efficient processes of health care delivery (IOM, 2003b). Although still in a minority, hospitals and ambulatory practices are increasingly investing in EHRs; these investments typically are being made by larger facilities, creating what is referred to as the “adoption gap” between large and small organizations (Brailer and Terasawa, 2003). Although sharing of patient information maintained in paper-based records can still take place, the capture and storage of patient information electronically is endorsed as a more thorough and efficient mechanism for timely access to needed information by the many providers serving a patient.

Case (care) management Case (or care) management refers to varying combinations of actions performed by a designated individual¹⁸ (i.e., case manager) to arrange for, coordinate, and monitor health, psychological, and social services important to an individual's recovery from illness and the effects of these services on the patient's health. Although the services encompassed by case management often vary by the severity of the illness, the needs of the individual, and the specific model of case management

¹⁸We distinguish in this section between case management, provided by an additional resource *person* working with both the patient and the involved clinicians, and disease management *programs*. The latter often involve transfer of the overall medical and related health care management of a patient's specific disease to a separate organization or program, frequently through a contract. Disease management programs can also offer case management services by an individual as a part of their approach to disease management.

employed (Gilbody et al., 2003; Marshall et al., 2004), typical activities include assessment of the patient's need for supportive services; individual care planning, referral, and connection of the patient with other necessary services and supports; ongoing monitoring of the patients' care plan; advocacy; and monitoring of the patient's symptoms.

Although systematic reviews of the effectiveness of case management for individuals with serious mental illnesses have been conducted with different review strategies and produced conflicting findings (Marshall et al., 2004; Ziguras and Stuart, 2000) (perhaps in part because of the large number of different models of case management [Zwarenstein et al., 2000]), the approach continues to be a common component of many mental health treatment services for individuals with other than mild mental illnesses. A systematic review of studies of organizational and educational interventions to improve the management of depression in primary care settings found that although most initiatives used multiples strategies, case management was one of two approaches used most often in projects achieving positive outcomes and health-related quality of life¹⁹ (Gilbody et al., 2003). More recently, within The Robert Wood Johnson Foundation's national program for depression treatment in primary care, all eight demonstration sites independently designed their interventions to incorporate case management, often with expanded roles for case managers that include ensuring that treatment guidelines and protocols are followed and that a depression registry is used by clinicians. Case managers also serve as intermediaries between patients' primary care providers and mental health specialists (Anonymous, 2004; Rollman et al., 2003). Case management is an essential element as well of the MacArthur Foundation's RESPECT—Depression Project for improving the treatment of depression in primary care, and of disease management programs such The John A. Hartford Foundation and California Health Care Foundation's Project IMPACT program for treating late-life depression (Unutzer et al., 2001).

Formal agreements with external providers Formal agreements with external providers also can influence patients' appropriate utilization of needed services (Friedmann et al., 2000a). Such agreements can include, for example, a substance-use treatment or mental health organization that contracts with a medical group practice to provide physical examinations and routine medical care for its patients. The advantages of this approach are

¹⁹In some studies, the case manager role was of low intensity and included follow-up phone calls to monitor medication adherence, providing brief patient education and medication counseling, or giving support over the phone. In other programs, nurse case managers took on additional roles that included, for example, ongoing support and monitoring of patient therapy and treatment response according to algorithms.

that it requires fewer organizational and physical plant resources than do collocated services, and it makes use of existing community resources (Samet et al., 2001). Specialty consultation with primary care providers is another frequently identified service that can be secured through a formal agreement with an external provider (Pincus et al., 2003). At a minimum, formal agreements with external providers should include not just the agreement to provide the referred service, but also provisions addressing information sharing, joint treatment planning, and monitoring of patient outcomes.

Organizational Support for Collaboration

Successfully implementing the above strategies for care coordination requires facilitating structures and processes within treatment settings. Collaboration also often requires changes in the design of work processes at treatment sites, in particular, flexibility in professional roles. Effective leadership is an overarching need to help health care providers successfully adopt, adapt to, and sustain these changes.

Facilitating structures and processes at treatment sites Structures and processes that encourage multidisciplinary providers to come together for joint treatment planning foster collaboration. For example, in acute, general inpatient care, there is evidence that using interdisciplinary rounds can be effective in improving patient care (Curley et al., 1998). Improvement in care can also be achieved by involving primary and mental health care providers in interdisciplinary team meetings (Druss et al., 2001; Unutzer et al., 2001) at which joint care planning takes place, or by providing case managers (see above) to facilitate patient education, monitoring, and communication between primary care providers and M/SU specialists (Feldman et al., 2005). In addition, a number of more general quality improvement strategies, such as medication algorithms, hold the potential to improve coordination of care by standardizing care processes and creating channels of communication. For instance, the Texas Medication Algorithm Project includes a clinical coordinator to help ensure appropriate coordination among clinicians, patients, and family members in promoting adherence to medication guidelines (Miller et al., 2004; Rush et al., 2003).

In a randomized controlled trial of the integration of medical care with mental health services, it was found that same-site location, common charting, enhanced channels of communication (including joint meetings and e-mail), and in-person contact facilitated the development of common goals and sharing of information between medical and mental health providers. Interdisciplinary team meetings involving primary and behavioral health care providers can do the same (Druss et al., 2001).

Heavy workloads can interfere with the formation of collaborative relationships. Collaboration requires that staff have the time to participate in such activities as interdisciplinary team meetings (Baggs and Schmitt, 1997). Illustrating this point, additional staff resources and reduced caseload were identified as two of several components of success in a randomized controlled trial of collocating and integrating medical care with mental health care (Druss et al., 2001). When staff are overwhelmed with caregiving responsibilities, they may not take the time to collaborate. Yet while unilateral decision making is easier in the short run, collaborative relationships are viewed as saving time in the long run (Baggs and Schmitt, 1997).

The committee also calls attention to the Chronic Care Model, used to improve the health care of individuals with chronic illnesses in primary care settings. This model has six components: (1) providing chronic illness self-management support to patients and their families (see Chapter 3); (2) redesigning care delivery structures and operations; (3) linking patients and their care with community resources to support their management of their illness (described above); (4) providing decision support to clinicians (see Chapter 4); (5) using computerized clinical information systems to support compliance with treatment protocols and monitor patient health indicators (see Chapter 6); and (6) aligning the health care organization's (or provider's) structures, goals, and values to support chronic care (discussed below) (Bodenheimer et al., 2002). The Chronic Care Model has been applied successfully to the treatment of a wide variety of general chronic illnesses, such as diabetes, asthma, and heart failure (The National Coalition on Health Care and The Institute for Healthcare Improvement, 2002), as well as to common mental illnesses such as depression (Badamgarev et al., 2003), and has been theorized to have the potential for improving the quality of care for persons with other M/SU illnesses (Watkins et al., 2003).

The Chronic Care Model also emphasizes the use of certain organizational structures and processes, including interdisciplinary practices in which a clear division of the roles and responsibilities of the various team members fosters their collaboration. Instituting such arrangements may necessitate new roles and divisions of labor among clinicians with differing training and expertise. In the Chronic Care Model, for example, physician team members are often responsible for the treatment of patients with acute conditions, intervene in stubbornly difficult chronic care problems, and train other team members. Nonphysician personnel support patients in the self-management of their illnesses and arrange for routine periodic health monitoring and follow-up. Providing chronic care consistent with this model requires support from health care organizations, health plans, purchasers, insurers, and other providers. Elements of the Chronic Care Model have been implemented in a variety of care settings, including private general medical practices, integrated delivery systems, and a community health

center for general health care (Bodenheimer et al., 2002). The committee believes this model should be developed for use in the care of individuals with chronic M/SU illnesses as a mechanism for improving coordination of care, as well as other dimensions of quality.

Flexibility in professional roles As seen in the Chronic Care Model, collaboration sometimes requires revision in professional roles, including the shifting of roles among health care professionals and the expansion of roles to include new tasks (Gilbody et al., 2003; Katon et al., 2001). It also often requires participating as part of an interdisciplinary team with certain prescribed roles (Unutzer et al., 2001). Research findings and other empirical evidence show that health care workers of all types are capable of performing new tasks necessitated by advances in therapeutics, shortages in the health care workforce, and the pressures of cost containment. For example, the development of safer and more effective medications for mental and substance-use illnesses (e.g., selective serotonin reuptake inhibitors) has enabled the treatment of depression by primary care clinicians. Other medications, such as buprenorphine, may do the same. Other developments that are likely to require redefinition of professional roles include the use of peer support personnel (described in Chapter 3) and the delivery of more M/SU health care in primary care settings and by primary care providers (Strosahl, 2005).

However, new communication patterns and changes in roles, especially functioning as part of an interdisciplinary team, can at times be uncomfortable for health professionals. Role confusion and conflict are a frequent barrier to interdisciplinary collaboration (Rice, 2000). As a result, it may be necessary to provide training and development in collaborative practice behaviors, such as effective communication and conflict resolution (Disch et al., 2001; Strosahl, 2005). Collaboration is enhanced by a shared understanding of agreed-upon collective goals and new individual roles (Gittell et al., 2000).

Leadership Leadership is well known to be a critical factor in the success of any major change initiative or quality improvement effort (Baldrige National Quality Program, 2003; Davenport et al., 1998) and an essential feature of successful programs in care coordination (NASMHPD, NASADAD, 2002). Effective leadership in part models the behaviors that are expected at the clinical care level. For example, in The Robert Wood Johnson Foundation's *Initiative on Depression in Primary Care*, leadership was one of six component interventions to overcome barriers to the delivery of effective care for depression in primary care settings. Teams of primary care, mental health, and senior administrative personnel were responsible for securing needed resources, representing stakeholder interests, promot-

ing adherence to practice standards, setting goals for key process measures and outcomes, and encouraging sustained efforts at continuous quality improvement (Pincus et al., 2003). Such activities ensure that the structures and processes that enable and nurture collaboration are in place at the locus of care.

Practices of Purchasers, Quality Oversight Organizations, and Public Policy Leaders

Clinicians and health care organizations will not be able to achieve full coordination of patient care without complementary and supporting activities on the part of federal and state governments, health care purchasers, quality oversight organizations, and other organizations that shape the environment in which clinical care is delivered. As noted earlier, care coordination has been identified by the IOM as one of 20 priority areas deserving immediate attention by all participants in the American health care system. Health care purchasers, quality oversight organizations, and public policy leaders can help give care coordination this immediate attention by (1) clarifying their expectations for information sharing, collaboration, and coordination in their purchasing agreements; (2) including the care coordination practices recommended above in their quality oversight standards and purchasing criteria; and (3) modeling collaborative practices across health care for general, mental, and substance-use health conditions in their policy-making and operational activities.

Purchaser Practices

Purchasers can stimulate and incentivize better coordination of care among general, mental, and substance-use health care by including care coordination as one of the quality-of-care parameters used to evaluate proposals and award contracts for the delivery of general, specialty M/SU, and comprehensive (general and M/SU) health care (see Chapter 8). In soliciting health plans and providers to deliver these health care services, purchasers can ask bidders to specify what care coordination practices they require of their clinicians, and how the organization supports clinicians and measures care coordination. When awarding contracts, purchasers can clarify in contracts with health care plans their expectations for information sharing, collaboration, and coordination. In addition, purchasers should allow primary care providers to bill for the M/SU treatment services they provide, a practice now under way in some MBHO settings (Feldman et al., 2005). Doing so will allow consumers and their primary care providers to determine jointly, as they do for other medical conditions, when specialty consultation and care are appropriate; enable coordination of care

through the use of a single provider to treat general and M/SU conditions; and eliminate the adverse consequences that arise when primary care providers code visits related to M/SU problems and illnesses as being due to somatic complaints.

Quality Oversight Practices

Many purchasers delegate their attention to care coordination and other quality-related issues by accepting the quality-of-care determinations made by expert quality oversight organizations, such as accrediting bodies. Four main organizations accredit M/SU health care organizations (and sometimes individual providers). The National Committee for Quality Assurance (NCQA) accredits managed care organizations, MBHOs, and disease management programs and recognizes physician practices through other oversight programs. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accredits hospitals and specialty behavioral health care organizations. The Commission on Accreditation of Rehabilitation Facilities accredits a wide variety of behavioral health programs and services. Finally, the Council on Accreditation for Children and Family Services, Inc. accredits a wide variety of counseling and other M/SU programs and services, as well as EAPs. These accrediting bodies generally perform their quality oversight activities either through review of an organization's structures and operational practices or through measurement of an organization's or provider's clinical care processes and outcomes. Clinical care processes and outcomes are generally evaluated through performance measures (discussed in Chapter 4). Organizational structures and processes such as the linking strategies recommended above are typically reviewed through evaluation of compliance with the established structural and procedural standards that make up an organization's accreditation standards.

Although the accreditation standards of each of the above four organizations address care coordination and collaboration to some extent (CARF, 2005; COA, 2001; JCAHO, 2004; NCQA, 2004), accreditation standards for care coordination could be improved. For example, NCQA's MBHO accreditation standards address care coordination between M/SU and general health care in Standard QI 10, "Continuity and Coordination between Behavioral Health and Medical Care," which states (NCQA, 2004:91):

The organization collaborates with relevant medical delivery systems or primary care physicians to monitor and improve coordination between behavioral health and medical care.

However, the following note is appended to this standard:

Note: If the organization does not have any formal relationship with the medical delivery system through contracts, delegation, or otherwise, NCQA considers this standard NA. (NCQA, 2004:91). NCQA's customer support line clarifies that "NA" means "Not Applicable."²⁰

Collaboration and Coordination in Policy Making and Programming

Throughout this report, the committee emphasizes the need for collaboration and coordination in mental, substance-use, and general health care policy making and programming that parallels desired collaboration and coordination at the care delivery level—for example, in the dissemination of information on innovations in new treatments (see Chapter 4), in the measurement of the quality of M/SU care (see Chapter 4), and in the development of information technology for M/SU care (see Chapter 6). Such attention to coordination and collaboration at the policy and programming represents an opportunity for federal, state, and local officials to model and promote the coordination and collaboration needed at the clinical level—across M/SU health care and across providers of these specialty health care services and general health care. The importance of seizing this opportunity is emphasized in the IOM report *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality*. That report, commissioned by Congress to examine and recommend quality improvement activities in six major federal programs,²¹ concluded that the federal government must assume a strong leadership role in quality improvement:

By exercising its roles as purchaser, regulator, provider of health services, and sponsor of applied health services research, the federal government has the necessary influence to direct the attention and resources of the health care sector in pursuit of quality. There is no other stakeholder with such a combination of roles and influence. (IOM, 2002:x)

Because coordination of care is one dimension of quality, the federal government needs to exercise leadership and model coordination and collaboration in general, mental, and substance-use health care. This coordination and collaboration should be practiced across the separate Centers

²⁰Conversation with NCQA Customer Support on July 22, 2005.

²¹Even this initiative represents a missed opportunity for collaboration and coordination. Congress charged the IOM with examining the roles of Medicare, Medicaid, the Indian Health Service, the State Children's Health Insurance Program, the Department of Defense's TRICARE program, and the program of the Veterans Health Administration in enhancing health care quality, but not the role of federal M/SU programs administered by SAMHSA.

for Substance Abuse Prevention and Treatment and Center for Mental Health Services within SAMHSA, across SAMHSA and other operating divisions of the Department of Health and Human Services (DHHS), across DHHS and other departments, and across the public and private sectors.

A strong example of such leadership in coordination and collaboration is found in the federal action agenda, *Transforming Mental Health Care in America*, formulated to implement the recommendations of the President's New Freedom Commission on Mental Health. This action agenda is the collaborative product of 12 DHHS agencies (the Administration on Aging, Administration for Children and Families, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services, Health Resources and Services Administration, Indian Health Service, National Institutes of Health, Office for Disability, Office for Civil Rights, Office of Public Health and Science, and SAMHSA), five other departments (Education, Housing and Urban Development, Justice, Labor, and Veterans Affairs), and the Social Security Administration. To guide the implementation of this agenda, DHHS is leading an intra- and interagency Federal Executive Steering Committee composed of high-level representatives from DHHS agencies and other federal departments that serve individuals with mental illnesses (SAMHSA, 2005). This strong model of collaboration and coordination could be strengthened by including on the action agenda items addressing the substance-use problems and illnesses that so frequently accompany mental illnesses, and by including more explicitly in implementation activities the SAMHSA centers and state agencies responsible for planning and arranging for care for co-occurring substance-use illnesses. Similarly engaging key private-sector entities, especially those in the general health sector who deliver much care for mental illnesses, would strengthen this collaborative approach and help break down the separations discussed earlier in this chapter between mental and substance-use illnesses, between specialty M/SU and general health care, and between the public and private sectors.

New Mexico provides one example of processes now under way to achieve such coordination and collaboration at the state level (see Box 5-1). While the fruits of this initiative are not yet known, these efforts are testimony to the critical need for such coordination and collaboration at the policy level and the importance of high-level leadership in meeting this need.

BOX 5-1 New Mexico's Behavioral Health Collaborative: A Case Study in Policy Coordination

In 2003 the Governor of New Mexico identified as a major policy issue the fact that New Mexico's behavioral health system (like others across the United States) reflected the problems cited in the report of the President's New Freedom Commission: insufficient and inappropriate services, uneven access and quality, failure to maximize resources across funding streams, duplication of effort, higher administrative costs for providers, and overall fragmentation that makes service systems difficult to access and manage effectively. After consultation with key cabinet secretaries, the governor announced a new approach to address these problems through the creation of a high-level policy collaborative. This executive-level body was charged specifically with achieving better access, better services, and better value for taxpayer dollars in mental and substance-use health care.

This group, consisting of 17 members including the heads of 15 agencies, was established in law by the New Mexico legislature effective May 2004 and charged with creating a single behavioral health (mental and substance-use treatment) delivery system across multiple state agencies and funding sources. The vision that guided this effort, based on months of public participation, was that this single system must support recovery and resiliency so that consumers can participate fully in the life of their communities. The agencies forming the collaborative reflected these broad goals and included those responsible for such areas as housing, corrections, labor, and education, as well as primary health and human services agencies.

To ensure that this broad perspective would be reflected in the collaborative's actions, the group decided that decisions would be made whenever feasible by consensus, but that if votes were required, each agency would have a single vote regardless of its budget or size. The group is cochaired by the secretary of Human Services and (in alternating years) the secretary of Children, Youth, and Families or the secretary of Health. Such a broad policy vision clearly also required that the collaborative develop coordinated structures for the efficient management of a broad range of funds and services. Therefore, a request for proposals was issued, and a contractor was selected as the single statewide entity to manage approximately \$350,000,000 in cross-agency funds for the first phase of the change process. In addition, the collaborative has formed senior-level coordination teams, including one focused specifically on cross-cutting policy issues. A single Behavioral Health Planning Council has also been established to form an ongoing partnership with consumers, families, providers, and state agencies in keeping the system on track. In addition, local collaboratives are being formed with cross-agency state assistance across all of the state's 13 judicial districts, as well as in its Native American communities, to ensure strong feedback and coordination involving stakeholders at the local level as a guide for collaborative state policies and actions. The overall transformation also is being carefully evaluated by multiple groups to help guide future work of this broad policy nature.

SOURCE: Personal communication, Leslie Tremaine, Behavioral Health Coordinator, New Mexico BH Collaborative, on July 28, 2005.

Recommendations

To address the complex obstacles to care coordination and collaboration described above, the committee recommends a set of related actions to be undertaken by individual clinicians, health care organizations, health plans, health care purchasers, accrediting organizations, and policy officials.

Recommendation 5-1. To make collaboration and coordination of patients' M/SU health care services the norm, providers of the services should establish clinically effective linkages within their own organizations and between providers of mental health and substance-use treatment. The necessary communications and interactions should take place with the patient's knowledge and consent and be fostered by:

- Routine sharing of information on patients' problems and pharmacologic and nonpharmacologic treatments among providers of M/SU treatment.
- Valid, age-appropriate screening of patients for comorbid mental, substance-use, and general medical problems in these clinical settings and reliable monitoring of their progress.

Recommendation 5-2. To facilitate the delivery of coordinated care by primary care, mental health, and substance-use treatment providers, government agencies, purchasers, health plans, and accreditation organizations should implement policies and incentives to continually increase collaboration among these providers to achieve evidence-based screening and care of their patients with general, mental, and/or substance-use health conditions. The following specific measures should be undertaken to carry out this recommendation:

- Primary care and specialty M/SU health care providers should transition along a continuum of evidence-based coordination models from (1) formal agreements among mental, substance-use, and primary health care providers; to (2) case management of mental, substance-use, and primary health care; to (3) collocation of mental, substance-use, and primary health care services; and then to (4) delivery of mental, substance-use, and primary health care through clinically integrated practices of primary and M/SU care providers. Organizations should adopt models to which they can most easily transition from their current structure, that best meet the needs of their patient populations, and that ensure accountability.

- DHHS should fund demonstration programs to offer incentives for the transition of multiple primary care and M/SU practices along this continuum of coordination models.
- Purchasers should modify policies and practices that preclude paying for evidence-based screening, treatment, and coordination of M/SU care and require (with patients' knowledge and consent) all health care organizations with which they contract to ensure appropriate sharing of clinical information essential for coordination of care with other providers treating their patients.
- Organizations that accredit mental, substance-use, or primary health care organizations should use accrediting practices that assess, for all providers, the use of evidence-based approaches to coordinating mental, substance-use, and primary health care.
- Federal and state governments should revise laws, regulations, and administrative practices that create inappropriate barriers to the communication of information between providers of health care for mental and substance-use conditions and between those providers and providers of general care.

With respect to the need for purchasers to modify practices that preclude paying for evidence-based screening, treatment, and coordination of health care for mental and substance-use conditions, the committee calls particular attention to practices that prevent primary care providers from receiving payment for delivery of the M/SU health services they provide and the failure of some benefit plans to cover certain evidence-based treatments.

Recommendation 5-3. To ensure the health of persons for whom they are responsible, M/SU providers should:

- Coordinate their services with those of other human services and education agencies, such as schools, housing and vocational rehabilitation agencies, and providers of services for older adults.
- Establish referral arrangements for needed services.

Providers of services to high-risk populations—such as child welfare agencies, criminal and juvenile justice agencies, and long-term care facilities for older adults—should use valid, age-appropriate, and culturally appropriate techniques to screen all entrants into their systems to detect M/SU problems and illnesses.

Recommendation 5-4. To provide leadership in coordination, DHHS should create a high-level, continuing entity reporting directly to the secretary to improve collaboration and coordination across its mental,

substance-use, and general health care agencies, including the Substance Abuse and Mental Health Services Administration; the Agency for Healthcare Research and Quality; the Centers for Disease Control and Prevention; and the Administration for Children, Youth, and Families. DHHS also should implement performance measures to monitor its progress toward achieving internal interagency collaboration and publicly report its performance on these measures annually. State governments should create analogous linkages across state agencies.

With respect to recommendation 5-4, the committee notes that this recommendation echoes the call made in the report *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality* for Congress to consider directing the Secretary of DHHS to produce an annual progress report “detailing the collaborative and individual efforts of the various government programs to redesign their quality enhancement processes” (IOM, 2002:11).

REFERENCES

- Aarons GA, Brown SA, Hough RL, Garland AF, Wood PA. 2001. Prevalence of adolescent substance use disorders across five sectors of care. *Journal of the American Academy of Child & Adolescent Psychiatry* 40(4):419–426.
- Abraham HD, Degli-Esposti S, Marino L. 1999. Seroprevalence of hepatitis C in a sample of middle class substance abusers. *Journal of Addictive Diseases* 18(4):77–87.
- AHRQ (Agency for Healthcare Research and Quality). 2002–2003. *U.S. Preventive Services Task Force Ratings: Strength of Recommendations and Quality of Evidence. Guide to Clinical Preventive Services*. Periodic updates, 2002–2003. Rockville, MD: AHRQ. [Online]. Available: <http://www.ahrq.gov/clinic/3rduspstf/ratings.htm> [accessed February 28, 2005].
- Alter MJ. 1999. Hepatitis C virus infection in the United States. *Journal of Hepatology* 31 (Supplement 1):88–91.
- American Academy of Child & Adolescent Psychiatry and Child Welfare League of America. 2003. *Policy Statement: AACAP/CWLA Policy Statement on Mental Health and Use of Alcohol and Other Drugs, Screening and Assessment of Children in Foster Care*. [Online]. Available: <http://www.aacap.org/publications/policy/collab02.htm> [accessed December 2, 2005].
- American Diabetes Association, American Psychiatric Association, American Association of Clinical Endocrinologists, North American Association for the Study of Obesity. 2004. Consensus development conference on antipsychotic drugs and obesity and diabetes. *Journal of Clinical Psychiatry* 65(2):267–272.
- Anonymous. 2004. *Depression in Primary Care—Linking Clinical & System Strategies*. [Online]. Available: <http://www.wpic.pitt.edu/dppc> [accessed December 23, 2004].
- Badamgarev E, Weingarten S, Henning J, Knight K, Hasselblad V, Gano A Jr, Ofman J. 2003. *American Journal of Psychiatry* 160(12):2080–2090.
- Baggs J, Schmitt M. 1988. Collaboration between nurses and physicians. *IMAGE: Journal of Nursing Scholarship* 20(3):145–149.
- Baggs J, Schmitt M. 1997. Nurses’ and resident physicians’ perception of the process of collaboration in an MICU. *Research in Nursing & Health* 20(1):71–80.

- Baggs J, Schmitt M, Mushlin A, Mitchell PH, Eldredge DH, Oakes D, Hutson AD. 1999. Association between nurse-physician collaboration and patient outcomes in three intensive care units. *Critical Care Medicine* 27(9):1991–1998.
- Baldrige National Quality Program. 2003. *Criteria for Performance Excellence*. National Institute of Standards and Technology, U.S. Department of Commerce. [Online]. Available: http://www.quality.nist.gov/PDF_files/2003_Business_Criteria.pdf [accessed April 24, 2003].
- Barry CL, Gabel JR, Frank RG, Hawkins S, Whitmore HH, Pickreign JD. 2003. Design of mental health benefits: Still unequal after all these years. *Health Affairs* 22(5):127–137.
- Berwick DM. 1998. Keynote Address: Taking action to improve safety: How to increase the odds of success. 1998 *Conference: Enhancing Patient Safety and Reducing Errors in Health Care*. National Patient Safety Foundation. Rancho Mirage, CA, on November 8–10, 1998. [Online]. Available: http://www.npsf.org/congress_archive/1998/html/keynote.html [accessed December 16, 2004].
- Bodenheimer T, Wagner EH, Grumbach K. 2002. Improving primary care for patients with chronic illness. *Journal of the American Medical Association* 288(14):1775–1779.
- Brailer DJ, Terasawa E. 2003. *Use and Adoption of Computer-Based Patient Records in the United States*. Presentation to IOM Committee on Data Standards for Patient Safety on January 23, 2003. [Online]. Available: <http://www.iom.edu/file.asp?id=10988> [accessed October 17, 2004].
- Brunette MF, Drake RE, Marsh BJ, Torrey WC, Rosenberg SD. 2003. Five-Site Health and Risk Study Research Committee. Responding to blood-borne infections among persons with severe mental illness. *Psychiatric Services* 54(6):860–865.
- Burns BJ, Phillips SD, Wagner R, Barth RP, Kolko DJ, Campbel Y, Landsverk J. 2004. Mental health need and access to mental health services by youths involved with child welfare: A national survey. *Journal of the American Academy of Child and Adolescent Psychiatry* 43(8):960–970.
- Bush DE, Ziegelstein RC, Patel UV, Thombs BD, Ford DE, Fauerbach JA, McCann UD, Stewart KJ, Tsilidis KK, Patel AL, Feuerstein CJ, Bass EB. 2005. *Post-Myocardial Infarction Depression. Summary*. AHRQ Publication Number 05-E018-1. Evidence Report/Technology Assessment Number 123. Rockville, MD: Agency for Healthcare Research and Quality.
- Canagasaby A, Vinson DC. 2005. Screening for hazardous or harmful drinking using one or two quantity-frequency questions. *Alcohol and Alcoholism* 40(3):208–213.
- CARF (Commission on Accreditation of Rehabilitation Facilities). 2005. *Standards Manual with Survey Preparation Questions, July 2005–June 2006*. Washington, DC: CARF.
- Carlsson S, Hammar N, Efendic S, Persson PG, Ostenson CG, Grill V. 2000. Alcohol consumption, Type 2 diabetes mellitus and impaired glucose tolerance in middle-aged Swedish men. *Diabetes Medicine* 17(11):776–781.
- CDC (Centers for Disease Control and Prevention). 2001. HIV Prevention Strategic Plan through 2005. [Online]. Available: www.cdc.gov/nchstp/od/hiv_plan [accessed October 13, 2005].
- COA (Council on Accreditation for Children and Family Services, Inc). 2001. *Standards and Self-Study Manual, 7th ed., version 1.1*. New York: COA.
- Cocozza JJ. 2004. *Juvenile Justice Systems: Improving Mental Health Treatment Services for Children and Adolescents*. Paper commissioned by the Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. Available from the Institute of Medicine.
- Cocozza JJ, Skowrya K. 2000. Youth with mental disorders: Issues and emerging responses. *Juvenile Justice* 7(1):3–13.

- Conigliaro J, Gordon AJ, McGinnis KA, Rabeneck L, Justice AC. 2003. How harmful is hazardous alcohol use and abuse in HIV infection: Do health care providers know who is at risk? *JAIDS: Journal of Acquired Immune Deficiency Syndromes* 33(4):521–525.
- Cook RI, Render M, Woods DD. 2000. Gaps in the continuity of care and progress on patient safety. *British Medical Journal* 320(7237):791–794.
- Corrao G, Rubbiati L, Bagnardi V, Zanbon A, Poikolainen K. 2000. Alcohol and coronary heart disease: A meta-analysis. *Addiction* 95(10):1505–1523.
- Curley C, McEachern JE, Speroff T. 1998. A firm trial of interdisciplinary rounds on the inpatient medical wards: An intervention designed using continuous quality improvement. *Medical Care* 36(8 Supplement):AS4–AS12.
- D'Aunno TA. 1997. Linking substance abuse treatment and primary health care. In: Egertson JA, Fox DM, Leshman AI, eds. *Treating Drug Users Effectively*. Malden, MA: Blackwell. Pp. 311–351.
- Davenport T, DeLong D, Beers M. 1998. Successful knowledge management projects. *Sloan Management Review* Winter(1):43–57.
- De Alba I, Samet J, Saitz R. 2004. Burden of medical illness in drug- and alcohol-dependent persons without primary care. *The American Journal on Addiction* 13(1):33–45.
- DHHS (U.S. Department of Health and Human Services). 1999. *Mental Health: A Report of the Surgeon General*. Rockville, MD: DHHS.
- Dietrich AJ, Oxman TE, Williams JW Jr, Kroenke K, Schulberg HC, Bruce M, Barry SL. 2004. Going to scale: Re-engineering systems for primary care treatment of depression. *Annals of Family Medicine* 2(4):301–304.
- Disch J, Beilmann G, Ingbar D. 2001. Medical directors as partners in creating healthy work environments. *AACN Clinical Issues* 12(3):366–377.
- Ditton P. 1999. *Mental Health and Treatment of Inmates and Probationers*. Bureau of Justice Statistics, NCJ 174463. Washington, DC: Department of Justice.
- Donohue J, Frank RG. 2000. Medicaid behavioral health carve-outs: A new generation of privatization decisions. *Harvard Review of Psychiatry* 8(5):231–241.
- Druss B, Rohrbaugh R, Levinson C, Rosenheck R. 2001. Integrated medical care for patients with serious psychiatric illness: A randomized trial. *Archives of General Psychiatry* 58(9):861–868.
- Edlund MJ, Unutzer J, Wells KB. 2004. Clinician screening and treatment of alcohol, drug, and mental problems in primary care: Results from Healthcare for Communities. *Medical Care* 42(12):1158–1166.
- Fein G, Fletcher DJ, Di Sclafani V. 1998. Effect of chronic alcohol abuse on the CNS morbidity of HIV disease. *Alcoholism: Clinical and Experimental Research* 22(5 Supplement): 196S–200S.
- Feldman MD, Ong MK, Lee DL, Perez-Stable EJ. 2005. Realigning economic incentives for depression care at UCSF. *Administration and Policy in Mental Health and Mental Health Services Research* 33(1):35–39.
- Feldman S. 2003. Choices and challenges. In: Feldman S, ed. *Managed Behavioral Health Services: Perspectives and Practice*. Springfield, IL: Charles C. Thomas Publisher, Pp. 3–23.
- Fox A, Oss M, Jardine E. 2000. *OPEN MINDS Yearbook of Managed Behavioral Health Market Share in the United States 2000-2001*. Gettysburg, PA: OPEN MINDS.
- Friedmann PD, D'Aunno TA, Jin L, Alexander J. 2000a. Medical and psychosocial services in drug abuse treatment: Do stronger linkages promote client utilization? *HSR: Health Services Research* 35(2):443–465.
- Friedmann PD, McCulloch D, Chin MH, Saitz R. 2000b. Screening and intervention for alcohol problems: A national survey of primary care physicians and psychiatrists. *Journal of General Internal Medicine* 15(2):84–91.

- Friedmann PD, McCullough D, Saitz R. 2001. Screening and intervention for illicit drug abuse: A national survey of primary care physicians and psychiatrists. *Archives of Internal Medicine*. 161(2):248–251.
- Fronstin P. 2003. *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2003 Current Population Survey*. Washington, DC: Employee Benefit Research Institute.
- GAO (U.S. General Accounting Office). 2003. *Child Welfare and Juvenile Justice: Federal Agencies Could Play a Stronger Role in Helping States Reduce the Number of Children Placed Solely to Obtain Mental Health Services*. GAO-03-397. [Online]. Available: <http://www.gao.gov/new.items/d03397.pdf> [accessed October 25, 2004].
- Garfein RS, Vlahov D, Galai N, Doherty MC, Nelson KE. 1996. Viral infections in short-term injection drug users and the prevalence of the hepatitis C, hepatitis B, human immunodeficiency, and human T-lymphotropic viruses. *American Journal of Public Health* 86(5):655–661.
- Gilbody S, Whitty P, Grimshaw J, Thomas R. 2003. Educational and organizational interventions to improve the management of depression in primary care: A systematic review. *JAMA* 289(23):3145–3151.
- Gittel J, Fairfield K, Bierbaum B, Head W, Jackson R, Kelly M, Laskin R, Lipson S, Siliski J, Thornhill T, Zuckerman J. 2000. Impact of relational coordination on quality of care, postoperative pain and functioning, and length of stay. *Medical Care* 38(8):807–819.
- Goff DC, Cather C, Ewins AE, Henderson DC, Freudenreich O, Copeland PM, Bierer M, Duckworth K, Sacks FM. 2005. Medical morbidity and mortality in schizophrenia: Guidelines for psychiatrists. *Journal of Clinical Psychiatry* 66(2):183–194.
- Goldstrom I, Jaiquan F, Henderson M, Male A, Manderscheid R. 2001. The Availability of Mental Health Services to Young People in Juvenile Justice Facilities: A National Survey. In: Manderscheid RW, Henderson MJ, eds. *Mental Health, United States 2000*. (SMA) 01-3537. Washington, DC: U.S. Government Printing Office.
- Graber M, Bergus G, Dawson J, Wood G, Levy B, Levin I. 2000. Effect of a patient's psychiatric history on physicians' estimation of probability of disease. *Journal of General Internal Medicine* 15(3):204–206.
- Grant BF, Stinson FS, Dawson DA, Chou P, Dufour MC, Compton W, Pickering RP, Kaplan K. 2004a. Prevalence and co-occurrence of substance use disorders and independent mood and anxiety disorders: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry* 61(8):807–816.
- Grant BF, Stinson FS, Dawson DA, Chou SP, Ruan WJ, Pickering RP. 2004b. Co-occurrence of 12-month alcohol and drug use disorders and personality disorders in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry* 61(4):361–368.
- Grazier KL, Eselius LL. 1999. Mental health carve-outs: Effects and implications. *Medical Care Research and Review* 56 (Supplement 2):37–59.
- Green AI, Canuso CM, Brenner MJ, Wojcik JD. 2003. Detection and management of comorbidity in patients with schizophrenia. *Psychiatric Clinics of North America* 26(1):115–138.
- Grisso T. 2004. *Double Jeopardy: Adolescent Offenders with Mental Disorders*. Chicago, IL: University of Chicago Press.
- Haney C, Specter D. 2003. Treatment rights in uncertain legal times. In: Ashford JB, Sales BD, Reid WH, eds. *Treating Adult and Juvenile Offenders with Special Needs*. Washington, DC: American Psychological Association. Pp. 51–80.
- Harrison PM, Karberg JC. 2004. *Prison and Jail Inmates at Midyear 2003*. Bureau of Justice Statistics Bulletin, Office of Justice Programs, NCJ 203947. Washington, DC: U.S. Department of Justice. [Online]. Available: <http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim03.pdf> [accessed August 4, 2004].

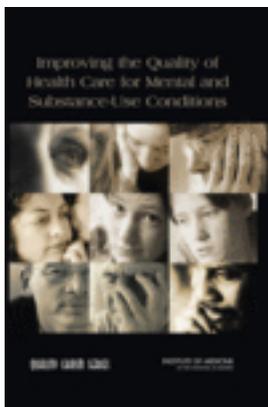
- Harter MC, Conway KP, Merikangas KR. 2003. Associations between anxiety disorders and physical illness. *European Archives of Psychiatry and Clinical Neurosciences* 253(6): 313–320.
- Havassy BE, Alvidrez J, Own KK. 2004. Comparisons of patients with comorbid psychiatric and substance use disorders. Implications for treatment and service delivery. *American Journal of Psychiatry* 161(1):139–145.
- Henningsen P, Zimmerman T, Sattel H. 2003. Medically unexplained physical symptoms, anxiety, and depression: A meta-analytic review. *Psychosomatic Medicine* 65(4):528–533.
- Hogan MF. 1999. Public-sector mental health care: New challenges. *Health Affairs* 18(5): 106–111.
- Hughes TA, Wilson DJ, Beck AJ. 2001. *Trends in State Parole, 1990–2000*. Bureau of Justice Statistics, NCJ 184735. Washington, DC: Department of Justice. [Online]. Available: <http://www.Ojp.USdoj.Gov/Bjs/Pub/Pdf/Tsp00.Pdf> [accessed July 31, 2005].
- Hurlburt MS, Leslie LK, Landsverk J, Barth RP, Burns BJ, Gibbons RD, Slymen DJ, Zhang J. 2004. Contextual predictors of mental health service use among children open to child welfare. *Archives of General Psychiatry* 61(12):1217–1224.
- Hutchinson AB, Foster EM. 2003. The effect of Medicaid managed care on mental health care for children: A review of the literature. *Mental Health Services Research* 5(1): 39–54.
- IOM (Institute of Medicine). 1997. Edmunds M, Frank, R, Hogan M, McCarty D, Robinson-Beale R, Weisner C, eds. *Managing Managed Care—Quality Improvement in Behavioral Health*. Washington, DC: National Academy Press.
- IOM. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press.
- IOM. 2002. Eden J, Smith BM, eds. *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality*. Washington, DC: The National Academies Press.
- IOM. 2003a. Corrigan JM, Adams K, eds. *Priority Areas for National Attention: Transforming Health Care Quality*. Washington, DC: The National Academies Press.
- IOM. 2003b. *Key Capabilities of an Electronic Health Record System*. Washington, DC: The National Academies Press.
- IOM. 2004a. Fostering interdisciplinary collaboration. *Keeping Patients Safe: Transforming the Work Environment of Nurses*. Washington, DC: The National Academies Press. Pp. 212–217.
- IOM. 2004b. Page A, ed. *Keeping Patients Safe: Transforming the Work Environment of Nurses*. Washington, DC: The National Academies Press.
- Jaycox LH, Morral AR, Juvonen J. 2003. Mental health and medical problems and service use among adolescent substance users. *Journal of the American Academy of Child & Adolescent Psychiatry* 42(6):701–719.
- JCAHO (Joint Commission for the Accreditation of Healthcare Organizations). 2004. *Comprehensive Accreditation Manual for Behavioral Health Care 2004–2005*. Oakbrook Terrace, IL: Joint Commission Resources.
- Katon W. 2003. Clinical and health services relationships between major depression, depressive symptoms, and general medical illness. *Biological Psychiatry* 54(3):216–226.
- Katon W, Von Korff M, Lin E, Simon G. 2001. Rethinking practitioner roles in chronic illness: The specialist, primary care physician, and the practice nurse. *General Hospital Psychiatry* 23(3):138–144.
- Kessler RC. 2004. The epidemiology of dual diagnosis. *Biological Psychiatry* 56(10): 730–737.

- Kessler RC, Nelson CB, McGonagle KA, Edlund MJ, Frank, RG, Leaf PJ. 1996. The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry* 66(1):17–31.
- Kessler RC, Costello EJ, Merikangas KR, Ustun TB. 2001. Psychiatric epidemiology: Recent advances and future directions. In: Manderscheid RW, Henderson MJ, eds. *Mental Health, United States, 2000*. DHHS Publication Number: (SMA) 01-3537. Washington, DC: U.S. Government Printing Office. Pp. 29–42.
- Knaus W, Draper E, Wagner D, Zimmerman J. 1986. An evaluation of outcome from intensive care in major medical centers. *Annals of Internal Medicine* 104(3):410–418.
- Kroenke K. 2003. Patients presenting with somatic complaints: Epidemiology, psychiatric comorbidity and management. *International Journal of Methods in Psychiatric Research* 12(1):34–43.
- Kroenke K, Taylor-Vaisey A, Dietrich AJ, Oxman TE. 2000. Interventions to improve provider diagnosis and treatment of mental disorders in primary care: A critical review of the literature. *Psychosomatics* 41(1):39–52.
- Landsverk J. 2005. *Improving the Quality of Mental Health and Substance Use Treatment Services for Children Involved in Child Welfare*. Paper commissioned by the Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders.
- Leslie LK, Hurlburt MS, Landsverk J, Rolls JA, Wood PA, Kelleher KJ. 2003. Comprehensive assessments for children entering foster care: A national perspective. *Pediatrics* 112(1): 134–142.
- Marshall M, Gray A, Lockwood A, Green R. 2004. *Case Management for People with Severe Mental Disorders (Cochrane Review)*. Chichester, UK: John Wiley & Sons. Issue 4.
- Masi D. 2004. *Issues in Delivering Mental Health and Substance Abuse Services through Employee Assistance Programs (EAPs)*. Testimony to the Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders on November 15, 2004. Irvine, California.
- Masi D, Altman L, Benayon C, Healy H, Jorgensen DG, Kennish R, Keary D, Thompson C, Marsden B, McCann B, Watkins G, Williams C. 2004. Employee assistance programs in the year 2002. In: Manderscheid RW, Henderson MJ, eds. *Mental Health, United States, 2002*. DHHS Publication Number: SMA 3938. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Mertens JR, Lu YW, Parthasarathy S, Moore C, Weisner CM. 2003. Medical and psychiatric conditions of alcohol and drug treatment patients in an HMO: Comparison with matched controls. *Archives of Internal Medicine* 163(20):2511–2517.
- Metzner JL. 2002. Class action litigation in correctional psychiatry. *Journal of the American Academy of Psychiatry and the Law* 30(1):19–29.
- Mickus M, Colenda CC, Hogan AJ. 2000. Knowledge of mental health benefits and preferences for type of mental health providers among the general public. *Psychiatric Services* 51(2):199–202.
- Miller AL, Crismon ML, Rush AJ, Chiles J, Kashner TM, Toprac M, Carmody T, Biggs M, Shores-Wilson K, Chiles J, Witte B, Bow-Thomas C, Velligan DI, Trivedi M, Suppes T, Shon S. 2004. The Texas medication algorithm project: Clinical results for schizophrenia. *Schizophrenia Bulletin* 30(3):627–647.
- Miller CL, Druss BG, Dombrowski EA, Rosenheck RA. 2003. Barriers to primary medical care at a community mental health center. *Psychiatric Services* 54(8):1158–1160.
- Moore RD, Keruly JC, Chaisson RE. 2004. Differences in HIV disease progression by injecting drug use in HIV-infected persons in care. *JAIDS Journal of Acquired Immune Deficiency Syndromes* 35(1):46–51.

- NASMHPD, NASADAD (National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors). 2002. Final report of the NASMHPD-NASADAD Task Force on Co-Occurring Mental Health and Substance Use Disorders. *Exemplary Methods of Financing Integrated Service Programs for Persons with Co-Occurring Mental Health and Substance Use Disorders*. Alexandria, VA and Washington, DC: NASMHPD, NASADAD. [Online]. Available: http://www.nasmhpd.org/general_files/publications/NASADAD%20NASMHPD%20PUBS/Exemplary%20methods_3.pdf [accessed August 14, 2005].
- NCQA (National Committee for Quality Assurance). 2004. *Standards and Guidelines for the Accreditation of MBOs*. Washington, DC: NCQA.
- New Freedom Commission on Mental Health. 2003. *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Publication Number SMA-03-3832. Rockville, MD: U.S. Department of Health and Human Services.
- NIAAA (National Institute on Alcohol Abuse and Alcoholism). 2000. *10th Special Report to the U.S. Congress on Alcohol and Health*. [Online]. Available: http://www.niaaa.nih.gov/publications/10_report [accessed May 6, 2005].
- NIAAA. 2002. *Screening for Alcohol Problems: An Update*. Alcohol Alert. 56. [Online]. Available: <http://pubs.niaaa.nih.gov/publications/aa56.htm> [accessed October 13, 2005].
- NIAAA. 2005. *Helping Patients Who Drink Too Much: A Clinician's Guide*. [Online]. Available: http://pubs.niaaa.nih.gov/publications/Practitioner/Clinicians_Guide2005/guide.pdf [accessed October 12, 2005].
- Palepu A, Tyndall M, Yip B, Shaughnessy MV, Hogg RS, Montaner JSG. 2003. Impaired virologic response to highly active antiretroviral therapy associated with ongoing injection drug use. *JAIDS Journal of Acquired Immune Deficiency Syndromes* 32(5):522–526.
- Peele PB, Lave JR, Kelleher KJ. 2002. Exclusions and limitations in children's behavioral health care coverage. *Psychiatric Services* 53(5):591–594.
- Pignone MP, Gaynes BN, Rushton JL, Burchell CM, Orleans TC, Mulrow CD, Lohr KN. 2002. Screening for depression in adults: A summary of the evidence for the U.S. Preventive Services Task Force. *Annals of Internal Medicine* 136(10):765–776.
- Pincus HA. 2003. The future of behavioral health and primary care: Drowning in the mainstream or left on the bank? *Psychosomatics* 44(1):1–11.
- Pincus HA, Hough L, Houtsinger JK, Rollman BL, Frank R. 2003. Emerging models of depression care: Multi-level ('6P') strategies. *International Journal of Methods in Psychiatric Research* 12(1):54–63.
- Rice A. 2000. Interdisciplinary collaboration in health care: Education, practice, and research. *National Academies of Practice Forum: Issues in Interdisciplinary Care* 2(1):59–73.
- Rollman BL, Belnap BH, Reynolds CF, Schulberg HC, Shear MK. 2003. A contemporary protocol to assist primary care physicians in the treatment of panic and generalized anxiety disorders. *General Hospital Psychiatry* 25(2):74–82.
- Rones M, Hoagwood K. 2000. School-based mental health services: A research review. *Clinical Child and Family Psychology Review* 3(4):223–241.
- Rosenberg SD, Goodman LA, Osher FC, Swartz MS, Essock SM, Butterfield MI, Constantine NT, Wolford GL, Salyers MP. 2001. Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness. *American Journal of Public Health* 91(1):31–37.
- Rost K, Smith R, Matthews DB, Guise B. 1994. The deliberate misdiagnosis of major depression in primary care. *Archives of Family Medicine* 3(4):333–337.
- Rush AJ, Crismon ML, Kashner TM, Toprac MG, Carmody TJ, Trivedi MH, Suppes T, Miller AL, Biggs MM, Shores-Wilson K, Witte BP, Shon SP, Rago WV, Altshuler KZ, TMAP Research Group. 2003. Texas Medication Algorithm Project, phase 3 (TMAP-3): Rationale and study design. *Journal of Clinical Psychiatry* 64(4):357–369.

- Saitz R, Mulvey KP, Plough A, Samet JH. 1997. Physician unawareness of serious substance abuse. *American Journal of Drug and Alcohol Abuse* 23(3):343–354.
- Saitz R, Friedman PD, Sullivan LM, Winter MR, Lloyd-Travaglini C, Moskowitz MA, Samet J. 2002. Professional satisfaction experienced when caring for substance-abusing patients: Faculty and resident physician perspectives. *Journal of General Internal Medicine* 17(5):373–376.
- Samet JH, Friedmann P, Saitz R. 2001. Benefits of linking primary medical care and substance abuse services: Patient, provider, and societal perspectives. *Archives of Internal Medicine* 161(1):85–91.
- Samet JH, Horton NJ, Meli S, Freedberg KA, Palepu A. 2004. Alcohol consumption and antiretroviral adherence among HIV-infected persons with alcohol problems. *Alcoholism: Clinical and Experimental Research* 28(4):572–577.
- SAMHSA (Substance Abuse and Mental Health Services Administration). 2004. *Results from the 2003 National Survey on Drug Use and Health: National Findings*. DHHS Publication Number SMA 04-3964. NSDUH Series H-25. Rockville, MD: SAMHSA.
- SAMHSA. 2005. *Transforming Mental Health Care in America. The Federal Action Agenda: First Steps*. [Online]. Available: http://www.samhsa.gov/Federalactionagenda/NFC_TOC.aspx [accessed July 23, 2005].
- SAMHSA. undated. *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders*. [Online]. Available: <http://www.samhsa.gov/reports/congress2002/CoOccurringRpt.pdf> [accessed April 25, 2004].
- Schmitt M. 2001. Collaboration improves the quality of care: Methodological challenges and evidence from U.S. health care research. *Journal of Interprofessional Care* 15(1):47–66.
- Shortell S, Zimmerman J, Rousseau D, Gillies RR, Wagner DP, Draper EA, Knaus WA, Duffy J. 1994. The performance of intensive care units: Does good management make a difference? *Medical Care* 32(5):508–525.
- Shortell SM, Gillies RR, Anderson DA, Erickson KM, Mitchell JB. 2000. *Remaking Health Care in America: The Evolution of Organized Delivery Systems* 2nd ed. San Francisco, CA: Jossey-Bass.
- Sokol J, Messias E, Dickerson FB, Kreyenbuhl J, Brown CH, Goldberg RW, Dixon LB. 2004. Comorbidity of medical illnesses among adults with serious mental illness who are receiving community psychiatric services. *Journal of Nervous and Mental Diseases* 192(6):421–427.
- Spitzer RL, Kroenke K, Williams JBW. 1999. Validation and utility of a self-report version of PRIME-MD: The PHQ Primary Care Study. *Journal of the American Medical Association* 282(18):1737–1744.
- Strosahl KD. 2005. Training behavioral health and primary care providers for integrated care: A core competencies approach. In: O'Donohue WT, Byrd M, Cummings N, Henderson D, eds. *Behavioral Integrative Care: Treatments That Work in the Primary Care Setting*. New York: Brunner-Routledge.
- Sullivan G, Koegel P, Kanouse DE, Cournos F, McKinnon K, Young AS, Bean D. 1999. HIV and people with serious mental illness: The public sector's role in reducing HIV risk and improving care. *Psychiatric Services* 50(5):648–652.
- Teplin L, Abram K, McClelland G, Dulcan M, Mericle A. 2002. Psychiatric disorders in youth in juvenile detention. *Archives of General Psychiatry* 59(12):1133–1143.
- The National Coalition on Health Care, The Institute for Healthcare Improvement. 2002. *Curing the System: Stories of Change in Chronic Illness Care*. [Online]. Available: http://www.improvingchroniccare.org/ACT_Report_May_2002_Curing_The_System_.pdf [accessed July 24, 2005].

- Tyor WR, Middaugh LD. 1999. Do alcohol and cocaine abuse alter the course of HIV-associated dementia complex? *Journal of Leukocyte Biology* 65(4):475–481.
- Unutzer J, Katon W, Williams JW Jr, Callahan CM, Harpole L, Hunkeler EM, HOFFING M, Arian P, Hegel MT, Schoenbaum M, Oishi SM, Langston CA. 2001. Improving primary care for depression in late life. *Medical Care* 39(8):785–799.
- Upshur CC. 2005. Crossing the divide: Primary care and mental health integration. *Administration and Policy in Mental Health* 32(4):341–355.
- Watkins KE, Burnam A, Kung F-Y, Paddock S. 2001. A national survey of care for persons with co-occurring mental and substance use disorders. *Psychiatric Services* 52(8):1062–1068.
- Watkins K, Pincus HA, Tanielian TL, Lloyd J. 2003. Using the chronic care model to improve treatment of alcohol use disorders in primary care settings. *Journal of Studies on Alcohol* 64(2):209–218.
- Weisner C, Mertens J, Parthasarathy S, Moore C, Lu Y. 2001. Integrating primary medical care with addiction treatment: A randomized controlled trial. *Journal of the American Medical Association* 286(14):1715–1723.
- Weist MD, Paternite CE, Adelsheim S. 2005. *School-Based Mental Health Services*. Paper commissioned by the Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. Available from Institute of Medicine.
- Wierson M, Forehand R, Frame C. 1992. Epidemiology and treatment of mental health problems in juvenile delinquents. *Advances in Behavior Research and Therapy* 14: 93–120.
- Williams JW, Pignone M, Ramirez G, Perez SC. 2002. Identifying depression in primary care: A literature synthesis of case-finding instruments. *General Hospital Psychiatry* 24(4): 225–237.
- Wolff NP. 2004. *Law and Disorder: The Case Against Diminished Responsibility*. Paper commissioned by the Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. Center for Mental Health Services & Criminal Justice Research and Edward J. Bloustein School of Planning and Public Policy, Rutgers, the State University of New Jersey. Available from the author.
- Zarski JP, Bohn B, Bastie A, Pawlotsky JM, Baud M, Bost-Bezeaux F, Tran van Nhieu J, Seigneurin JM, Buffet C, Dhumeaux D. 1998. Characteristics of patients with dual infection by hepatitis B and C viruses. *Journal of Hepatology* 28(1):27–33.
- Ziguras SJ, Stuart GW. 2000. A meta-analysis of the effectiveness of mental health case management over 20 years. *Psychiatric Services* 51(11):1410–1421.
- Zwarenstein M, Stephenson B, Johnston L. 2000. Case management: Effects on professional practice and health care outcomes. (Protocol) *The Cochrane Database of Systematic Reviews* 2000, Issue 4. Art. No.: CD002797. DOI: 10.1002/14651858.CD002797.



Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series

Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders

ISBN: 0-309-65460-2, 528 pages, 6 x 9, (2006)

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7

Increasing Workforce Capacity for Quality Improvement

Summary

The health care workforce treating mental and/or substance-use (M/SU) conditions is not equipped uniformly and sufficiently in terms of knowledge and skills, cultural diversity and understanding, geographic distribution, and numbers to provide the access to and quality of M/SU services needed by consumers. This has long been the case and has been persistently resistant to change despite recurring acknowledgments of the problems and repeated recommendations for major improvements to address them.

Although similar to those that afflict the general health care workforce, these problems require special attention in the M/SU workforce not only because of the high prevalence and serious consequences of M/SU problems and illnesses (see Chapter 1), but also because of the great variation in the types of clinicians licensed to diagnose and treat M/SU conditions and substantial variations in their training. In contrast to general health care, in which the diagnosis and treatment of medical conditions are typically provided by physicians, individuals licensed to diagnose and treat M/SU problems and illnesses include a wide range of practitioners—psychologists, psychiatrists, primary care and specialist physicians, social workers, psychiatric nurses, marriage and family therapists, addiction therapists, and a wide variety of counselors (e.g., psychosocial rehabilitation, school, addiction, and pastoral counselors), many of whom are licensed to provide M/SU services in independent

practice. These practitioners are trained apart from each other—in different schools by different faculties, with curriculums encompassing few if any core competencies and little interdisciplinary training. Further, despite the wide variety of theories and therapies that have been developed to deal with M/SU problems and illnesses (see Chapter 4), there are no mechanisms in place to ensure that any given clinician has been adequately educated and trained to offer any specific therapy. Such a process is essential to the provision of safe, effective, and efficient care. The wide variety of provider types and treatments makes it difficult to provide consumers of M/SU health care with information on the competencies of any particular practitioner and to assist them in finding the right clinician for help, a key element of patient-centered care. Variations in state licensing requirements further complicate efforts to reduce inappropriate variations in care.

There is a long history of short-lived and unheeded commissions, expert panels, reports, and recommendations to improve the capacity and quality of the M/SU workforce. Reports dealing with the general health care workforce typically have failed to address the unique issues in M/SU health care. Those that have done so have addressed either mental health or substance use, but not both. Substance use, despite its magnitude and high rate of comorbidity with mental health problems, is often neglected in the professional training of all the major mental health disciplines and the training received by primary health care practitioners as well. Training does not sufficiently emphasize the advances made in evidence-based practice for treatment of mental and substance-use conditions, nor does it include enough content on self-help groups, community systems of support, and social services. Teaching methods across all the schools in which the M/SU disciplines are trained vary substantially as well, reflecting little cognizance of the advances that have been made in evidence-based teaching methods and lifelong learning.

Past recommendations calling for changes in the curriculums and methods for educating and training M/SU practitioners have typically been ignored. As a result, there continues to be a large gap between what is known, what is taught, and therefore what is done in practice. Sustained, multiyear attention and resources have been applied successfully to the education and training of physicians and nurses through the Council on Graduate Medical Education and the National Advisory Council on Nurse Education and Practice. A similar sustained, multiyear strategy, as well as action by institutions of higher education, licensing boards, accrediting

bodies, the federal government, and purchasers, is needed to increase the M/SU workforce's competencies to deliver high-quality care.

CRITICAL ROLE OF THE WORKFORCE AND LIMITATIONS TO ITS EFFECTIVENESS

Previous reports of the Institute of Medicine (IOM) and other authoritative bodies have documented the critical roles played by the health care workforce in the delivery of high-quality health care. *Crossing the Quality Chasm* identifies the health care workforce as the health system's most important resource, and critical to improving the quality of care (IOM, 2001). All of the recommendations of the previous chapters—providing patient-centered, safe, effective, and coordinated care and taking advantages of the opportunities offered by information technology—require a workforce sufficient in numbers, with the necessary competencies, and enabled by the environments in which they practice to deliver care consistent with these competencies. However, the entire health care workforce—including those who provide care for mental and substance-use conditions—faces numerous obstacles to delivering high-quality care. These include a shortage and geographic maldistribution of workers (see Box 7-1), work environments that thwart clinicians' delivery of quality health care (AHRQ, 2003; IOM, 2004b), a lack of ethnic diversity and cultural expertise (IOM, 2004a) (see Box 7-2), outdated education and training content and methods (IOM, 2003), state-to-state variation in scopes of practice and assurance of competency, and concerns about legal liability (IOM, 2001).

Although the M/SU health care workforce faces all of the same problems as the health care workforce overall, building its capacity to deliver higher-quality care for M/SU conditions is particularly problematic because of the greater variety of types of M/SU health care providers and an even greater variation in how they are educated, licensed, and certified/credentialed for practice. While recognizing the importance of such problems as workforce shortages, geographic maldistribution, and insufficient diversity that afflict the M/SU and general health care workforces alike, this chapter focuses on the special problems resulting from the greater diversity of the M/SU health care workforce, their varying education and training, and the difficulties of delivering high-quality patient care in the solo practices that are more typical among those who treat M/SU conditions.

GREATER VARIATION IN THE WORKFORCE TREATING M/SU CONDITIONS

Caregivers who provide care to individuals with M/SU problems and illnesses, like those who care for those with general health care problems

BOX 7-1 Workforce Shortages and Geographic Maldistribution

Shortages and maldistribution of M/SU treatment professionals, as in the general health care workforce, are a major and long-recognized problem. In 1999, the Surgeon General's report on mental health stated: "The supply of well-trained mental health professionals is inadequate in many areas of the country, especially in rural areas. Particularly keen shortages are found in the numbers of mental health professionals serving children and adolescents with serious mental disorders, and older people" (DHHS, 1999:455). Echoing this statement, in 2003 the President's New Freedom Commission on Mental Health reported: "In rural and other geographically remote areas, many people with mental illnesses have inadequate access to care [and] limited availability of skilled care providers. . ." (New Freedom Commission on Mental Health, 2003:51).

Despite recognition of the problem and various attempts to motivate people to work in underserved areas, however, little progress has been made. In the east south central region of the United States (Alabama, Kentucky, Mississippi, and Tennessee), for example, there are 8.2 psychiatrists per 100,000 population, compared with 22.1 per 100,000 in the mid-Atlantic region (New Jersey, New York, and Pennsylvania). Similarly, there are 53.0 psychologists per 100,000 people in New England, compared with 14.4 per 100,000 in the west south central states, such as Arkansas, Oklahoma, and Texas (Duffy et al., 2004). Shortages of clinicians with expertise in caring for certain groups, such as children and adolescents (Koppelman, 2004) and older adults (New Freedom Commission on Mental Health, 2003), also persist nationwide. This variation reflects the historical tendency of highly skilled professionals to locate in urban areas (Morris et al., 2004).

Similar problems in the substance-use treatment workforce have been documented. Low salaries are accompanied by high turnover rates in both managerial and clinical positions (McLellan et al., 2003). This situation can compromise continuity of care for patients and also threatens to leave the field without a leadership infrastructure through which advances in care can be infused. Moreover, the stigma experienced by individuals with substance-use illnesses is sometimes felt by their treatment providers (Kaplan, 2003).

and illnesses, include licensed clinicians; unlicensed, paid providers (both certified and uncertified); volunteers; and the patient's family and informal supports. The roles of patients and their families in care and illness management, as well as those of individuals in recovery who offer peer and recovery support services, are addressed in Chapter 3. In this chapter we focus on the role of the licensed M/SU treatment workforce.¹

¹Although the role of unlicensed and voluntary care providers is substantial and important, the committee focuses here on licensed caregivers because the education and oversight structures for unlicensed voluntary caregivers are less well developed at present. Moreover, the committee believes that a well-trained and -educated licensed and credentialed workforce, through its leadership and modeling of best-care practices such as patient-centered care, can do much to strengthen the knowledge, skills, and abilities of the unlicensed workforce and volunteer supports.

BOX 7-2 Insufficient Workforce Diversity

Like the health care workforce overall (IOM, 2004a), the M/SU workforce does not reflect the increasing ethnic and cultural diversity of the population it serves. At the beginning of the 1900s, only one of every eight Americans identified himself or herself as a race other than “white.” At the end of the century, one of four did so, as the white population grew more slowly than every other racial/ethnic group. Increasing diversity accelerated in the latter half of the century. From 1970 to 2000, the population of races other than “white” or “black” grew considerably, and by 2000 was comparable in size to the black population. The black population represented a slightly smaller share of the total U.S. population in 1970 than in 1900, while the Hispanic population more than doubled from 1980 to 2000. The racial/ethnic composition of the U.S. population according to the 2000 census was as follows: 75.1 percent white, 12.3 percent black, 3.6 percent Asian or Pacific Islander, 0.9 percent American Indian or Alaska Native, 5.5 percent claiming a race other than those already cited, and 2.4 percent claiming two or more races. Individuals (of any race) claiming Hispanic origin constituted 12.5 percent of the U.S. population (Hobbs and Stoops, 2002).

Despite this increasing diversity and decades of concern about the failure of the health care workforce to reflect it, there are still far too few minority M/SU professionals. The 2001 supplement to the Surgeon General’s report on mental health, *Mental Health: Culture, Race, and Ethnicity*, stated: “Racial and ethnic minorities continue to be badly underrepresented, relative to their proportion of the U.S. population, within the core mental health professions—psychiatry, psychology, and social work, counseling, and psychiatric nursing” (DHHS, 2001:167). The President’s New Freedom Commission on Mental Health echoed that observation: “Racial and ethnic minorities are seriously under-represented in the core mental health professions [and] . . . many providers are inadequately prepared to serve culturally diverse populations, and investigators are not trained in research on minority populations” (New Freedom Commission on Mental Health, 2003:50). Similarly, members of the substance-use treatment workforce do not reflect the gender, racial, and ethnic composition of those they treat (Mulvey et al., 2003).

As noted above, clinicians licensed to diagnose and treat M/SU problems and illnesses are uniquely varied. Although the diagnosis and treatment of general health conditions are typically limited to physicians, advanced practice nurses, and physician assistants,² M/SU health care clinicians include psychologists, psychiatrists, other specialty or primary care physicians, social workers, psychiatric nurses, marriage and family therapists, addiction therapists, psychosocial rehabilitation therapists, sociologists, and a variety of counselors with different education and certifications

²Dentists, chiropractors, and podiatrists also are licensed to diagnose and treat, but typically within prescribed domains.

(e.g., school counselors, pastoral counselors, guidance counselors, and drug and alcohol counselors), each with differing education and training.

The effect on clinical practice of this variation in provider types and in the corresponding education and training is unknown; however, variation in the education and training of different types of physicians who deliver care for mental illnesses has been shown to result in variations in the quality of care (Young et al., 2001). Also, although many different therapies have been developed for M/SU problems and illnesses (see Chapter 4), there is no mechanism in place to ensure that any given clinician has been adequately educated and trained to offer any specific therapy. Such a process is essential to the delivery of safe, effective, and efficient care. The wider variety of provider types also has implications for the ability to provide consumers with the information they need to select a clinician to help them—a key element of patient-centered care—as it is difficult to provide consumers with information on the competencies of any individual practitioner and to guarantee a uniform, safe level of abilities across all types of clinicians.

In spite of this, no mechanisms exist for routinely capturing adequate information on the characteristics of the M/SU workforce comparable to, for example, the National Sample Survey of Registered Nurses regularly conducted by the National Advisory Council on Nurse Education and Practice. Moreover, administrative data routinely collected as part of health care claims or billing do not include a code for provider type. Although it may not be necessary to capture this information in general health care, in which the great majority of billing clinicians are physicians, the failure to do so for M/SU services neglects a substantial opportunity to learn about the M/SU workforce and its patterns of care. The Substance Abuse and Mental Health Services Administration (SAMHSA) has organized periodic efforts to collect data on mental health practitioners (see Table 7-1) (Duffy et al., 2004), but the information collected is incomplete, collected inconsistently across professions, and insufficient for policy and workforce analysis. This and the few other available data sources provide only limited information about specialty and general health care clinicians providing M/SU treatment services.

Specialty Mental Health Providers

Specialty mental health providers include psychiatrists, psychologists, and psychiatric nurses possessing formal graduate degrees in mental health. They also include social workers, counselors, nurses, and therapists who either have received additional, specialized training in treating mental problems and illnesses prior to their professional practice, or have chosen to practice in a mental health care setting and gained advanced knowledge in treating mental problems and illnesses through experience (West et al.,

TABLE 7-1 Estimated Number of Clinically Active (CA) or Clinically Trained (CT) Mental Health Personnel and Rate per 100,000 Civilian Population in the United States, by Discipline and Year

Discipline	Number	Rate per 100,000 U.S. Civilian Population	Reporting Year
Counseling	111,931 (CA)	49.4	2002
Psychosocial Rehabilitation	100,000 (CT)	37.7	1996
Social Work	99,341 (CA)	35.3	2002
Psychology	88,491 (CT)	31.1	2002
Marriage and Family Therapy	47,111 (CA)	16.7	2002
Psychiatry ^a	38,436 (CT)	13.7	2001
School Psychology	31,278 (CT)	11.4	2003
Psychiatric Nursing	18,269 (CT)	6.5	2000
Pastoral Counseling	Data not available		

^aBased on clinically active psychiatrists in the private sector; excludes residents and fellows.
 SOURCE: Duffy et al., 2004.

2001). Individuals with more severe mental illnesses are more likely to receive care from specialty mental health providers (Wang et al., 2000). Psychiatrists, for example, are likely to treat individuals with illnesses such as schizophrenia and bipolar disorder (West et al., 2001). SAMHSA’s most recent estimates of the numbers of clinically trained and clinically active³ mental health personnel are shown in Table 7-1.

Specialty Substance-Use Treatment Providers

Data on the specialty substance-use treatment workforce overall are sparse; no database systematically collects such data (Kaplan, 2003). SAMHSA’s 1996–1997 Alcohol and Drug Services study (Phase I) published in 2003 (SAMHSA, 2003) collected data on the credentials of staff working in a national inventory of hospital, residential, and outpatient substance-use treatment facilities and programs (Mulvey et al., 2003). However, subsequent national surveys of substance-use treatment services have not collected data on staff licensure and certification (SAMHSA, 2004), and in studies of the health care workforce overall, “the addiction treatment workforce is generally overlooked” (McCarty, 2002:1). Experts also note the paucity of data on the preparation of this workforce (Morris et al., 2004).

³“Clinically trained” personnel include those who, because of formal training and experience, could provide direct clinical care for mental health conditions, whether or not they do so. “Clinically active” personnel are those actively providing such care.

It is known, however, that the specialty substance-use treatment workforce includes individuals from all of the above mental health professions (IOM, 1997) but is predominantly composed of counselors (McLellan et al., 2003). In 1998 approximately half of the staff delivering substance-use treatment services in about 13,000 outpatient clinics was licensed as substance-abuse counselors. The remainder were about equally composed of unlicensed counselors and “other” professionals who were predominantly master’s-level social workers, mental health counselors, marriage and family therapists, and psychologists with no certification or licensure as substance-use treatment providers; these “other” professionals also included psychiatrists and specialty-certified primary care physicians and nurses (Harwood, 2002). A more recent 2003 survey of 175 directors of inpatient/residential, outpatient, and methadone maintenance programs across the nation also found that apart from counselors, very few professional disciplines were represented among the treatment staff of these programs. With respect to program directors, 15 percent had no college degree; 58 percent had a bachelor’s degree, and 20 percent had a master’s degree. One program was under the direction of a physician (McLellan et al., 2003).

General Medical/Primary Care Providers

M/SU problems and illnesses are also treated by general internists, family medicine physicians, pediatricians, other medical specialists, and advanced practice nurses who have not been certified as mental health or substance-use treatment specialists and are delivering primary or specialty health care in office-based practices, clinics, acute general hospitals, and nursing homes. These providers are often the first point of contact for many adults with mental problems or illnesses. There is also some evidence that they are consumers’ preferred point of first contact for care: the majority of consumers initially turn to their primary care providers for mental health services (Mickus et al., 2000), and use of general medical providers for treatment of M/SU problems and illnesses increased more than 150 percent between 1990–1992 and 2001–2003—a significant shift away from other sectors of care (Kessler et al., 2005). An equal (DHHS, 1999) or greater (Wang et al., 2000) number of adults with M/SU problems and illnesses receive care from general medical providers relative to specialty mental health providers in a given year. Primary care physicians and physician specialists other than psychiatrists also prescribe the majority of psychotropic medications (Pincus et al., 1998). However, there also is evidence that the care provided by general, primary care physicians is less often consistent with clinical practice guidelines than that provided by psychiatrists (Friedmann et al., 2000; Young et al., 2001).

The diversity of professions and disciplines within the M/SU workforce has implications for quality of care. First, it is difficult for consumers to know which type of clinician has the best knowledge and skills to provide them with the safest, most effective, and most efficient care. This might not be a problem if all types of practitioners had a minimum level of competency and the special added competencies of the different types of clinicians were reliably known. This however, is not the case, as discussed in the next section. Professional licensure and ongoing assurance of competencies in specific therapies involve many different bodies. Experts in the education of the M/SU workforce report that prelicensure education is uneven, as are licensure standards and the use of postlicensure competency evaluation mechanisms (Daniels and Walter, 2002; Hoge, 2002; Hoge et al., 2002).

PROBLEMS IN PROFESSIONAL EDUCATION AND TRAINING⁴

Providers in the above multiple disciplines, many of whom are licensed to practice independently, differ in the amounts of education and training they receive prior to professional practice. The content of the education they receive and the places in which they are educated also differ. This section reviews these variations, as well as deficiencies in the professional education of the M/SU workforce overall.

Variation in Amounts and Types of Education

Psychiatry

Eligibility for board certification in psychiatry requires 4 years of college, 4 additional years of medical education leading to a medical degree, followed by a minimum of 4 years of residency training.

Psychology

Although the doctoral degree in psychology is the standard educational path for independent clinical practice, individuals with a master's degree in psychology also can practice under the direction of a doctorally prepared

⁴This section incorporates content from a paper commissioned by the committee on "Workforce Issues in Behavioral Health," by John A. Morris, MSW, Professor of Clinical Neuropsychiatry and Behavioral Science at the University of South Carolina School of Medicine; Eric N. Goplerud, PhD, Research Professor at the School of Public Health and Health Services at George Washington University Medical Center; and Michael A. Hoge, PhD, Professor of Psychology (in Psychiatry) at Yale University School of Medicine.

psychologist, or independently as school psychologists or counselors (American Psychological Association, 2003; Duffy et al., 2004). To become a licensed clinical psychologist, graduates from doctoral programs also must complete supervised postdoctoral training (Olvey and Hogg, 2002). Practicing as a school psychologist requires a minimum of a master's degree, followed by additional training leading toward certification or licensure at the state level or nationally by the National Association of School Psychologists (Morris et al., 2004).

Social Work

Although social workers can practice with a bachelor's, master's, or doctoral degree, the Master of Social Work (MSW) is considered the routine degree for practitioners and is the most common academic requirement for licensure. Obtaining an MSW degree usually requires 2 years of postundergraduate study and field placements/practica (Morris et al., 2004).

Psychiatric Nursing

Individuals may become a registered nurse (RN) through three different educational pathways: a 2-year program leading to an associate's degree (AD) in nursing, a 3-year program (usually hospital-based) leading to a diploma in nursing, or a 4-year college or university program leading to a bachelor's degree in nursing. Those completing all of these programs are eligible to take the RN licensing examination after graduation. Psychiatric nurses may have this basic level of education or a graduate degree. Specialty certification for psychiatric nurses at all levels is provided by the American Nurses Credentialing Center. Psychiatric nurses are certified at both the basic ("C" after RN) and advanced ("CS" or "BC" after RN) levels. The majority of psychiatric nurses are prepared at the basic level of education; advanced-level certification requires that the nurse have either a master's or doctoral degree. Many nurses working in psychiatric settings do not have advanced certification in psychiatric nursing (Morris et al., 2004).

Counseling

The master's degree is the most common practice degree in counseling and enables licensure as a counselor. Accredited graduate programs require a minimum of 72 quarter hours or 48 semester hours of postundergraduate study leading to a master's degree. Doctoral degree programs usually require a minimum of 2 additional years of study (Morris et al., 2004).

Marriage and Family Therapy

Marriage and family therapists are trained in three different ways: master's degree (requiring 2–3 years of postundergraduate training); doctoral program (requiring 3–5 years of postundergraduate training); or a postgraduate clinical training program following training in psychology, psychiatry, social work, nursing, pastoral counseling, or education (Morris et al., 2004).

Pastoral Counseling

Persons credentialed as clinical pastoral counselors are either ordained or otherwise recognized by identified groups of religious faith and have completed a course of study approved by the Association for Clinical Pastoral Counseling. There are only 2,812 certified pastoral counselors nationwide, making them one of the smallest specialty provider groups in mental health (Morris et al., 2004).

Psychosocial Rehabilitation

Psychosocial rehabilitation is an approach to working with individuals with severe mental illnesses to teach them the skills they need to achieve their goals for living in the community. This type of care typically includes some combination of residential services, training in community living skills, socialization services, crisis services, case management, vocational rehabilitation, and other related services. Educational options for psychosocial rehabilitation workers are diverse and range from training following high school to an associate's, bachelor's, master's, or doctoral degree in psychosocial rehabilitation. Recent statistics indicate that 2 percent of these workers have a doctoral degree, 24 percent a master's degree, 13 percent some college or an associate's degree, and 22 percent a high school diploma (Duffy et al., 2004).

Substance-Use Treatment Counseling

As described above, most of the substance-use treatment workforce consists of counselors. The composition of this workforce is shifting from those whose expertise is experience-based (from their personal experience with substance-use problems or illnesses and recovery) to those with more formal education at the graduate level (McCarty, 2002). However, a representative survey of all state-recognized substance-use treatment programs found that 26 percent of counselors did not have a bachelor's degree, 32 percent possessed a bachelor's degree only, and 42 percent possessed a

master's degree (none possessed a doctoral degree). And 39 percent of these counselors were clinically supervised by individuals who themselves lacked a graduate degree. This survey did not distinguish between counselors with and without a license/certification (Mulvey et al., 2003). A 1998 survey of staff delivering substance-use treatment services in approximately 13,000 outpatient clinics nationally found that 54 percent of unlicensed counselors had fewer than 4 years of college; in contrast, a master's degree was possessed by 56 percent of licensed counselors and 82 percent of "other behavioral health professionals" (Harwood, 2002). This higher level of formal education may not necessarily provide greater knowledge and expertise in providing effective care, however. Graduate programs in social work and psychology, for example, often do not provide specialized training in treatment of alcohol- and other drug-use problems and illnesses (Straussner and Senreich, 2002) and have a number of other limitations.

Deficiencies in Professional Education

The education of all health professionals is deficient in a number of areas and has not kept pace with advances in knowledge and changes in the delivery of health care (IOM, 2001, 2003), despite an IOM call that:

All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics (IOM, 2003:3).

Leaders in the education of clinicians to treat M/SU conditions testify that the educational preparation of this workforce does not address many of these areas adequately. For example, not all M/SU clinicians are educated about evidence-based care or receive training in the use of evidence-based clinical practice guidelines (Manderscheid et al., 2001). Without education in the use of such guidelines, these clinicians may be more committed to schools of practice than to providing the best therapy for a given patient (Jackim, 2003). The varying education of the different provider types discussed above results in differences in clinicians' theoretical orientations and therapeutic approaches, as well as in the professional journals they read and the professional organizations to which they belong. The result is little cross-fertilization of knowledge and skills across provider types, and few common standards of care and agreed-upon core competencies that transcend the borders of the separate schools of thought in which M/SU health care clinicians are trained.

Experts in the education of M/SU clinicians also report that graduate education is inadequately grounded in the scientific evidence base for treat-

ments and that some professional education and training programs have been reluctant to incorporate clinical practice guidelines in traditional classroom content as well as clinical education placements (Hoge et al., 2002). Moreover, quality improvement strategies have received little attention in M/SU education (Morris et al., 2004). Similarly, despite the need for interprofessional collaboration described in Chapter 5, graduate training in M/SU health care continues to be conducted in single-discipline silos with little interdisciplinary coordination. Multispecialty training, such as that involving both mental health and primary care providers, also remains infrequent (Hoge et al., 2002).

Further, available information shows that there is no agreed-upon level of competency within any profession (or across professions) with respect to providing M/SU health care. Graduate training has not kept pace with changes in health care delivery, and the achievement of expected educational outcomes has not been demonstrated (Hoge et al., 2002). Recent changes in the licensing examination for nurses have decreased the content devoted to psychosocial issues, which some fear will encourage nursing schools to weaken mental health content in their curriculums (Poster, 2004). There also is strong evidence that education of all clinicians inadequately addresses substance-use problems and illnesses despite their high rates of co-occurrence with mental problems and illnesses.

Little Assurance of Competencies in Discipline-Specific and Core Knowledge

A primary concern regarding M/SU clinicians' education and training is the general absence of clearly specified competencies that students are to develop and a process for routinely assessing whether those competencies have actually been achieved. Leaders in the education of M/SU health care clinicians cite a historical reluctance in some professional education and training programs to require students to demonstrate competence in specific treatments, and note that general M/SU graduate education does not guarantee competence in advanced or specialized skills. As a result, it is recommended that training programs specify the minimum competencies expected of their graduates and verify that these competencies have been achieved (Hoge et al., 2002).

Multiple organizations are in various (mainly early) stages of developing discipline-specific, population-specific, or subject matter-specific competencies for clinicians providing health care for mental or substance-use conditions. However, these competencies have not yet been adopted as standards of professional practice, and together represent a not-yet-finished "patchwork quilt" of competencies. Moreover, still less attention has been directed to developing and implementing strategies for assessing the extent

to which students and current members of the workforce possess or practice these competencies (Hoge et al., 2005a).

Leaders in M/SU education and clinical care also have called for certain knowledge, skills, and attitudes (i.e., core competencies) to be addressed by the education of *all* clinicians providing M/SU health care. Such competencies include, for example, detecting co-occurring mental and substance-use problems and illnesses, and avoiding the stigmatizing attitudes and practices of health care providers that obstruct patients' self-management of their illness and recovery, as described in Chapter 3. Several initiatives have been undertaken to develop and implement core competencies, including two for those treating substance use and one for those treating mental conditions. But these initiatives (described below) have not yet fully taken hold.

Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice In 1995, the National Curriculum Committee of the Addiction Technology Transfer Center program, a nationwide training system supported by SAMHSA's Center for Substance Abuse Treatment (CSAT), reached agreement on core competencies for addiction counseling across professional groups that may treat people with substance-use problems and illnesses. The resulting document, *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice*, identifies the basic knowledge and attitudes required for all disciplines in the addiction field, as well as those necessary for the professional practice of addiction counseling (clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities, each with its own set of competencies). The goal is for every addiction counselor and every specialty treatment facility to possess every competency, regardless of setting or treatment model (Addiction Technology Transfer Centers National Curriculum Committee, 1998; Hoge et al., 2005a).

Interdisciplinary Project to Improve Health Professional Education in Substance Abuse This 5-year cooperative project of the Health Resources and Services Administration (HRSA), the Association for Medical Education and Research in Substance Abuse (AMERSA), and CSAT produced (1) a strategic plan for interdisciplinary faculty development to prepare the general health professions workforce to provide care for substance-use problems and illnesses, (2) an interdisciplinary faculty development program to improve the educational curriculums for general health care professionals, and (3) an infrastructure to support faculty development in substance-use treatment. The initiative also produced a set of core and discipline-specific knowledge, attitudes, and competencies needed by health professionals to

effectively identify, intervene with, and refer patients with substance-use problems and illnesses (Haack and Adger, 2002). Transmission of this set of knowledge, attitudes, and competencies to the workforce was initiated by the Multi-Agency INitiative on Substance abuse TRaining and Education for AMerica (Project MAINSTREAM), which provided trainers to train interdisciplinary faculty (Samet et al., 2006). The students trained by these faculty enter the workforce with the knowledge and skills needed to provide care for individuals and communities dealing with substance-use problems and illnesses.

Annapolis Coalition on Behavioral Health Workforce Education The Annapolis Coalition on Behavioral Health Workforce Education (Annapolis Coalition) grew out of a 2001 conference convened by the American College of Mental Health Administration and the Academic Behavioral Health Consortium, with funding from SAMHSA and the Agency for Healthcare Research and Quality (AHRQ). The Annapolis Coalition distilled recommendations from a substantial number of peer-reviewed publications addressing the need for training reform in the M/SU treatment field and subjected those recommendations to further vetting by experts in the field by preparing and distributing for comment of a series of review papers (Daniels and Walter, 2002; Hoge et al., 2002), as well as discussing the recommendations at a national summit of experts on workforce development (Hoge and Morris, 2002). The result was a series of 10 recommended best practices for improving the quality and relevance of workforce education (Hoge et al., 2005a).

Paucity of Content on Substance-Use Care

Despite the frequency of co-occurrence of general medical, mental, and substance-use problems and illnesses, many providers in each of these areas receive little or no education in the others and their effects on the presenting condition. According to the congressionally mandated study of the prevention and treatment of co-occurring substance-use and mental conditions (SAMHSA, undated:15), “Perhaps one of the most significant program-level barriers, noted by consumers and family members as well as by providers. . . is the lack of staff trained in treating co-occurring disorders.” The limited content of substance-use education in most health professions is evidence of this.

Physician education Medical students can be educated about substance-use problems and illnesses in a variety of settings. During the first 2 years of medical school, however, the subject is often integrated into standard coursework; and separate courses on addiction medicine are rarely taught.

During the final 2 years of medical school, students also may have some experience with substance-use health care during required or elective clinical rotations in internal medicine, family medicine, neurology, or psychiatry. Overall, however, dedicated training in substance-use problems and illnesses is rarely offered in medical schools. A 1998–1999 survey of the Liaison Committee on Medical Education found that of the 125 accredited U.S. medical schools, 95 percent provided training in substance-use health care as part of a larger required course, 8 percent had a separate required course, and 36 percent offered an elective course (Haack and Adger, 2002). This current level of exposure of medical students to substance-use health care issues has not given recent medical school graduates the confidence to screen, assess, or provide needed interventions for these patients (Miller et al., 2001; Saitz et al., 2002; Vastag, 2003).

With respect to residency training, a 1997 national survey of residency program directors found that the percentage of programs with required training in care for substance-use problems and illnesses ranged from 32 percent in pediatrics to 95 percent in psychiatry, with an average of 56 percent across all emergency medicine, family medicine, internal medicine, obstetrics/gynecology, osteopathic medicine, pediatrics, and psychiatry residency programs. However, the survey found that even when there was required curriculum content in substance-use health care, the median number of curriculum hours dedicated to the subject varied greatly, ranging from 3 (emergency medicine and obstetrics/gynecology) to 12 (family medicine). Psychiatry residency programs reported an average of 8 hours devoted to substance-use health care in their curriculums (Isaacson et al., 2000). Even in preventive medicine residency training, most of the alcohol-, tobacco-, and other drug-use training focuses solely on tobacco (Abrams Weintraub et al., 2003).

Psychologist education Psychologists typically receive very little training in or preparation for dealing with substance-use problems and illnesses. Results of a 1994 survey indicated that although 91 percent of psychologists encountered substance-use problems or illnesses in their daily work, 74 percent had received no formal undergraduate or graduate coursework in the subject, and slightly more than half (54 percent) had received no training in substance-use conditions during their internships. Although few had received such training as part of their formal education, 86 percent subsequently acquired training in substance-use conditions through workshops, supervision, and other sources (Aanavai et al., 1999).

Social work education The Interdisciplinary Project to Improve Health Professional Education in Substance Abuse found that most schools of social work failed to provide students with a basic knowledge of alcohol-

and drug-use issues. Moreover, when graduate schools of social work offered a concentration or elective courses in the treatment of alcohol- and drug-use problems and illnesses, most students did not take these courses, and only a few schools of social work offered postgraduate training programs covering services for substance use. A significant factor contributing to this is that the Council on Social Work Education, the national policy-making body for social work education, does not mandate that curriculums contain substance-use content (Straussner and Senreich, 2002).

Nursing education Data on the amount of education in substance-use health care provided to nurses use are highly limited. The report of the Interdisciplinary Project to Improve Health Professional Education in Substance Abuse (Naegle, 2002) includes only information from two surveys conducted in 1987. The first found that undergraduate nursing curriculums typically offered 1–5 hours of instruction in substance-use problems and illnesses over 2–4 years of study, usually combined with other course content, and focused primarily on definitions and descriptions of the phenomena surrounding substance use and their health consequences. The second study likewise found little content on substance-use problems and illnesses incorporated into psychiatric nursing programs. A systematic review of studies of chemical dependency training within schools of nursing, covering the period 1966–1996, also found only a small number of studies, which frequently were methodologically flawed. Despite these shortcomings, the investigators concluded from the available data that schools of nursing generally provided minimal exposure to important concepts related to alcohol and drug dependence. Few classroom hours were dedicated to alcohol and drug issues, and individual courses devoted to substance-use problems and illnesses were rare. Clinical training also was neglected. “Neither the scope nor intensity of clinical instruction was sufficient to ensure that graduating nurses could effectively intervene with chemically dependent patients” (Howard et al., 1997:54).

Counselor education Even among substance-use treatment counselors, the duration and content of preprofessional training received by certified substance-use counselors varies widely. A large proportion of alcohol and other drug treatment counselors report receiving their counseling education through associate’s degree and certificate programs at 2-year community colleges. Little information exists on the quality of these programs, or on programs offering higher levels of education. These programs typically operate with little or no external review and accreditation (McCarty, 2002). However, a 2000–2001 review of undergraduate programs based on published catalogues and Internet sites found 260 programs listed on the website of the National Association of Alcohol and Drug Abuse Counselors

(NAADAC) as offering formal education in preparation for working as a substance-use treatment practitioner. Approximately 55 percent of these programs were at the community college or 2-year level, 13 percent at the bachelor's degree level, and 32 percent at the graduate level. Undergraduate programs varied in their titles, the types of degrees awarded, the numbers of credits and courses required for a degree, and in whether program graduates are prepared to function as counselors and be certified by states (Edmundson, 2002).

Inadequate Faculty Development

Training health professionals to provide them with the knowledge and skills needed to treat M/SU problems and illnesses requires not just strong curriculum content, but also high-quality faculty to present that curriculum who are well trained and knowledgeable about current effective M/SU therapies, contemporary practice, and interdisciplinary care (Haack and Adger, 2002; Hoge et al., 2002). Yet past deficiencies in the education of those serving in faculty positions, particularly generalist clinicians (e.g., physicians, nurses), have resulted in insufficient numbers of qualified generalist faculty to teach about M/SU health care issues even when curriculums concerning these issues exist.

The Career Teachers Program (1972–1982), sponsored by the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse, was one of the first multidisciplinary faculty development programs in substance use health care for health professionals (Galanter, 1980). Over the course of this program's existence, 59 career teachers (faculty in medical and public health schools) were challenged to enhance substance-use treatment education within their own professional schools. This program was followed by faculty development programs sponsored by federal agencies for medical, nursing, social work, public health, and psychology faculty. Projects associated with these programs enriched the curriculums of their respective schools and demonstrated that training providers, either community clinicians or emergency medicine residents, could increase the extent to which they addressed patients' unhealthy alcohol use (D'Onofrio et al., 2002; Saitz et al., 2000). The continuing need for faculty training programs is evident in the ongoing faculty development efforts of the Association for Medical Education and Research in Substance Abuse (Samet et al., 2006).

Summary

The above discussion illustrates that even when well-developed sets of competencies (such as those of the Interdisciplinary Project to Improve

Health Professional Education in Substance Abuse) exist, they often are not incorporated into education programs. Licensing and credentialing are two mechanisms used to assure the public that health care professionals are competent to deliver services once they have completed their preprofessional education. However, many of the core and discipline-, subject matter-, or population-specific professional competencies discussed above have not been adopted or incorporated into training programs, licensing standards, or certification requirements. Until this happens, the promulgation of competencies is likely to have limited impact (Hoge et al., 2005a). The variation in competencies resulting from differences in preprofessional education is compounded by state-to-state variation in licensing and credentialing, discussed next.

VARIATION IN LICENSURE AND CREDENTIALING REQUIREMENTS

Licensing standards for the health professions are set by the states and typically specify minimum standards for competency. In addition, the different health professional associations, such as NAADAC—the Association for Addiction Professionals, and the American Nurses Association, frequently establish independent certification or credentialing processes that formally recognize an individual's knowledge or competency in a specialized area. The latter standards often go beyond the requirements for state licensure, although there is some overlap as some states mandate credentialing as a part of licensure for certain professions (IOM, 2003).

Taking psychologists as an example, all but four states require a doctoral degree to practice clinical psychology independently; Alaska, Oregon, Vermont, and West Virginia also license master's-level clinicians to practice independently. All states except California and Pennsylvania require degrees to be from schools accredited by regional accrediting bodies; the two exceptions accept degrees recognized by state law. Mississippi and Oklahoma require the degrees to be from programs accredited by the American Psychological Association. All states further require supervised experience prior to independent practice, but the number of hours required varies. Most states require 1,500–2,000 postdoctoral hours, but Delaware requires 3,000 and Michigan and Washington 4,000 (Olvey and Hogg, 2002). Moreover, there are variations in how individuals with a master's degree in psychology can practice across states. Twenty-six states and the District of Columbia do not license master's-level psychologists to practice independently. In the other states, licensed master's-level psychologists are variably restricted in their scope of practice and amount of required supervision. Titles used in the states for these licensed and master's-prepared clinicians also vary; they include

psychological associate, psychological technician, psychological assistant, registered psychological assistant, licensed master's-level psychologist, certified psychological associate, psychological examiner, licensed psychological practitioner, psychologist associate, and others. The amount of supervision required varies from none to supervision of all practice activity. Requirements for supervised experience pre- and postlicensure also vary (Association of State and Provincial Psychology Boards, 2000).

Considerable variation exists as well in the certification of specializations provided by professional associations. Only a few state certification boards, for example, use SAMHSA's addiction counseling competencies as the basis for their education and training requirements (Hoge et al., 2005a). Although a number of states (e.g., New York, New Mexico, Arizona) are moving toward the establishment of a required basic level of competency for M/SU treatment providers who are offering integrated services, there remain no uniform standards of competency across states.

The above variations in licensure standards and credentialing processes contribute to the varying capacity of the M/SU workforce to deliver high-quality health care.

INADEQUATE CONTINUING EDUCATION

Beyond the variations in education, licensing, and credentialing discussed above, the rapidly expanding evidence base and broad range of specialized populations and treatment settings make it unlikely that all clinicians (especially those newly licensed) will come to their place of employment possessing the knowledge and skills needed to practice at a high level of expertise (Hoge et al., 2002). Prelicensure or preemployment education cannot provide sufficient frequency and diversity of experience (and sometimes offer no experience) in the performance of every therapeutic intervention appropriate for every clinical condition seen in patients, especially as the breadth of knowledge and technology expands. Practitioners, therefore, come to their initial place of employment as novices without certain skills and knowledge—their limited skill and expertise reflecting the limitations of time and experience in their academic education and the sheer number of effective therapies. Moreover, it is obviously impossible for prelicensure education to teach students about diagnostic and therapeutic advances not yet invented (IOM, 2004b). Many of the health professions are thus grappling with the need to ensure the continuing competency of licensed health professionals (IOM, 2003). Like professional practice education, however, continuing education for health professionals has been found lacking in content, methods, financing, and organizational support.

Content

Continuing education focuses on refining existing and developing new skills, as well as mastering changes in the knowledge base and treatment approaches. Unlike preservice education, which is organized around a formal curriculum, continuing education is commonly self-directed by the practitioner, who selects areas of interest to pursue (Daniels and Walter, 2002).

Few standards or guidelines govern the continuing education content that providers choose to study. Continuing education requirements are set principally by licensing and certification bodies, many of which are controlled by the states. These requirements are generally nonspecific, outlining only the number of hours of continuing education that must be completed during a specified number of years in order to maintain licensure or certification. While some states and disciplines mandate continuing education in specific content areas, such as professional ethics (Daniels and Walter, 2002), “the general absence of standards or guidelines regarding content raises concern that many practitioners may never become educated about critical, emerging issues in the field, such as patient safety” (Morris et al., 2004:18), illness self-management (see Chapter 3), or the Chronic Care Model (see Chapter 5).

A 2001 survey of the continuing education requirements for M/SU disciplines set by the states for licensure renewal found a striking lack of consistency in the requirements for a given professional discipline across states, as well as in the requirements for different mental health disciplines within states. The requirements for psychologists, for example, range from zero hours of continuing education (11 states), to 12 hours per year (Alabama), to 50 hours per year (Kansas) (Daniels and Walter, 2002).

Methods

As usually provided (i.e., in single-session events such as conferences, lectures, workshops, and dissemination of written materials), continuing education has been found to have little effect in changing clinical practice (Davis et al., 1999). Teaching adult learners clearly requires different approaches; moreover, research has shown that not everyone learns the same way. While many individuals learn well through reading, for example, others learn better through approaches that allow them to use their motor skills. Clinicians also can benefit from being taught individually, rather than in a group, at a pace suited to their particular learning style (Lazear, 1991). Empirical support exists as well for education strategies such as interactive sessions (role playing, discussion groups, and experiential problem solving); academic detailing, in which trained experts meet with providers in their practice setting; audit and feedback (Morris et al., 2004); use

of information technology (IT) (IOM, 2003); and learning through decision support at the point of care delivery.

The IOM's report on health professions education (IOM, 2003) identifies utilizing information technology to communicate, manage knowledge, mitigate error, and support decision making as a core competency that should be possessed by all health professionals. Proficiency in using IT can also be an effective vehicle for continuing education. CD-ROM-based and text-based programs can be used to provide individualized learning during times when the clinician is not involved in direct patient care. Online learning also presents new opportunities for continuing education, and many state licensing boards accept completion of online courses as satisfying at least part of the continuing education requirements for license renewal (Flanagan and Needham, 2003).

Learning can take place as well through clinical decision-support software that integrates information on individual patients with a computerized knowledge base to generate patient-specific assessments or recommendations, thereby helping clinicians or patients make clinical decisions. In general health care, clinical decision-support systems assist clinicians in applying new information to patient care through the analysis of patient-specific clinical variables. These systems vary in complexity, function, and application; some but not all are computer based. According to AHRQ's evidence-based report *Making Health Care Safer: A Critical Analysis of Patient Safety Practices*, the preponderance of evidence suggests that these systems are at least somewhat effective, especially with respect to the prevention of medical errors (Trowbridge and Weingarten, 2001). Although such software is common in general health care, however, it is not highly developed or widely available in M/SU health care (Morris et al., 2004). Other decision supports (some "low tech") include using memory/cognition aids, such as protocols and checklists, and clinical pathways.

Financing

The financing of continuing education for M/SU practitioners has been identified as a critical issue (Daniels and Walter, 2002). Pharmaceutical companies have been a major source of funding for continuing education in M/SU health care, but that support is being curtailed. Provider organizations, which historically have financed a large share of the continuing education for their employees, also have substantially scaled back their training departments, staff, and programs, as well as travel support for continuing education conferences, as a result of severe budgetary pressures (IOM, 2004b; Morris et al., 2004).

The IOM report *Keeping Patients Safe: Transforming the Work Environment of Nurses* shows that the issue of continuing worker education

and training is not unique to the health care industry. In many industries, the ongoing acquisition and management of knowledge by employees is increasingly recognized as an essential responsibility of the employing organization. Organizations need to play an active role in managing their learning process and transferring knowledge quickly and efficiently to their employees. This organizational role is critical to supporting the continuing growth of clinicians' knowledge and skills (IOM, 2004b).

In general health care, for example, hospitals with high retention of nurses in the face of nursing shortages ("magnet hospitals") are characterized by the provision of high levels of postemployment training and education of nursing staff, beginning with orientation and lasting several weeks to months (McClure et al., 2002). Developing and managing human skills and intellect—more than managing physical and capital assets—is increasingly recognized as a dominant concern of managers in successful companies (Quinn, 1992). Given the career-long need for clinicians to maintain competency through the acquisition of new knowledge and skills and the essential role of health care organizations in helping to meet this need, *Keeping Patients Safe* recommends that all health care organizations routinely dedicate a defined portion of budgetary resources to support for staff in their ongoing acquisition and maintenance of knowledge and skills (IOM, 2004b).

Organizational Support

Extensive research has demonstrated that an individual's possession of required competencies by itself is not sufficient for safe and effective performance in the workplace (IOM, 2004b). When the organization in which an individual works does not support and reward competency, the worker is not likely to display competency on an ongoing basis (Hoge et al., 2005b; IOM, 2004b). In patient care, what matters is the clinician's *performance*, rather than the *possession* of necessary competencies. In the performance of clinical competencies, organizational characteristics are equally or more influential than individual education, training, and other characteristics (IOM, 2004b). Advances in education for M/SU clinicians therefore need to be coupled with efforts to help the organizations in which they work provide the culture and other practice supports that allow and promote competent performance (Hoge et al., 2005b).

In addition to the many problems discussed above, M/SU clinicians' ability to provide high-quality care is compromised by their frequent isolation from their peers and colleagues from other disciplines as a result of working in individual, or solo, practices (discussed next). Solo practice does not facilitate building the infrastructure needed to take up new knowledge and store, collect, and share the clinical information required to deliver high-quality collaborative patient care.

TABLE 7-2 Percentage of Clinically Trained Specialty Mental Health Personnel Reporting Individual Practice as Their Primary or Secondary Place of Employment

Discipline	Primary Employment	Secondary Employment	Reporting Year
Psychiatry	37.0	18.0	1998
Psychology	38.0	28.0	2002
Social work	18.5	27.1	2000
Counseling	15.1	21.6	2002
Marriage/family therapy	34.9	28.5	2000

SOURCE: Duffy et al., 2004.

MORE SOLO PRACTICE

Many mental health clinicians report that individual practice is either their primary or secondary⁵ employment setting (Duffy et al., 2004) (see Table 7-2).

Solo practice may impede the uptake of evidence-based practices and other changes needed in treatment settings. For example, as discussed in Chapter 6, the size of health care organizations has been shown to be related to the uptake of IT. Use of electronic health records (EHRs), for instance, is typically found in larger health care organizations (Brailer and Terasawa, 2003), and the size of a practice has been found to be the main determinant of IT adoption for five clinical functions—obtaining treatment guidelines, exchanging clinical data with other physicians, accessing patient notes, generating treatment reminders for physicians, and writing prescriptions. Indeed, physicians in solo or two-person practices are more than three times likelier to have limited IT support for patient care compared with large group practices of more than 50 physicians (Reed and Grossman, 2004). Observations from experts in the use of information systems by managed behavioral health care organizations support this conclusion.

With respect to administrative (as opposed to clinical) IT applications, smaller M/SU providers lag behind in the use of electronic claims submission (Trabin and Maloney, 2003). Likewise, a random sample of 175 directors of inpatient/residential, outpatient, and methadone maintenance pro-

⁵Many mental health practitioners work in multiple settings. For example, 60 percent of full-time psychiatrists reported working in two or more settings in 1998, as did 50 percent of psychologists, 20 percent of full-time counselors, and 29 percent of marriage/family therapists in 2002. Rates were higher for part-time counselors (Duffy et al., 2004).

grams across the nation found that approximately 20 percent of the programs had no information systems of any type, e-mail, or even voice mail for their phone system. In contrast, most of those that were part of larger hospital or health systems had access to well-developed clinical information systems, e-mail, and Internet services (McLellan and Meyers, 2004). Most public and private substance-use treatment programs are outside the purview of medical facilities where such technology might be more available. To the extent that other M/SU clinicians also provide care in solo or small group practices, low adoption of IT to support clinical care may also be present. Differences in IT uptake are theorized to reflect differences in provider size: larger groups and health maintenance organizations (HMOs) have readier access to capital and administrative support staff and the ability to spread acquisition and implementation costs among more providers (Reed and Grossman, 2004).

Knowledge uptake and application require other resources for timely identification of scientific advances and innovations. For example, as described in Chapter 4, SAMHSA's National Registry of Evidence-based Programs and Practices contains such information, but if no one in the care delivery organization has the time or responsibility to review this registry of effective practices and provide the information to the organization, improvements in care delivery are less likely to occur. Large organizations may have more capital resources and greater ability to create mechanisms for carrying out such activities; solo or smaller practices may need to band together to achieve the economies of scale required for this purpose (Berwick, 2003). In a study of the adoption of clinical practice guidelines for treatment of attention deficit hyperactivity disorder (ADHD), for example, having a solo practice was found to be associated with a reduced likelihood of adopting the practice guidelines (Rushton et al., 2004).

Evidence shows that an organization will assimilate innovations more readily if it is large, mature, functionally differentiated (i.e., divided into semiautonomous departments and units), and specialized, with foci of professional knowledge; if it has flexible resources to channel into new projects; and if it has decentralized decision-making structures. Size is almost certainly a proxy for these characteristics (Greenhalgh et al., 2004).

USE OF THE INTERNET AND OTHER COMMUNICATION TECHNOLOGIES FOR SERVICE DELIVERY

In addition to the telephone, communication technologies such as video conferencing and the Internet are increasingly being used to evaluate, diagnose, and provide M/SU services to people who lack face-to-face access to such services (Benderly, 2005) or prefer these other approaches. At a mini-

mum, advances in use of Internet-mediated and other communication technologies require research on their effectiveness, specialized training of clinicians in their use, additional protection of consumer information, and mechanisms for ensuring the competencies of those who provide such forms of care.

Like consumers of general health care services (Baker et al., 2003), many consumers of M/SU health care are already turning to the Internet to obtain information and support from peers to help them manage their M/SU problems and illnesses (Lamberg, 2003). Indeed, the Internet may be especially useful to consumers of M/SU health care as a source of clinical treatment. As some assert, “while face-to-face contact with patients is certainly desirable, the primary medium of treatment, psychotherapy, requires no direct physical contact; many assessment and treatment services could potentially be delivered, at least in part, over the Internet” (Flanagan and Needham, 2003:312).

However, use of the Internet to deliver M/SU health care carries several risks. One is the issue of the privacy and confidentiality of information transmitted by patients over the Internet—information that, when transmitted face to face and incorporated into the patient’s health record, is subject to greater privacy protections than exist for general health care (see Chapter 5 and Appendix B). Other concerns relate to questions about the safety and effectiveness of Internet-based therapy compared with traditional face-to-face therapy, especially since the practitioner is unable to observe the physical behaviors of the patient, which can inform experienced clinicians. Moreover, practitioners providing face-to-face care must be licensed by the state in which they practice—typically the same state in which the patient resides. If a counselor in California delivers care to an individual in Mississippi over the Internet, how is such a provider to be credentialed—by the state in which he or she resides, in which the patient resides, or both? The Internet makes delivery of services by a single practitioner to individuals in all 50 states feasible. Should licensing be required in all 50 states (Copeland and Martin, 2004; Flanagan and Needham, 2003)? At present, “consumers are able to find licensed, and for that matter unlicensed, professionals offering therapy. . .online” (Flanagan and Needham, 2003:313).

Despite these issues, there is no question that the communication technology exists to provide M/SU care and that people are willing to use it. For the Internet, as for the telephone and video conferencing, providing care that is clinically appropriate, therapeutically productive, and socially supportive requires that practitioners address issues of the technological parameters of electronic service delivery, requisite systems for credentialing and credential verification, and the appropriate balance between face-to-face and electronic communications.

LONG HISTORY OF WELL-INTENTIONED BUT SHORT-LIVED WORKFORCE INITIATIVES

Most of the issues discussed above are not new; they have been acknowledged for many years—some for decades. They have also been the subject of many short-lived, ad hoc initiatives that overall have failed to provide the sustained leadership, attention, resources, and collaboration necessary to resolve them. A chronology of these efforts is provided below. In the next section, the committee calls for a sustained, multiyear, collaborative initiative to address these issues, modeled after those created for the physician and nursing workforces.

1956. The American Psychiatric Association Committee on Medical Education proposes a curriculum for teaching psychiatry in medical schools and recommends that physician training develop “well-rounded physicians, who, in their relationships with all patients, recognize the importance of unconscious motivation, the role of emotional maladjustment in the ideology and chronicity of illness, the emotional and personality problems engendered by various illnesses; and who habitually see the patient in his family and general environmental setting” (APA Committee on Medical Education, 1956:128). The committee also recommends that during the first 2 years, all medical students be exposed to themes of personality growth, development, structure, and integration; adaptive needs; social and cultural forces affecting personality and behavior; the role of language and mentation; the role played by emotions and physiological functioning; and psychopathology.

1961. In the final report of the Joint Commission on Mental Illness and Health, titled *Action for Mental Health*, the commission makes the following recommendation: “Child specialists offer a considerable potential for helping emotionally disturbed children, but in many cases lack sufficient psychiatric orientation to capitalize on this potential. The National Institute of Mental Health should provide support for resident training programs in pediatrics that make well-designed efforts to incorporate adequate psychiatric information as a part of the pediatrician’s graduate training. It should also provide stipends for pediatricians who wish to take post-graduate courses in psychiatry. The aim is not to convert pediatricians into psychiatrists, but to increase the mental patient care resources of the community in which the pediatrician practices” (Joint Commission on Mental Illness and Health, 1961:*xiii*).

1972. The National Association of Alcohol and Drug Abuse Counselors is founded, in part to begin a national credentialing/certification program for addiction counselors (NAADAC, 2005).

1972–1982. The Career Teachers Program is sponsored by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the Na-

tional Institute on Drug Abuse (NIDA) as one of the first multidisciplinary health professional faculty development programs in substance-use education (Galanter, 1980).

1976. The Association for Medical Education and Research in Substance Abuse (AMERSA) is created to expand education in substance-use health care for all health care professionals (Samet et al., 2006).

1976–1982. The National Institute of Mental Health Staff College is created to enhance the effectiveness of the leaders of federally funded community mental health centers across the United States. It closes with a change in administrations in Washington.

1978. The President’s Commission on Mental Health points out problems in the M/SU workforce and recommends several actions to address them, including more systematic training for all mental health professions in the social structures, beliefs, value systems, and patterns of various subcultures, and how to work with individuals from these subcultures in therapy. The commission also recommends multidisciplinary training to address what it identifies as “problems of role-blurring, rivalries, and turf battles” (President’s Commission on Mental Health, 1978:459). In addition, the commission reaffirms the need to provide training in administration in both the basic and continuing education curriculums of all mental health professionals.

1978–1986. A 5-year doctorate in mental health at the University of California-Berkeley and the University of California-San Francisco Medical School is initiated. The program aims to develop a new profession combining three main areas of knowledge—biological science, psychological science, and social science—in a clinical curriculum, with the goal of unifying the way behavioral health professionals are trained (Wallerstein, 1991).

1979. NIAAA initiates a State Manpower Development Program to provide categorical grant funding to each of the state alcoholism authorities for the development of a manpower plan and training of treatment providers. The program ends in 1982 when its funding is incorporated into block grants to states (IOM, 1990).

1984. NIAAA publishes core competencies and credentialing standards for counselors treating alcohol dependence (Birch and Davis Associates, 1984).

1990. The IOM documents the “serious lack of accurate, timely data at the national level” on the workforce treating alcohol-use problems and illnesses and notes: “This lack of data compromises efforts to plan for future training and professional needs. Fundamental questions for each of the disciplines involved cannot be answered. . . .As a consequence it is not possible to formulate a forward-looking workforce training policy” (IOM, 1990:131).

1993. SAMHSA issues *Workforce Training and Development for Mental Health Systems*.

1999. *Mental Health: A Report of the Surgeon General* again documents the inadequate supply of well-trained mental health professionals, especially those serving children and adolescents and individuals with severe mental illnesses, and those providing specific forms of psychotherapy effective for many types of mental illnesses (DHHS, 1999).

2000. SAMHSA's National Treatment Plan Initiative for Improving Substance Abuse Treatment calls for a National Workforce Development Office to secure valid, nationwide workforce data to guide policy making and support development of the substance-use treatment workforce at the national level. That office's efforts would address the implementation of core competency guidelines, credentialing standards, and other education and training activities (SAMHSA, 2000).

2001–2002. The American College of Mental Health Administration (ACMHA) and the Academic Behavioral Health Consortium (ABHC) initiate the Annapolis Coalition on Behavioral Health Workforce Education to build national consensus on the nature of the problems facing the M/SU treatment workforce and improve the quality and relevance of their education and training. The coalition's findings and recommendations are published in 2002 (Adams and Daniels, 2002; Daniels and Walter, 2002; Hoge, 2002; Hoge and Morris, 2002; Hoge et al., 2002).

2002. The HRSA–AMERSA–SAMHSA/CSAT Interdisciplinary Project to Improve Health Professional Education in Substance Abuse issues a strategic plan to enable the nation's health professions workforce to care for individuals with substance-use problems and illnesses. The plan makes 12 recommendations for the Secretary of DHHS, the U.S. Surgeon General, other federal agencies, and agencies and organizations in the public and private sectors, calling for, in part, the creation of a Secretary's Advisory Committee on Health Professions Education on Substance-Use Disorders; a Surgeon General's report on the state of substance abuse prevention and treatment, similar to the Surgeon General's report on mental health; the convening of a national forum on health professions education on substance-use disorders; the creation of national centers of excellence for leadership in interdisciplinary faculty development; and other mechanisms to strengthen workforce competencies in substance-use health care (Haack and Adger, 2002).

2003. In its report *Health Professions Education: A Bridge to Quality*, the IOM makes 10 recommendations for improving all health professions education to support improvements in health care quality (IOM, 2003).

2003. The President's New Freedom Commission on Mental Health (2003) reports that "the Commission heard consistent testimony from con-

sumers, families, advocates, and public and private providers about the ‘workforce crisis’ in mental health care. Today, not only is there a shortage of providers, but those providers who are available are not trained in evidenced-based and other innovative practices. This lack of education, training, or supervision leads to a workforce that is ill-equipped to use the latest breakthroughs in modern medicine” (p. 70). The commission further states that the mental health field needs “a comprehensive strategic plan to improve workforce recruitment, retention, diversity, and skills training” and calls on DHHS to “initiate and coordinate a public-private partnership to undertake such a strategy” (p. 75).

2004. The Annapolis Coalition on Behavioral Health Workforce Education convenes a national meeting that generates 10 consensus recommendations to guide the development of M/SU health care workforce competencies (Hoge et al., 2005a).

2005. SAMHSA contracts with the Annapolis Coalition on the Behavioral Health Workforce to develop a national strategic plan on workforce development by December 2005.

NEED FOR A SUSTAINED COMMITMENT TO BRING ABOUT CHANGE

Some changes have taken place as result of the initiatives described above. In general, however, M/SU health care professionals are trained the way they have been for many years, and problems such as maldistribution and the lack of representation of minorities in the workforce have improved only slightly, if at all. Despite significant efforts, attempts to train non-psychiatric physicians to do a better job of caring for people with M/SU problems and illnesses have not been particularly effective. Broader efforts to bring about similar changes in the M/SU treatment workforce overall have had similar results.

The committee finds, as others have before, that without a properly trained, culturally relevant, and appropriately distributed M/SU health care workforce, significant improvements in the quality of care are not likely. The committee further finds that the problems that attenuate the effectiveness of the M/SU health workforce in America are so complex that they require an ongoing, priority commitment of attention and resources, as opposed to the short-term, ad hoc initiatives that have often characterized responses to the problem in the past. As noted above, the committee recommends that the approach used to educate and train other key providers (physicians and nurses) in the health care workforce, as described below, be employed to marshal the sustained attention, collaboration, and resources needed to produce a stronger M/SU health care workforce.

Council on Graduate Medical Education

The Council on Graduate Medical Education (COGME) was authorized by Congress in 1986 to “provide an ongoing assessment of physician workforce trends, training issues and financing policies, and to recommend appropriate federal and private sector efforts to address identified needs” (HRSA, 2002). Council members include “representatives of practicing primary care physicians, national and specialty physician organizations, international medical graduates, medical student and house staff associations, schools of medicine and osteopathy, public and private teaching hospitals, health insurers, business, and labor. Federal representation includes the Assistant Secretary for Health, the U.S. Department of Health and Human Services (DHHS); the Administrator of the Centers for Medicare and Medicaid Services; and the Chief Medical Director of the Veterans Administration.” COGME advises and makes recommendations to the Secretary of DHHS; the Senate Committee on Health, Education, Labor and Pensions; and the House of Representatives Committee on Commerce.

The charge to COGME is broader than its name implies. Its authorizing legislation requires its advice and recommendations to address the following (HRSA, 2002):

- The supply and distribution of physicians in the United States.
- Current and future shortages or excesses of physicians in specialties and subspecialties.
- Related federal policies, including the financing of undergraduate and graduate medical education programs and the types of medical education and training in the latter programs.
- Efforts to be carried out by hospitals, educational institutions, and accrediting bodies with respect to these matters, including changes in undergraduate and graduate medical education programs.
- Improvements needed in databases concerning the supply and distribution of, and postgraduate training programs for, physicians in the United States and steps that should be taken to eliminate those deficiencies.

COGME periodically studies and issues reports on these issues that have been influential in health care policy arenas. While these reports have sometimes been controversial (Phillips et al., 2005), they have been successful in focusing national attention on the issues and stimulating policy responses.

National Advisory Council on Nurse Education and Practice

The National Advisory Council on Nurse Education and Practice (NACNEP) was established as the Advisory Council on Nurse Training in 1964 and renamed in 1988. It similarly advises the Secretary of DHHS and

the U.S. Congress on policy issues related to the nursing programs administered by HRSA's Bureau of Health Professions Division of Nursing, including nurse workforce supply, education, and practice improvement. Among its reports are the following: *Basic Registered Nurse Workforce*, *National Informatics Agenda for Nursing Education and Practice*, *Collaborative Education to Ensure Patient Safety*, *A National Agenda for Nursing Workforce Racial/Ethnic Diversity*, *Federal Support for the Preparation of the Nurse Practitioner Workforce through Title VIII*, and *Federal Support for the Preparation of the Clinical Nurse Specialist Workforce through Title VIII*.

The efforts of COGME and NACNEP have resulted in a number of accomplishments in workforce development. With respect to furthering interdisciplinary education and practice, for example, the two worked together to produce the report *Collaborative Education to Ensure Patient Safety* (COGME and NACNEP, 2000), which makes recommendations pertaining to faculty development, quality improvement, interdisciplinary collaboration, and competency development. These recommendations fostered cooperative agreements with public and private nonprofit entities that were cosponsored by HRSA's nursing and medicine divisions (NACNEP, 2002).

Recommendations

To secure sustained attention and resources for the development of the M/SU treatment workforce similar to what has been accomplished for the physician and nurse workforces, the committee makes the following recommendations:

Recommendation 7-1. To ensure sustained attention to the development of a stronger M/SU health care workforce, Congress should authorize and appropriate funds to create and maintain a Council on the Mental and Substance-Use Health Care Workforce as a public-private partnership. Recognizing that the quality of M/SU services is dependent upon a highly competent professional workforce, the council should develop and implement a comprehensive plan for strengthening the quality and capacity of the workforce to improve the quality of M/SU services substantially by:

- Identifying the specific clinical competencies that all M/SU professionals must possess to be licensed or certified and the competencies that must be maintained over time.
- Developing national standards for the credentialing and licensure of M/SU providers to eliminate differences in the standards now

used by the states. Such standards should be based on core competencies and should be included in curriculums and education programs across all the M/SU disciplines.

- Proposing programs to be funded by government and the private sector to address and resolve such long-standing M/SU workforce issues as diversity, cultural relevance, faculty development, and continuing shortages of the well-trained clinicians and consumer providers needed to work with children and the elderly; and of programs for training competent clinician administrators.
- Providing a continuing assessment of M/SU workforce trends, issues, and financing policies.
- Measuring the extent to which the plan's objectives have been met and reporting annually to the nation on the status of the M/SU workforce.
- Soliciting technical assistance from public-private partnerships to facilitate the work of the council and the efforts of educational and accreditation bodies to implement its recommendations.

Recommendation 7-2. Licensing boards, accrediting bodies, and purchasers should incorporate the competencies and national standards established by the Council on the Mental and Substance-Use Health Care Workforce in discharging their regulatory and contracting responsibilities.

Recommendation 7-3. The federal government should support the development of M/SU faculty leaders in health professions schools, such as schools of nursing and medicine, and in schools and programs that educate M/SU professionals, such as psychologists and social workers. The aim should be to narrow the gaps among what is known through research, what is taught, and what is done by those who provide M/SU services.

Recommendation 7-4. To facilitate the development and implementation of core competencies across all M/SU disciplines, institutions of higher education should place much greater emphasis on interdisciplinary didactic and experiential learning and should bring together faculty and trainees from their various education programs.

The committee calls particular attention to two components of recommendation 7-1. First, the recommendation calls for a public-private partnership to address the problems plaguing the M/SU workforce. Federal leadership can provide sustained national policy attention to these problems and unique influence with the educational institutions and their

accreditors, licensing bodies, health professions associations, and health care organizations that need to be engaged in resolving the issues involved. At the same time, private-sector organizations such as AMERSA (Samet et al., 2006) and, more recently, the Annapolis Coalition on Behavioral Health Workforce Education can offer the expertise, collaboration, and flexibility necessary to collect and analyze additional evidence that needs to be brought to bear on these issues. Therefore, the committee strongly recommends that the council seek out AMERSA and the Annapolis Coalition as partners in this process.

Second, with respect to the portion of recommendation 7-1 that calls for the Council on the Mental and Substance-Use Health Care Workforce to provide “an ongoing assessment of M/SU workforce trends, issues, and financing policies,” the committee underscores the paucity of comprehensive and reliable data on the M/SU workforce that it encountered in conducting this study. Thus the committee strongly recommends the inclusion of a mechanism or mechanisms for collecting better data on the M/SU workforce as a part of the process for assessing workforce trends and issues.

REFERENCES

- Aanavai MP, Taube DO, Ja DY, Duran EF. 1999. The status of psychologists’ training about and treatment of substance-abusing clients. *Journal of Psychoactive Drugs* 31(4):441–444.
- Abrams Weintraub T, Saitz R, Samet JH. 2003. Education of preventive medicine residents: Alcohol, tobacco, and other drug abuse. *American Journal of Preventive Medicine* 24(1):101–105.
- Adams N, Daniels AS. 2002. Sometimes a great notion. . . a common agenda for change. *Administration and Policy in Mental Health* 29(4–5):319–324.
- Addiction Technology Transfer Centers National Curriculum Committee. 1998. *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice*. DHHS Publication No. (SMA)98-3171. Technical Assistance Publication Series 21. Rockville, MD: U.S. Department of Health and Human Services. [Online]. Available: <http://www.nattc.org/pdf/accksa.pdf> [accessed June 28, 2005].
- AHRQ (Agency for Healthcare Research and Quality). 2003. *The Effect of Health Care Working Conditions on Patient Safety: Summary*. AHRQ Publication Number/ 03-E024. [Online]. Available: <http://www.ahrq.gov/clinic/epcsums/worksum.pdf> [accessed July 1, 2005].
- American Psychological Association (APA). 2003. *Psychology: Scientific Problem Solvers—Careers for the 21st Century*. [Online]. Available: www.apa.org/students/brochure/brochurenew.pdf [accessed June 28, 2005]. Washington, DC: American Psychological Association.
- APA Committee on Medical Education. 1956. An outline for a curriculum for teaching psychiatry in medical schools. *Journal of Medical Education* 31(2):115–128.
- Association of State and Provincial Psychology Boards. 2000. *Handbook of Licensing and Certification Requirements for Psychologists in the U.S. and Canada*. Montgomery, AL: Association of State and Provincial Psychology Boards.

- Baker L, Wagner TH, Singer S, Bundorf MK. 2003. Use of the Internet and e-mail for health care information: Results from a national survey. *Journal of the American Medical Association* 289(18):2400–2406.
- Benderly BL. 2005. Conference explores high-tech treatments. *SAMHSA NEWS* 13(1):1–4.
- Berwick DM. 2003. Dissemination innovations in health care. *Journal of the American Medical Association* 289(15):1969–1975.
- Birch and Davis Associates, Inc. 1984. *Development of Model Professional Standards for Counselor Credentialing*. Prepared for the National Institute on Alcohol Abuse and Alcoholism. Reprinted in 1986. Dubuque, IA and Washington, DC: Kendall/Hunt Publishing.
- Brailer DJ, Terasawa E. 2003. *Use and Adoption of Computer-Based Patient Records in the United States*. Presentation to IOM Committee on Data Standards for Patient Safety on January 23, 2003. [Online]. Available: <http://www.iom.edu/file.asp?id=10988> [accessed October 17, 2004].
- COGME, NACNEP (Council on Graduate Medical Education, National Advisory Council on Nurse Education and Practice). 2000. *Collaborative Education to Ensure Patient Safety*. [Online]. Available: <ftp://ftp.hrsa.gov/bhpr/nursing/patientsafety/safetyreport.pdf> [accessed November 16, 2005].
- Copeland J, Martin G. 2004. Web-based interventions for substance use disorders: A qualitative review. *Journal of Substance Abuse Treatment* 26(2):109–116.
- D’Onofrio G, Nadel ES, Degutis LC, Sullivan LM, Casper K, Bernstein E, Samet JH. 2002. Improving emergency medicine residents’ approach to patients with alcohol problems: A controlled educational trial. *Annals of Emergency Medicine* 40(1):50–62.
- Daniels AS, Walter DA. 2002. Current issues in continuing education for contemporary behavioral health practices. *Administration and Policy in Mental Health* 29(4/5):359–376.
- Davis D, O’Brien M, Freemantle N, Wolf F, Mazmanian P, Taylor-Vaisey A. 1999. Impact of formal continuing medical education: Do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or health care outcomes? *Journal of the American Medical Association* 282(9):867–874.
- DHHS (U.S. Department of Health and Human Services). 1999. *Mental Health: A Report of the Surgeon General*. Rockville, MD: DHHS.
- Duffy FF, West JC, Wilk J, Narrow WE, Hales D, Thompson J, Regier DA, Kohout J, Pion GM, Wicherski MM, Bateman N, Whitaker T, Merwin EI, Lyon D, Fox JC, Delaney KR, Hanrahan N, Stockton R, Garbelman J, Kaladow J, Clawson TW, Smith SC, Bergman DM, Northey WF, Blankertz L, Thomas A, Sullivan LD, Dwyer KP, Fleischer MS, Woodruff CR, Goldsmith HF, Henderson MJ, Atay JJ, Manderscheid RW. 2004. Mental health practitioners and trainees. In: Manderscheid RW, Henderson MJ, eds. *Mental Health, United States, 2002*. DHHS publication Number: (SMA) 3938. Rockville, MD: DHHS Substance Abuse and Mental Health Services Administration. Pp. 327–368.
- Edmundson E. 2002. Significant variation in undergraduate training programs *Frontlines: Linking Alcohol Services Research and Practice*. Washington, DC: National Institute on Alcohol Abuse and Alcoholism in conjunction with AcademyHealth.
- Flanagan RD, Needham SL. 2003. The internet. In: Feldman S, ed. *Managed Behavioral Health Services: Perspectives and Practice*. Springfield, IL: Charles C. Thomas, Publisher Pp. 307–325.
- Friedmann PD, McCulloch D, Chin MH, Saitz R. 2000. Screening and intervention for alcohol problems: A national survey of primary care physicians and psychiatrists. *Journal of General Internal Medicine* 15(2):84–91.
- Galanter M. 1980. *Alcohol and Drug Abuse in Medical Education*. Washington, DC: U.S. Government Printing Office.

- Greenhalgh T, Robert G, MacFarlane F, Bate P, Kyriakidou O. 2004. Diffusion of innovations in service organizations: Systematic review and recommendations. *The Milbank Quarterly* 82(4):581–629.
- Haack MR, Adger H, eds. 2002. *Strategic Plan for Interdisciplinary Faculty Development: Arming the Nation's Health Professional Workforce for a New Approach to Substance Use Disorders*. Dordrecht, the Netherlands: Kluwer Academic/Plenum Publishers.
- Harwood HJ. 2002. Survey on behavioral health workplace. *Frontlines: Linking Alcohol Services Research and Practice*. Washington, DC: National Institute on Alcohol Abuse and Alcoholism in conjunction with AcademyHealth. P. 3.
- Hobbs F, Stoops N, Census Bureau, U.S. Department of Commerce. 2002. *Demographic Trends in the 20th Century*. Washington, DC: U.S. Government Printing Office. Census 2000 Special Reports. Series CENSR-4. [Online]. Available: <http://landview.census.gov/prod/2002pubs/censr-4.pdf> [accessed October 4, 2003].
- Hoge MA. 2002. The training gap: An acute crisis in behavioral health education. *Administration and Policy in Mental Health* 29(4-5):305–317.
- Hoge MA, Morris JA. 2002. Guest editors' introduction. *Administration and Policy in Mental Health* 29(4/5):297–303.
- Hoge MA, Jacobs S, Belitsky R, Migdole S. 2002. Graduate education and training for contemporary behavioral health practice. *Administration and Policy in Mental Health* 29(4/5):335–357.
- Hoge MA, Morris JA, Daniels AS, Huey LY, Stuart GW, Adams N, Paris M Jr, Goplerud E, Horgan CM, Kaplan L, Storti SA, Dodge JM. 2005a. Report of recommendations: The Annapolis Coalition conference on behavioral health work force competencies. *Administration and Policy in Mental Health* 32(5):651–663.
- Hoge MA, Tondora J, Marrelli AF. 2005b. The fundamentals of workforce competency: Implications for behavioral health. *Administration and Policy in Mental Health* 32(5):509–531.
- Howard MO, Walker RD, Walker PS, Suchinsky RT. 1997. Alcohol and drug education in schools of nursing. *Journal of Alcohol and Drug Education* 42(3):54–80.
- HRSA (Health Resources and Services Administration). 2002. *COGME: About the Council*. [Online]. Available: <http://www.cogme.gov/whois.htm> [accessed July 1, 2005].
- IOM (Institute of Medicine). 1990. *Broadening the Base of Treatment for Alcohol Problems*. Washington, DC: National Academy Press.
- IOM. 1997. Edmunds M, Frank R, Hogan M, McCarty D, Robinson-Beale R, Weisner C, eds. *Managing Managed Care: Quality Improvement in Behavioral Health*. Washington, DC: National Academy Press.
- IOM. 2001. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press.
- IOM. 2003. Greiner AC, Knebel E, eds. *Health Professions Education: A Bridge to Quality*. Washington, DC: The National Academies Press.
- IOM. 2004a. *In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce*. Washington, DC: The National Academies Press.
- IOM. 2004b. Page A, ed. *Keeping Patients Safe: Transforming the Work Environment of Nurses*. Washington, DC: The National Academies Press.
- Isaacson JH, Fleming M, Kraus M, Kahn R, Mundt M. 2000. A national survey of training in substance use disorders in residency programs. *Journal of Studies on Alcohol* 61(6): 912–915.
- Jackim LW. 2003. Is all the evidence in? Range of popular treatments subsist despite lack of science base. Is that damaging? *Behavioral Healthcare Tomorrow* 12(5):21–26.

- Joint Commission on Mental Illness and Health. 1961. *Action for Mental Health: Final Report of the Joint Commission on Mental Illness and Health*. New York: John Wiley and Sons.
- Kaplan L. 2003. *Substance Abuse Treatment Workforce Environmental Scan*. Contract #282-98-0006, Task Order #29. Bethesda, MD. Abt Associates, Inc.
- Kessler RC, Demler O, Frank RG, Olfson M, Pincus HA, Walters EE, Wang P, Wells KB, Zaslavsky AM. 2005. Prevalence and treatment of mental disorders, 1990 to 2003. *New England Journal of Medicine* 352(24):2515–2523.
- Koppelman J. 2004. The provider system for children's mental health: Workforce capacity and effective treatment. NHPF Issue Brief No. 801. Washington, DC: The George Washington University National Health Policy Forum.
- Lamberg L. 2003. Online empathy for mood disorders: Patients turn to internet support groups. *Journal of the American Medical Association* 289(23):3073–3077.
- Lazear D. 1991. *Seven Ways of Knowing: Teaching to Multiple Intelligences*. Palatine, IL: Skylight Publishing.
- Manderscheid RW, Henderson MJ, Brown DY. 2001. Status of national accountability efforts at the millenium. In: Manderscheid RW, Henderson MJ, eds. *Mental Health, United States, 2000*. DHHS Publication number: (SMA) 01-3537. Washington DC: U.S. Government Printing Office. Pp. 43–52.
- McCarty D. 2002. The alcohol and drug abuse treatment workforce. *Frontlines: Linking Alcohol Services Research and Practice*. Washington, DC: National Institute on Alcohol Abuse and Alcoholism in conjunction with AcademyHealth.
- McClure M, Poulin M, Sovie M, Wandelt M. 2002. Magnet hospitals: Attraction and retention of professional nurses (The Original Study). In: McClure M, Hinshaw A, eds. *Magnet Hospitals Revisited*. Washington, DC: American Nurses Publishing. Pp. 1–24.
- McLellan AT, Carise D, Kleber HD. 2003. Can the national addiction treatment infrastructure support the public's demand for quality care? *Journal of Substance Abuse Treatment* 25(2):117–121.
- McLellan AT, Meyers K. 2004. Contemporary addiction treatment: A review of systems problems for adults and adolescents. *Biological Psychiatry* 56(10):764–770.
- Mickus M, Colenda CC, Hogan AJ. 2000. Knowledge of mental health benefits and preferences for type of mental health providers among the general public. *Psychiatric Services* 51(2):199–202.
- Miller NS, Sheppard LM, Colenda CC, Magen J. 2001. Why physicians are unprepared to treat patients who have alcohol- and drug-related disorders. *Academic Medicine* 76(5): 410–418.
- Morris JA, Goplerud EN, Hoge MA. 2004. *Workforce Issues in Behavioral Health*. Paper commissioned by the IOM Committee on Crossing the Quality Chasm—Adaptation to Mental Health and Addictive Disorders. Available from the Institute of Medicine.
- Mulvey KP, Hubbard S, Hayashi S. 2003. A national study of the substance abuse treatment workforce. *Journal of Substance Abuse Treatment* 24(1):51–57.
- NAADAC (National Association of Alcohol and Drug Abuse Counselors). 2005. *About NAADAC*. [Online]. Available: <http://naadac.org/documents/index.php?CategoryID=1> [accessed October 16, 2005].
- NACNEP (National Advisory Council on Nurse Education and Practice). 2002. *Nurse Education and Practice: Second Report to the Secretary of Health and Human Services and the Congress*. [Online]. Available: <ftp://ftp.hrsa.gov/bhpr/nursing/secondreport.pdf> [accessed October 16, 2005].

- Naegle M. 2002. Nursing education in the prevention and treatment of SUD. In: Haack MR, Adger H, eds. *Strategic Plan for Interdisciplinary Faculty Development: Arming the Nation's Health Professional Workforce for a New Approach to Substance Use Disorders*. AH Dordrecht, The Netherlands: Kluwer Academic/Plenum Publishers.
- New Freedom Commission on Mental Health. 2003. *Achieving the Promise: Transforming Mental Health Care in America. Final Report*. DHHS Publication Number: SMA-03-3832. Rockville, MD: U.S. Department of Health and Human Services.
- Olvey CDV, Hogg A. 2002. Licensure requirements: Have we raised the bar too far? *Professional Psychology: Research and Practice* 33(3):323–329.
- Phillips RL, Doodoo M, Jaen CR, Green LA. 2005. COGME's 16th report to Congress: Too many physicians could be worse than wasted. *Annals of Family Medicine* 3(3):268–270.
- Pincus HA, Tanielian TL, Marcus SC, Olfson M, Zarin DA, Thompson J, Zito JM. 1998. Prescribing trends in psychotropic medications: Primary care, psychiatry, and other medical specialties. *Journal of the American Medical Association* 279(7):526–531.
- Poster EC. 2004. Psychiatric nursing at risk: The new NCLEX-RN test plan. *Journal of Child and Adolescent Psychiatric Nursing* 17(2):47–48.
- President's Commission on Mental Health. 1978. *Report of the President's Commission on Mental Health, Vol. II*. Washington, DC: U.S. Government Printing Office.
- Quinn J. 1992. *Intelligent Enterprise: A Knowledge and Service Based Paradigm for Industry*. New York: The Free Press.
- Reed MC, Grossman JM. 2004. *Limited Information Technology for Patient Care in Physician Offices*. No. 89. Washington, DC: Center for Studying Health System Change. Issue Brief. [Online]. Available: <http://www.hschange.org/CONTENT/708/708.pdf> [accessed November 1, 2004].
- Rushon JL, Fant K, Clark SJ. 2004. Use of practice guidelines in the primary care of children with Attention-Deficit Hyperactivity Disorder. *Pediatrics* 114(1):e23–e28. [Online]. Available: <http://www.pediatrics.aappublications.org/cgi/reprint/114/1/e23> [accessed on September 1, 2005].
- Saitz R, Sullivan LM, Samet JH. 2000. Training community-based clinicians in screening and brief intervention for substance abuse problems: Translating evidence into practice. *Substance Abuse* 21(1):21–31.
- Saitz R, Friedman PD, Sullivan LM, Winter MR, Lloyd-Travaglini C, Moskowitz MA, Samet J. 2002. Professional satisfaction experienced when caring for substance-abusing patients: Faculty and resident physician perspectives. *Journal of General Internal Medicine* 17(5):373–376.
- Samet JH, Galanter M, Briden C, Lewis DC. 2006. Association for Medical Education and Research in Substance Abuse. *Addiction* 101(1):10–15.
- SAMHSA (Substance Abuse and Mental Health Services Administration). 2000. *Changing the Conversation: Improving Substance Abuse Treatment: The National Treatment Plan Initiative*. DHHS Publication No. (SMA) 00-3479. U.S. Department of Health and Human Services.
- SAMHSA. 2003. *Alcohol and Drug Services Study (ADSS): The National Substance Abuse Treatment System: Facilities, Clients, Services, and Staffing*. Rockville, MD: Office of Applied Studies. [Online]. Available: <http://www.oas.samhsa.gov/ADSS/ADSSorg.pdf> [accessed June 30, 2005].
- SAMHSA. 2004. *National Survey of Substance Abuse Treatment Services (N-SSATS): 2003—Data on Substance Abuse Treatment Facilities*. DASIS Series: S-24. DHHS Publication Number: (SMA) 04-3966. Rockville, MD: U.S. Department of Health and Human Services.

- SAMHSA. undated. *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders*: U.S. Department of Health and Human Services. [Online]. Available: <http://www.samhsa.gov/reports/congress2002/CoOccurringRpt.pdf> [accessed April 25, 2004].
- Straussner SLA, Senreich E. 2002. Educating social workers to work with individuals affected by substance use disorders. In: Haack MR, Adger H Jr, eds. *Strategic Plan for Interdisciplinary Faculty Development: Arming the Nation's Health Professional Workforce for a New Approach to Substance Use Disorders* 23:319–340. Dordrecht, the Netherlands: Kluwer Academic/Plenum Publishers.
- Trabin T, Maloney W. 2003. Information systems. In: Feldman S, ed. *Managed Behavioral Health Services: Perspectives and Practices*. Springfield, IL: Charles C. Thomas Publisher. Pp. 326–370.
- Trowbridge R, Weingarten S. 2001. Clinical decision support systems. In: Shojania K, Duncan B, McDonald K, Wachter R, eds. *Making Health Care Safer: A Critical Analysis of Patient Safety Practices*. Evidence Report/Technology Assessment Number 43. AHRQ Publication No. 01-E058. Rockville, MD: Agency for Healthcare Research and Quality.
- Vastag B. 2003. Addiction poorly understood by clinicians: Experts say attitudes, lack of knowledge hinder treatment. *Journal of the American Medical Association* 290(10): 1299–1303.
- Wallerstein R, ed. 1991. *The Doctorate in Mental Health: An Experiment in Mental Health Professional Education*. Lanham, MD: University Press of America.
- Wang PS, Berglund P, Kessler RC. 2000. Recent care of common mental disorders in the United States: Prevalence and conformance with evidence-based recommendations. *Journal of General Internal Medicine* 15(5):284–292.
- West J, Kohout J, Pion GM, Wicherski MM, Vandivort-Warren RE, Palmiter ML, Merwin EI, Lyon D, Fox JC, Clawson TW, Smith SC, Stockton R, Nitza AG, Ambrose JP, Blankertz L, Thomas A, Sullivan LD, Dwyer KP, Fleischer MS, Goldsmith HF, Henderson MJ, Atay JE, Manderscheid RW. 2001. Mental health practitioners and trainees. In: Manderscheid RW, Henderson MJ, eds. *Mental Health, United States, 2000*. DHHS Publication No. (SMA) 01-3537. Washington, DC: U.S. Government Printing Office. Pp. 279–315.
- Young AS, Klap R, Sherbourne C, Wells KB. 2001. The quality of care for depressive and anxiety disorders in the United States. *Archives of General Psychiatry* 58(1):55–61.



Marriage and Family Therapy Core Competencies©

December, 2004

The marriage and family therapy (MFT) core competencies were developed through a collaborative effort of the American Association for Marriage and Family Therapy (AAMFT) and interested stakeholders. In addition to defining the domains of knowledge and requisite skills in each domain that comprise the practice of marriage and family therapy, the ultimate goal of the core competencies is to improve the quality of services delivered by marriage and family therapists (MFTs). Consequently, the competencies described herein represent the minimum that MFTs licensed to practice independently must possess.

Creating competencies for MFTs and improving the quality of mental health services was considered in the context of the broader behavioral health system. The AAMFT relied on three important reports to provide the framework within which the competencies would be developed: *Mental Health: A Report of the Surgeon General*; the President's New Freedom Commission on Mental Health's *Achieving the Promise: Transforming Mental Health Care in America*; and the Institute of Medicine's *Crossing the Quality Chasm*. The AAMFT mapped the competencies to critical elements of these reports, including IOM's 6 Core Values that are seen as the foundation for a better health care system: 1) Safe, 2) Person-Centered, 3) Efficient, 4) Effective, 5) Timely, and 6) Equitable. The committee also considered how social, political, historical, and economic forces affect individual and relational problems and decisions about seeking and obtaining treatment.

The core competencies were developed for educators, trainers, regulators, researchers, policymakers, and the public. The current version has 128 competencies; however, these are likely to be modified as the field of family therapy develops and as the needs of clients change. The competencies will be reviewed and modified at regular intervals to ensure the competencies are reflective of the current and best practice of MFT.

The core competencies are organized around 6 primary domains and 5 secondary domains. The primary domains are:

- 1) **Admission to Treatment** – All interactions between clients and therapist up to the point when a therapeutic contract is established.
- 2) **Clinical Assessment and Diagnosis** – Activities focused on the identification of the issues to be addressed in therapy.
- 3) **Treatment Planning and Case Management** – All activities focused on directing the course of therapy and extra-therapeutic activities.
- 4) **Therapeutic Interventions** – All activities designed to ameliorate the clinical issues identified.
- 5) **Legal Issues, Ethics, and Standards** – All aspects of therapy that involve statutes, regulations, principles, values, and mores of MFTs.
- 6) **Research and Program Evaluation** – All aspects of therapy that involve the systematic analysis of therapy and how it is conducted effectively.

The subsidiary domains are focused on the types of skills or knowledge that MFTs must develop. These are: a) Conceptual, b) Perceptual, c) Executive, d) Evaluative, and e) Professional.

Although not expressly written for each competency, the stem "Marriage and family therapists..." should begin each. Additionally, the term "client" is used broadly and refers to the therapeutic system of the client/s served, which includes, but is not limited to individuals, couples, families, and others with a vested interest in helping clients change. Similarly, the term "family" is used generically to refer to all people identified by clients as part of their "family system," this would include fictive kin and relationships of choice. Finally, the core competencies encompass behaviors, skills, attitudes, and policies that promote awareness, acceptance, and respect for differences, enhance services that meet the needs of diverse populations, and promote resiliency and recovery.

Domain 1: Admission to Treatment

Number	Subdomain	Competence
1.1.1	Conceptual	Understand systems concepts, theories, and techniques that are foundational to the practice of marriage and family therapy
1.1.2	Conceptual	Understand theories and techniques of individual, marital, couple, family, and group psychotherapy
1.1.3	Conceptual	Understand the behavioral health care delivery system, its impact on the services provided, and the barriers and disparities in the system.
1.1.4	Conceptual	Understand the risks and benefits of individual, marital, couple, family, and group psychotherapy.
1.2.1	Perceptual	Recognize contextual and systemic dynamics (e.g., gender, age, socioeconomic status, culture/race/ethnicity, sexual orientation, spirituality, religion, larger systems, social context).
1.2.2	Perceptual	Consider health status, mental status, other therapy, and other systems involved in the clients' lives (e.g., courts, social services).
1.2.3	Perceptual	Recognize issues that might suggest referral for specialized evaluation, assessment, or care.
1.3.1	Executive	Gather and review intake information, giving balanced attention to individual, family, community, cultural, and contextual factors.
1.3.2	Executive	Determine who should attend therapy and in what configuration (e.g., individual, couple, family, extrafamilial resources).
1.3.3	Executive	Facilitate therapeutic involvement of all necessary participants in treatment.
1.3.4	Executive	Explain practice setting rules, fees, rights, and responsibilities of each party, including privacy, confidentiality policies, and duty to care to client or legal guardian.
1.3.5	Executive	Obtain consent to treatment from all responsible persons.
1.3.6	Executive	Establish and maintain appropriate and productive therapeutic alliances with the clients.
1.3.7	Executive	Solicit and use client feedback throughout the therapeutic process.
1.3.8	Executive	Develop and maintain collaborative working relationships with referral resources, other practitioners involved in the clients' care, and payers.
1.3.9	Executive	Manage session interactions with individuals, couples, families, and groups.
1.4.1	Evaluative	Evaluate case for appropriateness for treatment within professional scope of practice and competence.
1.5.1	Professional	Understand the legal requirements and limitations for working with vulnerable populations (e.g., minors).
1.5.2	Professional	Complete case documentation in a timely manner and in accordance with relevant laws and policies.
1.5.3	Professional	Develop, establish, and maintain policies for fees, payment, record keeping, and confidentiality.

Domain 2: Clinical Assessment and Diagnosis

Number	Subdomain	Competence
2.1.1	Conceptual	Understand principles of human development; human sexuality; gender development; psychopathology; psychopharmacology; couple processes; and family development and processes (e.g., family, relational, and system dynamics).
2.1.2	Conceptual	Understand the major behavioral health disorders, including the epidemiology, etiology, phenomenology, effective treatments, course, and prognosis.
2.1.3	Conceptual	Understand the clinical needs and implications of persons with comorbid disorders (e.g., substance abuse and mental health; heart disease and depression).
2.1.4	Conceptual	Comprehend individual, marital, couple and family assessment instruments appropriate

Number	Subdomain	Competence
		to presenting problem, practice setting, and cultural context.
2.1.5	Conceptual	Understand the current models for assessment and diagnosis of mental health disorders, substance use disorders, and relational functioning.
2.1.6	Conceptual	Understand the strengths and limitations of the models of assessment and diagnosis, especially as they relate to different cultural, economic, and ethnic groups.
2.1.7	Conceptual	Understand the concepts of reliability and validity, their relationship to assessment instruments, and how they influence therapeutic decision making.
2.2.1	Perceptual	Assess each clients' engagement in the change process.
2.2.2	Perceptual	Systematically integrate client reports, observations of client behaviors, client relationship patterns, reports from other professionals, results from testing procedures, and interactions with client to guide the assessment process.
2.2.3	Perceptual	Develop hypotheses regarding relationship patterns, their bearing on the presenting problem, and the influence of extra-therapeutic factors on client systems.
2.2.4	Perceptual	Consider the influence of treatment on extra-therapeutic relationships.
2.2.5	Perceptual	Consider physical/organic problems that can cause or exacerbate emotional/interpersonal symptoms.
2.3.1	Executive	Diagnose and assess client behavioral and relational health problems systemically and contextually.
2.3.2	Executive	Provide assessments and deliver developmentally appropriate services to clients, such as children, adolescents, elders, and persons with special needs.
2.3.3	Executive	Apply effective and systemic interviewing techniques and strategies.
2.3.4	Executive	Administer and interpret results of assessment instruments.
2.3.5	Executive	Screen and develop adequate safety plans for substance abuse, child and elder maltreatment, domestic violence, physical violence, suicide potential, and dangerousness to self and others.
2.3.6	Executive	Assess family history and dynamics using a genogram or other assessment instruments.
2.3.7	Executive	Elicit a relevant and accurate biopsychosocial history to understand the context of the clients' problems.
2.3.8	Executive	Identify clients' strengths, resilience, and resources.
2.3.9	Executive	Elucidate presenting problem from the perspective of each member of the therapeutic system.
2.4.1	Evaluative	Evaluate assessment methods for relevance to clients' needs.
2.4.2	Evaluative	Assess ability to view issues and therapeutic processes systemically.
2.4.3	Evaluative	Evaluate the accuracy and cultural relevance of behavioral health and relational diagnoses.
2.4.4	Evaluative	Assess the therapist-client agreement of therapeutic goals and diagnosis.
2.5.1	Professional	Utilize consultation and supervision effectively.

Domain 3: Treatment Planning and Case Management

Number	Subdomain	Competence
3.1.1	Conceptual	Know which models, modalities, and/or techniques are most effective for presenting problems.
3.1.2	Conceptual	Understand the liabilities incurred when billing third parties, the codes necessary for reimbursement, and how to use them correctly.
3.1.3	Conceptual	Understand the effects that psychotropic and other medications have on clients and the treatment process.
3.1.4	Conceptual	Understand recovery-oriented behavioral health services (e.g., self-help groups, 12-step

Number	Subdomain	Competence
		programs, peer-to-peer services, supported employment).
3.2.1	Perceptual	Integrate client feedback, assessment, contextual information, and diagnosis with treatment goals and plan.
3.3.1	Executive	Develop, with client input, measurable outcomes, treatment goals, treatment plans, and after-care plans with clients utilizing a systemic perspective.
3.3.2	Executive	Prioritize treatment goals.
3.3.3	Executive	Develop a clear plan of how sessions will be conducted.
3.3.4	Executive	Structure treatment to meet clients' needs and to facilitate systemic change.
3.3.5	Executive	Manage progression of therapy toward treatment goals.
3.3.6	Executive	Manage risks, crises, and emergencies.
3.3.7	Executive	Work collaboratively with other stakeholders, including family members, other significant persons, and professionals not present.
3.3.8	Executive	Assist clients in obtaining needed care while navigating complex systems of care.
3.3.9	Executive	Develop termination and aftercare plans.
3.4.1	Evaluative	Evaluate progress of sessions toward treatment goals.
3.4.2	Evaluative	Recognize when treatment goals and plan require modification.
3.4.3	Evaluative	Evaluate level of risks, management of risks, crises, and emergencies.
3.4.4	Evaluative	Assess session process for compliance with policies and procedures of practice setting.
3.4.5	Professional	Monitor personal reactions to clients and treatment process, especially in terms of therapeutic behavior, relationship with clients, process for explaining procedures, and outcomes.
3.5.1	Professional	Advocate with clients in obtaining quality care, appropriate resources, and services in their community.
3.5.2	Professional	Participate in case-related forensic and legal processes.
3.5.3	Professional	Write plans and complete other case documentation in accordance with practice setting policies, professional standards, and state/provincial laws.
3.5.4	Professional	Utilize time management skills in therapy sessions and other professional meetings.

Domain 4: Therapeutic Interventions

Number	Subdomain	Competence
4.1.1	Conceptual	Comprehend a variety of individual and systemic therapeutic models and their application, including evidence-based therapies and culturally sensitive approaches.
4.1.2	Conceptual	Recognize strengths, limitations, and contraindications of specific therapy models, including the risk of harm associated with models that incorporate assumptions of family dysfunction, pathogenesis, or cultural deficit.
4.2.1	Perceptual	Recognize how different techniques may impact the treatment process.
4.2.2	Perceptual	Distinguish differences between content and process issues, their role in therapy, and their potential impact on therapeutic outcomes.
4.3.1	Executive	Match treatment modalities and techniques to clients' needs, goals, and values.
4.3.2	Executive	Deliver interventions in a way that is sensitive to special needs of clients (e.g., gender, age, socioeconomic status, culture/race/ethnicity, sexual orientation, disability, personal history, larger systems issues of the client).
4.3.3	Executive	Reframe problems and recursive interaction patterns.
4.3.4	Executive	Generate relational questions and reflexive comments in the therapy room.
4.3.5	Executive	Engage each family member in the treatment process as appropriate.
4.3.6	Executive	Facilitate clients developing and integrating solutions to problems.

Number	Subdomain	Competence
4.3.7	Executive	Defuse intense and chaotic situations to enhance the safety of all participants.
4.3.8	Executive	Empower clients and their relational systems to establish effective relationships with each other and larger systems.
4.3.9	Executive	Provide psychoeducation to families whose members have serious mental illness or other disorders.
4.3.10	Executive	Modify interventions that are not working to better fit treatment goals.
4.3.11	Executive	Move to constructive termination when treatment goals have been accomplished.
4.3.12	Executive	Integrate supervisor/team communications into treatment.
4.4.1	Evaluative	Evaluate interventions for consistency, congruency with model of therapy and theory of change, cultural and contextual relevance, and goals of the treatment plan.
4.4.2	Evaluative	Evaluate ability to deliver interventions effectively.
4.4.3	Evaluative	Evaluate treatment outcomes as treatment progresses.
4.4.4	Evaluative	Evaluate clients' reactions or responses to interventions.
4.4.5	Evaluative	Evaluate clients' outcomes for the need to continue, refer, or terminate therapy.
4.4.6	Evaluative	Evaluate reactions to the treatment process (e.g., transference, family of origin, current stress level, current life situation, cultural context) and their impact on effective intervention and clinical outcomes.
4.5.1	Professional	Respect multiple perspectives (e.g., clients, team, supervisor, practitioners from other disciplines who are involved in the case).
4.5.2	Professional	Set appropriate boundaries, manage issues of triangulation, and develop collaborative working relationships.
4.5.3	Professional	Articulate rationales for interventions related to treatment goals and plan, assessment information, and systemic understanding of clients' context and dynamics.

Domain 5: Legal Issues, Ethics, and Standards

Number	Subdomain	Competence
5.1.1	Conceptual	Know state, federal, and provincial laws and regulations that apply to the practice of marriage and family therapy.
5.1.2	Conceptual	Know professional ethics and standards of practice that apply to the practice of marriage and family therapy.
5.1.3	Conceptual	Know policies and procedures of the practice setting.
5.1.4	Conceptual	Understand the process of making an ethical decision.
5.2.1	Perceptual	Recognize situations in which ethics, laws, professional liability, and standards of practice apply.
5.2.2	Perceptual	Recognize ethical dilemmas in practice setting.
5.2.3	Perceptual	Recognize when a legal consultation is necessary.
5.2.4	Perceptual	Recognize when clinical supervision or consultation is necessary.
5.3.1	Executive	Monitor issues related to ethics, laws, regulations, and professional standards.
5.3.2	Executive	Develop and assess policies, procedures, and forms for consistency with standards of practice to protect client confidentiality and to comply with relevant laws and regulations.
5.3.3	Executive	Inform clients and legal guardian of limitations to confidentiality and parameters of mandatory reporting.
5.3.4	Executive	Develop safety plans for clients who present with potential self-harm, suicide, abuse, or violence.
5.3.5	Executive	Take appropriate action when ethical and legal dilemmas emerge.
5.3.6	Executive	Report information to appropriate authorities as required by law.

Number	Subdomain	Competence
5.3.7	Executive	Practice within defined scope of practice and competence.
5.3.8	Executive	Obtain knowledge of advances and theory regarding effective clinical practice.
5.3.9	Executive	Obtain license(s) and specialty credentials.
5.3.10	Executive	Implement a personal program to maintain professional competence.
5.4.1	Evaluative	Evaluate activities related to ethics, legal issues, and practice standards.
5.4.2	Evaluative	Monitor attitudes, personal well-being, personal issues, and personal problems to insure they do not impact the therapy process adversely or create vulnerability for misconduct.
5.5.1	Professional	Maintain client records with timely and accurate notes.
5.5.2	Professional	Consult with peers and/or supervisors if personal issues, attitudes, or beliefs threaten to adversely impact clinical work.
5.5.3	Professional	Pursue professional development through self-supervision, collegial consultation, professional reading, and continuing educational activities.
5.5.4	Professional	Bill clients and third-party payers in accordance with professional ethics, relevant laws and polices, and seek reimbursement only for covered services.

Domain 6: Research and Program Evaluation

Number	Subdomain	Competence
6.1.1	Conceptual	Know the extant MFT literature, research, and evidence-based practice.
6.1.2	Conceptual	Understand research and program evaluation methodologies, both quantitative and qualitative, relevant to MFT and mental health services.
6.1.3	Conceptual	Understand the legal, ethical, and contextual issues involved in the conduct of clinical research and program evaluation.
6.2.1	Perceptual	Recognize opportunities for therapists and clients to participate in clinical research.
6.3.1	Executive	Read current MFT and other professional literature.
6.3.2	Executive	Use current MFT and other research to inform clinical practice.
6.3.3	Executive	Critique professional research and assess the quality of research studies and program evaluation in the literature.
6.3.4	Executive	Determine the effectiveness of clinical practice and techniques.
6.4.1	Evaluative	Evaluate knowledge of current clinical literature and its application.
6.5.1	Professional	Contribute to the development of new knowledge.

CalSWEC II Mental Health Initiative
Mental Health Competencies
Foundation Year
August 2006

**A Competency-Based Curriculum in Community Mental Health
For Graduate Social Work Students**

Introduction

The Mental Health Competencies were developed by a collaborative partnership consisting of California practitioners, educators, community leaders, and other stakeholders from the fields of mental health and social work. The competencies support and promote recovery and wellness through independence, hope, personal development and resiliency for children, adults and older adults with serious emotional disturbances and severe mental illness. The competencies support the development and utilization of evidence-based and promising practices throughout the mental health system and promote culturally and linguistically competent services that are sensitive and responsive to the needs of local communities and focus on issues of ethnicity, age, gender, sexual orientation and religious/spiritual beliefs. Consistent with the shared vision of the mental health partnership, services are to be provided in the least restrictive and most appropriate setting with attention to consumer and family involvement at all levels of the mental health system.

The Mental Health competencies are divided into Foundation and Advanced/Specialization categories, which correspond roughly to the first and second years of the MSW program. The Competencies are based on a series of principle statements adapted from the Mental Health Services Act (December 2004) and the California Mental Health Master Plan: A Vision for California (March 2003).

Foundation Competencies (1st Year)	Advanced Competencies (2nd Year)
I. Culturally and Linguistically Competent Generalist Practice	I. Culturally and Linguistically Competent Mental Health Practice
II. Foundation Practice	II. Advanced Mental Health Practice
III. Human Behavior and the Social Environment	III. Human Behavior and the Mental Health Environment
IV. Workplace Management	IV. Mental Health Policy, Planning And Administration

California Community Mental Health Curriculum Principles

The CalSWEC Mental Health Competencies are designed to prepare an MSW level workforce to effectively provide mental health services to children, adults and older adults, and to contribute to a Mental Health system which:

- 1. Promotes recovery/wellness through independence, hope, personal development and resiliency for adults and older adults with severe mental illness and for children with serious emotional disorders and their families.*
- 2. Provides culturally and linguistically competent services that are sensitive and responsive to the needs of the local community, and addresses issues of ethnicity, age, gender, sexual orientation and religious/spiritual beliefs.*
- 3. Strives to involve clients and families appropriately in all aspects of the public mental health system, including but not limited to: planning, policy development, service delivery and evaluation.*
- 4. Strives to create a partnership of cooperation and a shared vision of mental health services with other agency partners in the social service arena.*
- 5. Is an advocate for clients' rights.*
- 6. Promotes the development and use of self-help, peer support and peer education for all persons with mental illness and their families.*
- 7. Assists clients in their recovery to return to the most constructive and satisfying lifestyle of their own definition and choice.*
- 8. Provides persons with severe mental illness and/or serious emotional disturbances effective treatment and high priority for receiving services in the most timely manner.*
- 9. Provides services in the least restrictive and most appropriate setting.*
- 10. Supports a Children's System of Care consisting of family-driven, culturally competent, individualized, coordinated and integrated care with accountability to positive outcomes, which meet the unique needs of children and their families.*
- 11. Supports an Adult System of Care consisting of client driven, culturally competent, coordinated, integrated and effective services meeting the unique needs of adults with severe mental illness, their families and their extended social support system.*
- 12. Supports an Older Adult System of Care consisting of comprehensive and integrated service meeting the unique needs of older adults with severe mental illness, their families, their caregivers and their extended community support system.*
- 13. Addresses the special mental health needs of all persons with severe mental illness and/or serious emotional disorders who also present with co-occurring substance abuse, psychiatric disabilities and/or other multiple vulnerabilities.*

I. Culturally and Linguistically Competent Generalist Practice

A working knowledge of and sensitivity to the dynamics of ethnic and cultural differences is at the core of mental health services. As a result of their personal experiences with mental illness, mental health systems and their own cultural identity, mental health consumers and social workers alike develop attitudes regarding mental health, along with their individual values, beliefs and lifestyles. Given that cultural awareness and sensitivity are key aspects of providing effective mental health services, this section includes the foundation knowledge, values and skills essential to working with multicultural populations. Linguistically competent practice not only underscores the importance of language itself, but also includes an understanding of the complexities of effective communication in rendering culturally competent services.

1. Student demonstrates understanding of the influence of racial, ethnic, age, class, cultural identity, gender identity, and sexual orientation identity on interpersonal relationships in community mental health practice.
2. Student demonstrates knowledge of immigration, migration, resettlement and relocation patterns of the major ethnic groups in the United States in the context of both historical and current manifestations of oppression, racism, prejudice, discrimination, bias and privilege.
3. Student demonstrates knowledge of differences between the experiences of immigrants and refugees and the different impact those experiences have on individuals and families.
4. Student demonstrates awareness of the effects of acute and accumulative trauma on the health status, health beliefs, help-seeking behavior, health practices, customs, and traditions of diverse consumers and communities.
5. Student demonstrates knowledge of the unique legal, historical and current relationships between the American Indian/Alaska Native nations and the United States government and the effect these relationships have on the health status and practices, health beliefs, and help-seeking behaviors, as well as on the customs and traditions within and among their diverse tribal communities.
6. Student demonstrates understanding of the influence and value of traditional ethnic and culturally based practices, which affect the mental health of the individual or family and uses this knowledge in working with consumers, families and the community.
7. Student demonstrates knowledge of legal, social, political, economic and psychological issues facing immigrants and their families in new environments. Student uses this knowledge to better understand consumer's choices/decisions related to multiple health care systems (mental health care, health care, etc.).
8. Student demonstrates understanding of the impact and importance of assimilation and acculturation processes in working effectively with culturally diverse individuals, families, and communities
9. Student is able to apply appropriate theories of practice to various ethnic and cultural groups, as well as other diverse groups.

10. Student demonstrates a commitment to cultural competence by undertaking an ongoing self evaluation process with regard to his/her own multicultural awareness and perceptions of difference.
11. Student demonstrates understanding of the importance and necessity of using the consumer and community's native language in all forms of communication (staff, signage, forms, etc.) and its importance to mental health treatment.
12. Student demonstrates understanding of the full range of implications for assessment and diagnosis, including the danger of misdiagnosis when English is not the consumer's primary language and professional translation services are not utilized.
13. Student demonstrates understanding of how variance in a consumer's language can impact the expression and understanding of symptoms and attributions of illness.
14. Student demonstrates understanding and awareness of how his/her own cultural values, beliefs, norms, and world view influence perception and interpretation of events and can influence the relationship with consumers.
15. Student respects religious and or spiritual beliefs and values about physical and mental functioning that differ from his/her personal beliefs and values.
16. Student demonstrates understanding of how biases, prejudices and beliefs are formed about poverty, gender identities, sexual orientation, homelessness, substance abuse and mental illness and how these biases affect relationships with consumers.
17. Student demonstrates understanding of disparities for racial and ethnic minorities, and other culturally diverse groups in terms of access, appropriateness, availability and quality of mental health services.
18. Student demonstrates understanding of the value, necessity, and promotion of consumer and community engagement, participation and involvement in mental health program design and treatment

II. Foundation Practice

This section identifies the foundation skills that are essential for basic practice in the public mental health domain. Competencies include interviewing, assessment, treatment planning and intervention using an ethno, bio-psycho-social strength-based approach. This approach includes skills in working with children, and adolescents with serious emotional and behavioral disorders, as well as adults and older adults with severe mental illness. Underlying principles of these competencies include knowledge of cultural diversity, linguistic sensitivity and client strength as well as knowledge of concepts of recovery, empowerment, and a consumer-centered, family driven, community mental health perspective. These competencies are demonstrated in accordance with legal and ethical standards, principles of cultural diversity, and commitment to social and economic justice, with sensitivity to the needs of vulnerable populations.

Practice with Individuals

1. Student demonstrates understanding of human development and the life cycle. Student understands the major themes and tasks of each developmental stage.
2. Student demonstrates recognition of personal values and biases and can distinguish life-style choices from clinical issues.
3. Student demonstrates effective interviewing and engagement skills with individuals and families.
4. Student demonstrates understanding of the role and limitations of using interpreters and translators in providing services.
5. Student demonstrates the ability to complete a comprehensive assessment of an individual and his/her family. Student follows legal and ethical guidelines and obtains appropriate collaborative information for assessment.
6. Student demonstrates an understanding of contributing factors to serious emotional and behavioral disorders.
7. Student demonstrates an understanding of the factors that contribute to the disabling effects of severe mental illness.
8. Student is able to identify the signs of abuse/neglect with minors, older adults and dependent adults. Student demonstrates knowledge of reporting laws and collaborates with supervisors in reporting.
9. Student demonstrates knowledge of reporting laws regarding suicidal and homicidal intent. Student collaborates with his/her supervisor regarding appropriate action including involuntary commitment.
10. Student demonstrates knowledge of ethical issues pertaining to treatment including boundaries, dual relationships and confidentiality.
11. Student understands and utilizes proper documentation/charting as required by the agency.
12. Student demonstrates knowledge of natural, community and institutional supports for persons in crisis.
13. Student demonstrates beginning knowledge of crisis intervention models of suicide and family violence prevention.
14. Student demonstrates knowledge of the diagnostic criteria for substance abuse and dependence.
15. Student demonstrates beginning ability to develop a diagnostic formulation based on thorough assessment.

16. Student is able to develop a coordinated intervention plan, including treatment and/or case management services and a discharge plan.
17. Student demonstrates beginning skills using time-limited interventions.
18. Student demonstrates understanding of therapeutic ‘use of self’ as an intervention tool for delivery of effective services.
19. Student demonstrates knowledge of the principles of integrated dual diagnosis treatment.
20. Student demonstrates knowledge of the principles underlying recovery supportive practice.

Practice with Families

1. Student demonstrates understanding of interdisciplinary theories and clinical models that guide social work intervention with diverse family systems.
2. Student demonstrates awareness of the changes that affect family functioning occurring across the life span of family members.
3. Student is able to assess from an ecological perspective the diversity of family characteristics (i.e. membership in an ethnic and racial group, gender, sexual orientation, etc.) as these guide the design and implementation of interventions.
4. Student demonstrates ability to implement a psycho-educational intervention model which provides information, support and structure for families of a consumer with a major mental illness.
5. Student demonstrates ability to engage and work with a family in an effective family-driven manner.

Practice with Groups

1. Student demonstrates understanding of the appropriateness of group intervention following a comprehensive assessment.
2. Student is able to distinguish the different types of groups (i.e. psycho-educational, psychodynamic, self-help) and formats for group structure (i.e. open ended vs. closed, directive vs. non-directive).
3. Student demonstrates understanding of the cultural dynamics of the consumer and how this affects the consumer’s involvement in a group.
4. Student demonstrates knowledge of the normative stages of group development.
5. Student demonstrates knowledge of available resources in the community that utilize group interventions.
6. Student is able to use strategies that improve adherence to group participation.

7. Student demonstrates ability to work with persons with co-occurring mental illness and substance abuse in group intervention.

Practice with Community

1. Student demonstrates understanding of the resource advocate role in relation to the policies and programs that impact public mental health agencies and their consumers.
2. Student understands and supports the consumer movement, including issues of patient's rights, peer support, self-help and advocacy.
3. Student is able to respect, value, and effectively work with diverse communities.
4. Student demonstrates knowledge of current target population eligibility criteria for publicly funded mental health services.
5. Student demonstrates understanding of the development and resource potential of the self-help movement such as reciprocal help and family advocacy for children, youth, adults and older adults.

III. Human Behavior and the Social Environment

The competencies in this section include knowledge and understanding of how developmental, psychological, social and cultural theories influence the life span of human development, and the evolution of community and societal change, and how these processes affect practice with children and adolescents with serious emotional disorders, and adults and older adults with severe mental illness

1. Student is able to identify the major theories, categories and models used to explain serious emotional disturbances in children and serious mental illness in adults and older adults.
2. Student demonstrates understanding of mental illness along the life cycle, and the effect of cultural, bio-psycho-social and environmental conditions.
3. Student demonstrates understanding of the family life cycle, the intergenerational conceptual framework and human development across cultures and social classes.
4. Student demonstrates appreciation for the special strengths, issues and variations found in various family models (i.e. two-parent family, single parent family, blended family, extended family, etc.)
5. Student demonstrates understanding of the developmental, intergenerational and life cycle approach to community mental health practice transculturally.
6. Student understands the impact of mental illness and substance abuse on the consumer and family members at all stages of the life cycle.

7. Student demonstrates awareness of the difference between protective factors and risk factors in individuals and families, and how these factors influence the development of coping skills.
8. Student demonstrates understanding of the dynamics of trauma in its various forms and the impact on individuals, families and communities.
9. Student demonstrates understanding of the unique mental health needs of people in transition between life stages.

IV. Workplace Management

This section contains competencies concerning important aspects of agency practice. They address internal relations, organizational requirements, and interdisciplinary and community collaboration for empowerment and social justice. In the foundation year, the students acquire strategies for self-care and safety on the job. Students demonstrate understanding of practice and policy advocacy. Students also understand the importance of consumer, family, organization and community feedback for evaluation of practice processes and outcomes.

1. Student demonstrates awareness of the need to negotiate and advocate for the development of community based and culturally sensitive resources to assist mental health populations in meeting their goals.
2. Student demonstrates ability to work effectively with agency personnel and consumers in an environment characterized by human diversity.
3. Student demonstrates understanding of consumer and system problems and strengths from the perspectives of all participants in a multidisciplinary team and can effectively maximize the positive contributions of each member.
4. Student is able to identify the interaction between a community and an organization's strengths and limitations, and is able to assess their effects on services for community mental health populations.
5. Student is able to identify the strengths and limitations of an organization's cultural competence and commitment to human diversity and how these are demonstrated.
6. Student is able to seek consumer, family, organization and community feedback (including mental health consumer advocacy groups) for evaluation of practice, process and outcomes.
7. Student demonstrates ability to utilize interdisciplinary collaborative skills and techniques in organizational and community settings to enhance service quality.
8. Student demonstrates understanding of how organizations operate and how their organizational culture impacts service delivery and social work roles, including internal and external forces that both promote and inhibit organizational change.

9. Student is able to plan, prioritize and effectively monitor completion of assigned activities and tasks within required time frames and standards.
10. Student demonstrates awareness of organizational risk management issues, and is able to appropriately respond to potentially harmful situations, including workplace violence.
11. Student demonstrates awareness of potential work-related stress factors and is able to develop self-care and organizational strategies to minimize their impact.
12. Student demonstrates knowledge of fiduciary responsibilities tied to funding streams, regulatory compliance and practice requirements.
13. Student demonstrates understanding of the relationship between accountability for performance outcome, the quality of service and the financial sustainability of the organization.

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THE FUNDAMENTALS OF WORKFORCE COMPETENCY: IMPLICATIONS FOR BEHAVIORAL HEALTH

Michael A. Hoge, Janis Tondora, and Anne F. Marrelli

ABSTRACT: Increasing attention is being directed to the competency of those who deliver healthcare in the United States. In behavioral health, there is growing recognition of the need to define, teach, and assess essential competencies. Since attention to this issue in behavioral health is relatively recent, there is much to be gained by learning from the principles, definitions, and conceptual models of competency that have been developed in other fields. This article outlines the forces that drive the current focus on competency of the healthcare workforce. Relevant history, principles, definitions, and models that have evolved through research and application in business and industry are reviewed. From this analysis, recommendations are offered to guide future work on competencies in behavioral health.

KEY WORDS: behavioral health; competency; education; training; workforce development.

In September 2001, a group of professionals, students, and consumer and family advocates gathered at the Annapolis Conference on Behavioral Health Workforce Education and Training. Their purpose was to address growing concerns about the preparation of providers for practice in contemporary healthcare systems (Hoge & Morris, 2002). As part of that process, an initial effort was made to define some of the competencies required to work effectively in this field. One of the formal re-

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This work was supported in part by Contract No. 03M00013801D from the Substance Abuse and Mental Health Services Administration.

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commendations generated by conference participants was that workforce competencies should be a priority for in-depth study and development.

The “competency” of individuals who provide services has rapidly emerged as a major focus in the field of behavioral health (Coursey et al., 2000a, b; Joint Commission on Accreditation of Healthcare Organization [JCAHO], 2000). At first glance, the concept of competency is both simple and compelling. It has been defined as the “quality of being properly or well qualified” (Pickett, 2000). Few would question that providers of healthcare should be competent. However, in actual practice, achieving or demonstrating competence is complex. Certainly, a diploma or license hanging on the office wall is no longer accepted by all as sufficient evidence of one’s abilities to provide safe and effective care (Drotos, 2001).

Behavioral health has much to learn from work on competencies conducted outside of this specialty. For example, the emphasis on competence, accountability, and outcomes, though relatively new to behavioral health, has been a fundamental aspect of corporate culture for some time (Prahalad & Hamel, 1990). The purpose of this article is to first examine the dynamics within healthcare that have heightened attention to this issue. This is followed by a review of the founding principles, initial research, and subsequent conceptual and practical work on competencies that has occurred mainly in business and industry. From this review we derive a series of recommendations to guide the application of competencies to the behavioral health workforce.

THE EMERGING FOCUS ON COMPETENCY IN HEALTHCARE

A complicated array of forces have been at play, driving the emphasis on workforce competency. First, purchasers of healthcare, concerned about the quality, value, and cost of services, turned to managed care well over a decade ago (Hoge, Thakur, & Jacobs, 2000). While there are differing opinions about the value and impact of managed care organizations, there is no doubt that they have played an active role in intensifying the debate about the effectiveness of specific treatments and the qualifications and competence of providers to deliver those treatments.

Demand for healthcare that is both clinically- and cost-effective has also led to the proliferation of practice guidelines (APA, 2000; Herz et al., 2002; Lehman et al., 1998; McEvoy, Scheifler, & Frances, 1999) and a clamor for evidence-based approaches to treatment (Drake et al., 2001). The fact that there is wide variation in clinical practice patterns (Coursey et al., 2000a) and frequent failures to deliver care in

accordance with established guidelines (Lehman et al., 1998; Milner & Valenstein, 2002) has generated concerns about the competence of the workforce.

A competency is a measurable human capability required for effective performance.

Concerns about provider competency and its impact on the quality of US healthcare also have been heightened by three major reports issued by the Institute of Medicine (IOM): *To Err is Human* (2000), *Crossing the Quality Chasm* (2001), and *Health Professions Education* (2003). These “calls to action” presented indictments of current healthcare delivery and the avoidable errors in care that lead to increased morbidity and mortality. Rather than blaming individual practitioners, the IOM heavily criticized the systems of care where individuals practice, as well as the educational systems responsible for preparing those practitioners.

There is substantial evidence that our educational systems have not kept pace with the dramatic changes in healthcare (Hoge, 2002). For example, educational programs have been slow to introduce practice guidelines into clinical training, or teach students to deliver evidence-based services (Crits-Christoph, Chambless, Frank, Brody, & Karp, 1995; Yager, Zarin, Pincus, & McIntyre, 1997). Too few students learn to work in managed health systems or manage the care of the individuals whom they serve (Blumenthal, Gokhale, Campbell, & Weissman, 2001; Moffic, 2000). Training also occurs in disciplinary silos, leaving students unprepared for multi-disciplinary practice (APA, 1998; Casto & Julia, 1994; Richards, 1996).

Looking beyond the formal classroom to the realm of continuing education, research has shown that the prevalent teaching format, the didactic lecture, workshop, or conference, tends to neither change a provider's practice nor improve consumer outcomes (Davis & Taylor-Vaisey, 1997). Of equal concern is the fact that little, if any, education or training is offered to the non-degreed and bachelor-degreed personnel who deliver a large proportion of all care, particularly in public sector and institutional settings (Morris & Stuart, 2002).

A final driver of the concern about competency is tied to the rise of consumerism in healthcare. Consumers increasingly demand meaningful participation in decisions about their care, and this dramatically shifts the traditional balance of power in the treatment relationship. More often, consumers now expect caregivers to be capable of providing information about treatment options and engaging them in collaborative decision-making in treatment planning. This unique set of practitioner

competencies is seldom addressed in education and training programs (Chinman et al., 1999; Dixon et al., 2001; Young, Forquer, Tran, Starzynski, & Shatkin, 2000).

As a result of these various forces and concerns, competency has become an “unavoidable” term in healthcare (JCAHO, 2000). Policymakers laud it, educational programs are required to produce it, and consumers increasingly demand it. Accreditation bodies, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), require provider organizations to ensure that the competence of all staff members is assessed, maintained, demonstrated, and improved on a continual basis (JCAHO, 2002).

In behavioral health, a common outcome of attention to the issue of competency has been published “lists” of the knowledge or skills considered essential for practice. Various national initiatives have resulted in extensive inventories of competencies (Addiction Technology Transfer Center, 2002; American Board of Examiners in Clinical Social Work, 2001; American Managed Behavioral Healthcare Association and American Society of Addiction Medicine, 2000; American Psychological Association, 1997; Carling, 1993; Coursey et al., 2000a, b; Gill, Pratt, & Barrett, 1997; Hartman, Young, & Forquer, 2000; Kuehnel & Liberman, 1997; Society for Education and Research in Psychiatric-Mental Health Nursing, 2002; Trochim & Cook, 1993).

One of the formal recommendations by conference participants was that workforce competencies should be a priority for in-depth study.

Several of these inventories have begun to address the complexities involved in specifying competencies for different types of providers, levels of training, areas of specialization, treatment settings, and populations. However, minimal conceptual work has been completed as a foundation for understanding and implementing competency approaches in the field of behavioral healthcare. Largely unaddressed are questions regarding what constitutes a competency and how it can be reliably assessed. These basic issues are further complicated by shifting standards of care (JCAHO, 2002), the rapidly growing and changing evidence base (Drake et al., 2001), and the inability of educational programs to handle a seemingly endless and ever-growing list of externally imposed requirements regarding the process and content of training (Hoge, Jacobs, Belitsky, & Migdole, 2002). The value of existing competency inventories will be enhanced in their practical application if there is a clearer foundation that provides a framework for both defining and assessing competency within the context of behavioral health practice.

HISTORICAL ORIGINS

The concept of competencies can be traced to the distant past. For 3,000 years, the Chinese empire recognized differences in individual abilities by employing civil service exams in selection for government jobs (Anastasi, 1968). In medieval times, apprentices were expected to develop the specific skills they would need for effective job performance by working with a master craftsman. For hundreds of years, educators have defined the knowledge and skills to be covered in their curricula (McLagan, 1997). The English biologist Sir Francis Galton and the American psychologist James McKeen Cattell pioneered the development of objective techniques to measure human intellectual capabilities in the late 19th and early 20th Centuries (Anastasi, 1968; Shippmann et al., 2000).

A Focus on Work and Employee Selection

In the 1940s and 1950s, Ernest Fleishman and John Flanagan systematically analyzed the work behavior of supervisors and identified broad performance factors (Shippmann et al., 2000). Beginning in the 1960s, many psychologists attempted to identify individual variables that would effectively predict job performance without inherent bias against subgroups (Shippmann et al., 2000). By this time in history, numerous research studies had demonstrated that assessments of academic aptitude, tests of knowledge, grades, and credentials were not good predictors of either job performance or success in life. Research had also demonstrated that academic tests and credentials were biased against women, racial minorities, and persons of lower socioeconomic status (Marrelli, 1998; Spencer, McClelland, & Spencer, 1994). Employees and rejected job candidates were beginning to file legal suits against employers, claiming that employment selection and promotion decisions were being made on the basis of factors other than valid qualifications for a job (Aamodt, 1991).

In 1978, the federal government published the *Uniform Guidelines on Employee Selection Procedures*. The *Guidelines* specified that the selection of workers had to be based on job-related qualifications. These qualifications were to be grounded in an analysis of the important work behaviors and desired outcomes of the job (Equal Employment Opportunity Commission, 1978; Harvey, 1991; Shippmann et al., 2000).

Many of the traditional job analysis approaches still in use today were developed in response to the pressing need to identify individual variables that were effective, unbiased predictors of future job performance,

and could be used in making employment decisions. Some of the job analysis techniques developed were Ernest Primoff's *Job-element Approach*; McCormick, Jeanneret, and Mechams' *Position Analysis Questionnaire*; Ammerman's *Ammerman Technique*; the *Threshold Traits Analysis* developed by Lopez, Kesselman, and Lopez; and the *Job Element Inventory* developed by Cornelius and Hakel (Aamodt, 1991).

Among the individuals working to identify predictive, unbiased variables were Harvard psychologist David McClelland and his colleagues. They developed a two-step strategy to guide their research: (1) the identification of criterion samples comprised of individuals who were either clearly successful in their work or life outcomes, or were significantly less successful, and (2) the comparison of these samples to determine which behaviors and other variables were causally related to the differences in success (Spencer, McClelland, & Spencer, 1994).

Another research strategy developed by McClelland and his colleague, C. Dailey, involved the Behavioral Event Interview (BEI). This was a structured interview process based on John Flanagan's Critical Incident Technique, where interviewees were asked to describe key successful and unsuccessful events that had occurred on the job. Following the interviewee's description of each major event, the interviewer asked a series of questions such as: What led up to the event? Who was involved? What happened? What did you do? What was the result? The BEI was administered to different groups of workers who were performing the same tasks, but had been differentiated as high, average, and poor performers. Using structured content analysis of their interview responses, McClelland identified the variables that distinguished superior performers from average and poor performers (Spencer, McClelland, & Spencer, 1994).

A diploma or license hanging on the office wall is no longer accepted by all as sufficient evidence of one's abilities to provide safe and effective care.

In 1973, McClelland published an influential article, "Testing for Competence Rather than for Intelligence." In that article, he proposed replacing intelligence and aptitude tests with "competency testing" or "criterion sampling." McClelland defined competencies as the knowledge, skills, traits, attitudes, self-concepts, values, or motives directly related to job performance or important life outcomes and shown to differentiate between superior and average performers (Shippmann et al., 2000; Spencer, McClelland, & Spencer, 1994).

The first field tests of McClelland's research in the early 1970s involved US State Department Foreign Service Information Officers and US Navy Race Relations Consultants. For the Foreign Service Information Officer

positions, McClelland identified numerous competencies that distinguished superior from average officers. He named some of these competencies “Cross-cultural Interpersonal Sensitivity,” “Maintenance of Positive Expectations of Others Despite Provocation,” and “Speed in Learning Personal Networks.” Traditional job analysis had primarily focused on the duties and tasks of the job, and McClelland’s focus on the behaviors and characteristics of the workers was an innovative approach to identifying the requirements for success at work (Spencer, McClelland, & Spencer, 1994).

Evolving Competency Frameworks

Early work on competencies has continued to evolve as different disciplines developed strategies to apply the concept in the workplace. Four disciplines have been especially influential: Industrial-Organizational Psychology, Differential Psychology, Educational Psychology, and Human Performance Technology. The differences among the four disciplines lie more in emphasis than in widely divergent principles and methodologies.

The Industrial-Organizational Psychology framework places more emphasis on the job itself rather than on the performer. Competency identification begins by fully describing the duties and tasks of the target job. Job incumbents and their supervisors are asked to identify the knowledge, skills, abilities, and personal characteristics needed to perform each task. All levels of performers are included in the identification of job duties, tasks, knowledge, and skills, and there is usually no effort to differentiate the input received about job duties from high, average, and low performers. Typically, long and detailed lists of knowledge, skills, abilities, and personal characteristics are developed. The most common application of competencies in Industrial-Organizational Psychology is identifying the competencies to be included in employee selection processes, such as interviews and written tests.

Practitioners in the Differential Psychology perspective have tended to focus on differences between superior and other performers. Emphasis is placed on physical and cognitive abilities, values, interests, and personality traits rather than knowledge and skills. Competencies are perceived as largely innate characteristics that are difficult to develop (McLagan, 1997). A common application of competencies in Differential Psychology involves identifying employees with high potential for leadership positions.

The Educational Psychology approach focuses on specifying the full range of competencies required for successful job performance. The differentiation of superior performers from others is not seen as crucial, and the emphasis is on developing people so they will be successful. Knowledge and skills that can easily be taught and developed are per-

ceived as important, as well as more complex abilities and personal characteristics that are more difficult to develop. Important applications of competencies in Educational Psychology are in identifying the competencies workers need in order to become effective performers, and creating performance management, training, and other development programs to help them build these competencies (McLagan, 1997).

The Human Performance Technology (HPT) framework approaches competencies from the perspective of performance improvement. What can the organization do to maximize the performance of its employees? HPT competency initiatives focus on identifying the knowledge, skills, abilities, and personal characteristics consistently demonstrated by exemplary performers. Exemplary performers are those who consistently exceed expectations for work accomplishments, in contrast to fully successful performers who consistently meet expectations (Dubois, 1999). The key idea is that if an organization can discover what makes an employee an exemplary performer, it can then apply that information in helping other employees build those competencies and increase their accomplishments (Gilbert, 1996). Typical applications of competencies in the HPT framework include organizational development and design initiatives, business process improvement, succession management, training and development programs, performance management, and implementation of incentive systems.

DEFINING COMPETENCIES

A fundamental challenge in the application of competency approaches is establishing consensus regarding an operational definition of the concept. The published literature contains numerous definitions that outline the core elements of competency (Athey & Orth, 1999; Lucia & Lepsinger, 1999; Marrelli, 1998; Mirabile, 1997; Spencer, McClelland, & Spencer, 1994; Spencer & Spencer, 1993). These elements and the language used to describe them, vary among authors. The same term may be used by different competency theorists and practitioners to describe two or more different capabilities. The particular terms used are not important in themselves. What matters is consistency within an organization or community of practice in the use of the terms. Offering and adopting a clear definition of an individual competency in a work environment is much more important than focusing on whether, in an abstract way, it is the "correct" definition (Marrelli, 1998).

Wide variation in clinical practice patterns and frequent failures to deliver care in accordance with established guidelines has generated concerns about the competence of the workforce.

We present a definition of the competency construct and four elements of competency based on a synthesis and distillation of previously published works and our practical experience in the application of competencies in the workforce:

A competency is a measurable human capability that is required for effective performance. It is comprised of knowledge, a single skill or ability, or personal characteristic—or a cluster of these building blocks of work performance. Successful completion of most tasks requires the simultaneous or sequenced demonstration of multiple competencies.

Competency experts often refer to the elements of competency as the KSAPs: *k*nowledge, *s*kills, *a*bilities, and *p*ersonal characteristics. Each of these elements is described below.

Knowledge

Knowledge is awareness, information, or understanding about facts, rules, principles, guidelines, concepts, theories, or processes needed to successfully perform a task (Marrelli, 2001b; Mirable, 1997). The information may be concrete, specific, and easily measurable or more complex, abstract, and difficult to assess (Lucia & Lepsinger, 1999). Knowledge is acquired through learning and experience. Examples include knowledge of the federal, state, and local regulations governing patient care; knowledge of the diagnostic characteristics of a disorder; or knowledge of a practice guideline.

Historically, training and education programs have placed heavy emphasis on imparting knowledge. From a competency perspective, it is important that knowledge considered essential for a task or job be identified as explicitly as possible. Consistent with McClelland's original set of premises, the knowledge imparted should also have a link to meaningful, work-related outcomes. Therefore, the assessment of knowledge as an element of competency should take into consideration the impact of that knowledge on individual job performance.

Skills

A skill is a capacity to perform physical or mental tasks *with a specified outcome* (Marrelli, 1998). Similar to knowledge, skills can range from highly concrete and easily identifiable tasks, such as completing a patient

registration form, to less tangible and more abstract tasks, such as facilitating a team meeting in order to achieve consensus on a treatment plan (Lucia & Lepsinger, 1999). Other examples of skills include formulating a diagnosis, administering a medication through injection, and following a structured interview protocol. Spencer and Spencer (1993) refer to knowledge and skills collectively as “surface” competencies, as they tend to be the easiest elements of competency to develop through training.

Abilities

An ability is a demonstrated cognitive or physical capability to successfully perform a task with a *wide range of possible outcomes* (Marrelli, 1998). It is often a constellation of several underlying capacities that enable us to learn and perform. Examples of abilities include thinking analytically, problem-solving, making projections based on current data, managing or evaluating a treatment program, and synthesizing and integrating information from several sources, as in preparing a review of the literature on the effectiveness of a treatment. Abilities are more complex than skills, and difficult and time consuming to develop, as they typically have a strong component of innate capacity. For example, analytical thinking comes more naturally to some people. Although most persons can develop a level of analytical thinking over time, for some it can be a long and difficult process.

Personal Characteristics

There are numerous other human characteristics that influence and may be required for effective performance. These include values, attitudes, traits, and the behaviors that are manifestations of these human characteristics. Distinguishing these characteristics and associated behaviors as distinct from skills and abilities is somewhat arbitrary, as these characteristics may be essential to effective performance and, at least to some extent, may be taught and learned. The reason that they are often considered separately relates to their emotional/affective quality or emphasis on personality, as opposed to the cognitive and physical quality of skills and abilities.

Marrelli (1998, 2001b) has suggested that it is useful to approach these “personal characteristics” by defining them as “enabling behaviors.” She describes an enabling behavior as a work habit or manner of conducting oneself that contributes to effective work performance. She prefers use of the term enabling behaviors, rather than attitudes, values, traits, characteristics, or other such abstract terms, to emphasize the importance, from a work performance perspective, of *demonstrating* rather than simply *possessing* competencies. What is important in the workplace is one’s behav-

ior and how it results in the accomplishment of work. Abstract constructs such as values, attitudes, and traits cannot be directly measured. Rather, assessment of these constructs requires inference. Thus, instead of focusing on trait or personality concepts that would label an individual as organized, intellectually curious, personable, or a high achiever, the related enabling behaviors might be described as follows: manages work assignments to meet schedule commitments, engages in continuous learning, develops rapport with others, and routinely exceeds expected results.

This discussion of the elements of competencies points out that these elements vary on several dimensions: learned versus innate, cognitive/physical versus emotional/personality, and simple versus complex. Table 1 compares knowledge, skill, ability, and personal characteristics on these dimensions.

The Importance of Clusters

To make most competencies practical for use in communication, selection, training, and evaluation, it is important to define them as a cluster of knowledge, skills, abilities, and personal characteristics. This contrasts with the traditional job analysis approach that breaks down work requirements into a multitude of specific elements. For example, a cluster labeled by competency experts as “Analytical Thinking” would likely be defined by traditional human resource personnel with a long list of distinct capacities such as deductive reasoning, inductive reasoning, information ordering, classification, ability to synthesize information, and pattern identification. In contrast to this “laundry list” approach, competencies are ideally developed as “user-friendly” clusters that can be easily understood and applied by students, educators, staff, and supervisors. If broken down in the traditional job analysis approach, a list of 10 clus-

TABLE 1
Attributes of Competency Elements

<i>Dimensions</i>	<i>Competency Elements</i>			
	<i>Knowledge</i>	<i>Skill</i>	<i>Ability</i>	<i>Personal Characteristic</i>
Learned	X	X	X	X
Innate			X	X
Cognitive/physical	X	X	X	
Emotional/personality				X
Simple	X	X		
Complex	X	X	X	X

tered competencies could easily expand into a list of 60 or 80 individual competencies, which would be an unworkable number for practical application in managing and developing human resources.

FROM COMPETENCIES TO COMPETENCY MODELS

Individual competencies are combined and organized into competency models. A competency model is simply a conceptual framework or organizing scheme that details the competencies that are required for effective performance in a particular job. To facilitate application, a competency model may be organized into different categories of competencies. For example, a model could be developed on three levels:

- “Core competencies” that apply to everyone in the organization, such as ensuring client rights, and practicing infection control.
- “Job family competencies” that apply to everyone providing a particular type of service in the organization, such as outpatient clinical treatment, case management, or rehabilitation therapy.
- “Level competencies” that apply to each job level working within a job family. For example, clinical staff could have three levels: unlicensed direct care staff, licensed/independent direct care staff, and clinical supervisors. Each level would have its own set of competencies, or may have the same competencies with different behavioral expectations.

In a behavioral healthcare setting, for example, an organization may develop a competency model for each type of job, such as an outpatient social worker or inpatient nurse practitioner. The competencies included in each model, and the levels of expected mastery of those competencies, will vary depending upon job function and role. Alternatively, the organization could identify core competencies that every staff person should demonstrate and then identify additional, specific competencies for each job.

A complete competency model typically includes categories of competencies and the list of individual competencies that comprise each category. The following information would be identified for each competency:

- Competency name
- Definition (the meaning of the competency within the organization)
- Descriptors (words or phrases that clarify or amplify the definition)

- Behavioral examples (how the competency is demonstrated on the job at different levels of proficiency)

The competencies included in a model should be determined by specific job performance requirements *and* organizational factors such as strategic direction, vision, culture, organizational dynamics, and challenges. Thus, competency models for the same job role in two different healthcare settings would most likely include some common competencies and some that are specific to the setting. Also, the competency definition, descriptors, and behavioral examples should be tailored specifically for the context in which they will be applied. Thus, although a competency labeled “Assessment” may be included in the competency models for clinical psychologists in both a for-profit substance use disorders treatment center and a government-operated mental health center, the competency may be defined quite differently, with dissimilar behaviors seen as desirable.

THE IMPORTANCE OF ORGANIZATIONAL CONTEXT

The competency of an individual is only one determinant of effective work performance. The characteristics of the organization where the work occurs can have a dramatic impact on performance. Those characteristics relate to the nature of information available, the environment, tools provided, and factors that enhance employee motivation. Ineffective job performance can be traced to the absence or insufficiency of one or more of these elements at the individual, work group, or organizational level.

The IOM heavily criticized the systems of care where individuals practice, as well as the educational systems responsible for preparing those practitioners.

The element of *information* is related to the clarity of performance goals, standards for performance, policies, work processes, reference materials, and feedback. The element of *environment* pertains to the organizational culture and values, as well as the physical characteristics of the work setting. *Tools* encompass job aids, computer systems, equipment, and supplies. The element of *motivational enhancements* includes consequences to the performer, the appraisal system, the promotional system,

compensation, monetary and non-monetary incentives, recognition and reward, and peer pressure (Marrelli, 2001a).

It is critical that behavioral healthcare organizations understand that possession of the required competencies is not sufficient for effective performance by their workforce. All five elements of performance—information, environment, tools, motivational enhancements, *and* individual competency—must be present in the organization to ensure effective performance. Extensive research in the organizational development and human performance technology fields strongly demonstrates that a competent individual placed in an organization where a competency is not understood, valued, supervised, supported, or rewarded is unlikely to display that competency on an ongoing basis (Gilbert, 1996; Langdon, 2000; Rummier & Brache, 1995). As Geary Rummier, a leader in the human performance technology field, has so cogently stated, “When you pit a bad system against a good performer, the system almost always wins” (Rummier, 2004).

One example, research on continuing medical education, has demonstrated that newly learned skills tend not to be routinely displayed when the learner returns to the workplace if the behavior is not rewarded or sanctioned, or runs counter to prevailing practices within the workplace (Davis & Taylor-Vaisey, 1997). Similarly, research on organizational change has demonstrated that the adoption by healthcare providers of evidence-based practices is influenced by the level of institutional resources, the attitudes of program leaders, and organizational climate (Corrigan, Steiner, McCracken, Blaser, & Barr, 2001; Lehman, Greener, & Simpson, 2002; Rosenheck, 2001). In the work setting, what truly matters is the performance of employees, rather than the “possession” of competencies in some abstract sense. Thus, managers striving to increase the effectiveness of their workforce must attend to both the competency of their employees and the characteristics of the organization where the employees function.

APPLICATION OF COMPETENCY MODELS

The pioneering work of McClelland and other psychologists on identifying specific competencies that lead to success on the job has been widely applied during the past decade in human resource management in business and industry. Thousands of organizations throughout the world have commissioned competency studies that are used as the basis for hiring, developing, managing, and promoting employees (Athey & Orth, 1999; Lucia & Lepsinger, 1999; Mirabile, 1997). It has been esti-

mated that US businesses spend as much as \$100 million per year in developing competency models for specific positions (Athey & Orth, 1999; Spencer & Spencer, 1993).

Competency modeling has drawn such interest because of the heated struggle for competitive advantage in corporate America and the belief that qualified employees are the key to success (Lucia & Lepsinger, 1999; Prahalad & Hamel, 1990). Organizations have discovered that using competencies as the basis of their people management systems offers many general benefits, including:

- Creating a culture where human capital is highly valued.
- Helping employees understand the need for continuous learning by identifying the competencies they will need to obtain desirable roles or positions within the organization.
- Replacing promotions and career ladders with opportunities for the lateral growth of individuals in organizations that have been “flattened” or become less hierarchical due to the drive for efficiency and cost containment.
- Replacing *job* security with the opportunity to develop new capabilities that employees can use to enhance their *career* security.
- Moving away from narrowly-defined individual jobs, and toward more functionally integrated work processes and team-based approaches (Marrelli, 1998).

Beyond these general benefits, competencies have been applied successfully in business and industry in eight different components of human resource management systems, which follow.

Strategic Workforce Planning is the process of defining organizational strategies and goals for the next several years, and then planning how to build a workforce that can implement the strategies and achieve the goals. In strategic workforce planning, strategies and goals are clearly defined, and then the specified functions necessary to achieve these are outlined. The subsequent steps involve defining the work roles needed for each function, the number of persons needed in each role, and the competencies required for successful execution of each role. The competencies of the current, and sometimes the projected, workforce are assessed, allowing gaps to be identified. Options for filling the gaps are examined and the selected approaches are planned and implemented. These alternatives may include reassigning employees to new roles, developing current employees, hiring new employees with the required competencies, or establishing special training programs to encourage new entrants into the workforce.

Selection is the process of matching people with open positions, including choosing external candidates for new or vacated positions, internal candidates for promotions or lateral moves, and employees for reassignment or displacement. Competency-based selection is driven by the premise that achieving a closer match between the requirements of the job and an employee's capabilities will result in higher job performance and satisfaction. In a competency-based selection process, the required competencies identified for the target positions are used as the selection criteria. Interviews, written tests, assessment centers, ratings of education and experience, and any other selection instruments to be used are based on these competencies.

Our educational systems have not kept pace with the dramatic changes in healthcare.

Performance Management consists of a continuous dialog between supervisors and employees in order to set performance goals and expectations; monitor progress; provide feedback, coaching, and development opportunities; and evaluate progress. Competency-based performance management focuses on assessing and rewarding both how work was accomplished (the process) and the goals achieved (the outcomes). The competencies employees need to succeed in their jobs are identified for them. These are the "how to" of work. Emphasis is placed on providing ongoing coaching and feedback to employees to help them build these competencies.

In competency-based *Employee Development* systems, the training and development programs, curricula, and activities are built around the competencies required for effective performance in specific functions or job roles. Employees participate in development programs to build required competencies for which they lack proficiency, or to further build already strong competencies to add additional value to the organization.

In competency-based *Career Planning and Development* systems, organizations design career paths that designate an upward sequence or lateral network of career moves. The competencies required for each step of the career path or network are identified. Employees and their supervisors then use the lists of required competencies to prepare employees for career movement.

The objective of *Succession Planning* is to ensure that several employees are prepared to assume each critical position when it becomes vacant. The competencies needed for each critical position are identified. These competency profiles are then used to nominate and rank employees with high potential for succeeding in each position. The profiles may also be used to identify external candidates.

Competency-based *Compensation Systems* reward employees for the development and application of the competencies the organization has identified as important for success. In these systems, employees' competencies can affect their assigned base pay grade, as well as pay increases and bonus incentive pay.

Competency-based *Reward and Recognition Programs* identify and reward employees based upon the demonstration of competencies that the organization highly values. An organization identifies the competencies it prizes, such as leadership, and establishes award programs to recognize employees who demonstrate high levels of these competencies in their work (Marrelli, 2001b).

IMPLICATIONS FOR BEHAVIORAL HEALTH

This review of the history and fundamentals of the concept of competency lead to a series of recommendations regarding workforce development efforts in behavioral health. An understanding of the foundations of the concept and its definition can ground and advance efforts to build competencies in the fields of mental health and substance use disorders treatment. This understanding has the potential to move the field beyond the compilation of required knowledge and skills to more thorough models of competency, and to more effective use of these models. Ten recommendations are offered below.

1. *Dedicate a greater proportion of the behavioral health field's investment in human resources to developing those resources.* Mental healthcare and substance use disorders treatment are labor-intensive endeavors. It is estimated that up to 75% of expenditures in behavioral health organizations are for human resources, while a very small percentage of the expenditures are used to develop that resource. The comprehensive use of competency-based approaches in business and industry to select, develop, and promote employees stems from a broad recognition of the payoff from investing in the individual human resources that comprise any organization.

2. *Adopt and integrate sophisticated methods for competency development and application that are readily available from business and industry.* Too a large extent, behavioral health has pursued an "armchair approach" to competency modeling, where a list of competencies is created based on the opinion of a panel of experts without empirical validation. As a first step, the field could benefit from employing a sound Industrial/Organizational Psychology approach that specifies job duties and tasks and then empirically identifies the knowledge, skills, abilities, and personal charac-

teristics (KSAPs) required to effectively perform each duty and task. A next step would be to follow the common practice in Human Performance Technology and cluster long lists of KSAPs into a limited number of essential competencies that can be more easily understood by employees and supervisors, and will be more manageable guides in workforce development efforts. Following the traditions of Educational Psychology, the field should also employ a variety of training and staff development practices to build the competencies needed by employees. Examining the differences between employees, as embodied in the Differential Psychology and Human Performance Technology approaches, will illuminate the competencies demonstrated by high achievers in the field, so that these can be incorporated into our competency models. Using these multiple approaches will yield more robust competency models, and will position the field to apply those models *comprehensively* in workforce planning, employee selection, performance management, development, career planning, succession planning, compensation, and employee reward and recognition systems.

3. *Observe “exemplary” employees in order to identify and describe essential competencies.* To date, this basic strategy has been used infrequently in behavioral health. Instead, it appears that expert opinion, as outlined in the published literature or in the recommendations of expert panels, has been the principal source of information about competencies. While the opinions of individual experts or panels of experts can be of significant value, observation of the actual behavior of highly effective practitioners may offer the most accurate blueprint of the range of competencies required for practice, and help identify the specific behaviors that comprise each of those competencies. This strategy guards against the development of competency models that are detached from the practical realities of delivering care.

4. *Provide detailed information about required competencies to direct care staff, supervisors, and trainers.* Historically, treatment in the behavioral health field has been largely driven by theory. Individuals entering the field have been taught the theory and accompanying principles that should guide therapeutic action. However, instruction has been light on guidelines or detail that trainees need in order to understand the specific behaviors expected of them. In a recent study, psychology interns lamented the lack of “road maps” in their attempts to learn how to treat individuals with serious mental illness (Hoge, Stayner, & Davidson, 2000). As the field now moves from teaching “schools of thought” to teaching “bodies of evidence,” the opportunity exists to develop and use competency models to make the expected behaviors more visible among different types of providers and for different types of practice. Students, trainers, direct care staff, and supervisors need “user-friendly” competency models that clearly

define the competencies needed for a particular job role, and provide specific behavioral examples at several levels of proficiency. Anecdotal case studies that illustrate the application of a competency or competency model in a realistic work situation would also be helpful.

5. *Increase the emphasis on developing skills and abilities in training.* While current educational efforts incorporate skill development, much of the actual activity in training and education programs revolves around didactic efforts to impart knowledge. Building a professional knowledge base is an important part of an education for behavioral health providers, but we must ensure that the knowledge taught is directly relevant to common work requirements and skills and abilities needed to provide effective care. For supervisors, it is also essential to build the leadership abilities necessary to successfully manage employees' performance.

Largely unaddressed are questions regarding what constitutes a competency and how it can be reliably assessed.

6. *Performance in "real world" settings should constitute the ultimate criterion of competency.* Formally assessing an individual's knowledge or proficiency in a skill or ability constitutes one criterion of competency. The formal assessment of proficiency, however, is an imprecise proxy for whether one *actually* demonstrates the competency on the job in a consistent fashion. Thus, the optimal criterion in efforts to build and assess competencies should be their demonstration in routine practice.

7. *Link competencies to outcomes.* Whether identified through expert opinion or the observation of exemplary practitioners, competencies outline behaviors that are *presumed* to have some link to desired outcomes. Since the behavioral healthcare field is in an early phase of evidence-based practice, the demonstrated links between specific practices and outcomes are fairly rare. Examining and establishing such links must be a priority in order to validate the competencies that are considered essential elements of evidence-based practice, and to ensure that these competencies constitute more than the opinions of experts or the common practices of those working in the field. This is a challenging and difficult objective. As such, it must be considered an intermediate and long-term objective.

8. *Teach students and practitioners to be self-directed learners and problem solvers.* Training programs are increasingly overwhelmed with the rapid expansion of knowledge in the field and the burgeoning number of requirements issued by organizations that accredit training programs. A paradigm shift is required that abandons efforts to teach *all* competencies that are required for practice. This approach should be replaced

with an effort to provide training in core competencies and in selected specialty skills. Simultaneously, students should be taught self-directed learning and problem solving techniques that they can apply when faced with novel clinical problems, populations, or treatment interventions. A self-directed learner and problem-solver is better equipped to adapt to the rapidly changing healthcare environment.

9. *Distinguish between difficult-to-develop and easier-to-develop competencies.* In the process of developing competency models for work roles in behavioral health care, it is advisable to distinguish the competencies that are readily amenable to development, such as most knowledge and skills, and those that are difficult to develop, such as many abilities and enabling behaviors. Possession of the difficult-to-develop competencies, such as interpersonal skills and problem-solving abilities, could be increasingly used as selection criteria for entry into educational programs and jobs. The easier-to-develop competencies could then become the focus of training. Among psychologists, there has been much discussion about which abilities and enabling behaviors can and cannot be developed, or cannot be developed within a reasonable span of time (Green, 1999; McClelland, 1973; Spencer & Spencer, 1993; Sternberg, 1998). A relevant question with respect to the behavioral health care workforce is whether a specific competency is worth developing or whether the investment required, in terms of time and costs, will outweigh the benefits derived.

10. *Shape treatment organizations to promote competent behavior.* There is a seemingly natural focus on individuals when attempting to develop competencies. However, initiatives in behavioral health to promote competencies must recognize that organizational variables may be as important as *or even more important* than individual variables, training, and education in producing effective performance. It is imperative to couple advances in behavioral healthcare education with efforts to help the managers of behavioral health organizations provide their employees with an organizational culture and the necessary supports that will foster competent behavior (Marrelli, 2001a).

CONCLUSION

The Institute of Medicine recently described the chasm that exists between what is optimal and what is routine in the delivery of healthcare in America (Institute of Medicine, 2001). In its call for corrective action, the IOM focused not on individuals, but on the need to reform the programs that educate practitioners and the healthcare systems where these practitioners work.

A similar theme emerges when considering efforts to build competencies in the behavioral health workforce. Without sufficient guidance or direction, providers have been asked to treat individuals with mental illness and substance use disorders. Too often, these providers have been asked to conduct this work in organizations that fail to support or even thwart attempts to engage in “competent” practices. As we strive to improve our systems of care, the burden clearly lies with researchers, educators, and the administrators of healthcare organizations to identify the competencies required for effective practice, to effectively teach these competencies, and to support their application in daily process of caring for those in need.

REFERENCES

- Aamodt, M. (1991). *Applied industrial/organizational psychology*. Belmont, CA: Wadsworth.
- Addiction Technology Transfer Center. (2002). Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice. Addiction Technology Transfer Center with SAMHSA and CSAT.
- American Board of Examiners in Clinical Social Work. (2001). Professional development and practice competencies in clinical social work. Author..
- American Managed Behavioral Healthcare Association and American Society of Addiction Medicine (2000). Addiction guidelines offer much-needed direction on credentialing. *Behavioral Health Accreditation and Accountability Alert*, 5(4), 1–4.
- American Psychiatric Association. (2000). Practice guidelines for the treatment of psychiatric disorders: Compendium 2000. Washington, DC: Author.
- American Psychological Association. (1997). Changes in the health care delivery system: Recommendations for the education, training, and continuing professional education of psychologists. Washington, DC: Author.
- American Psychological Association. (1998). Interprofessional health care services in primary care settings: Implications for the education and training of psychologists. Washington, DC: Author..
- Anastasi, A. (1968). *Psychological testing*. New York: Macmillan.
- Athey, T.R., & Orth, M.S. (1999). Emerging competency methods for the future. *Human Resource Management*, 38(3), 215–225.
- Blumenthal, D., Gokhale, M., Campbell, E.G., & Weissman, J.S. (2001). Preparedness for clinical practice: Reports of graduating residents at academic health centers. *Journal of the American Medical Association*, 286, 1027–1034.
- Carling, P.J. (1993). *Training standards for staff who work with serious mental illness in public mental health services*. Waterbury, VT: Vermont: Department of Mental Health and Mental Retardation.
- Casto, R.M., & Julia, M.C. (1994). *Interprofessional care and collaborative practice*. Pacific Grove, CA: Brooks/Cole.
- Chinman, M., Allende, M., Weingarten, R., Steiner, J., Tworowski, S., & Davidson, L. (1999). On the road to collaborative treatment planning. *The Journal of Behavioral Health Services and Research*, 26(2), 211–218.
- Corrigan, P., Steiner, L., McCracken, S., Blaser, B., & Barr, M. (2001). Strategies for disseminating evidence-based practices to staff who treat people with serious mental illness. *Psychiatric Services*, 52, 1598–1606.
- Coursey, R.D., Curtis, L., Marsh, D.T., Campbell, J., Harding, C., & Spaniol, L., et al. (2000a). Competencies for direct service staff members who work with adults with severe mental illnesses in outpatient public mental health/managed care systems. *Psychiatric Rehabilitation Journal*, 23(4), 370–377.

- Coursey, R.D., Curtis, L., Marsh, D.T., Campbell, J., Harding, C., & Spaniol, L., et al. (2000b). Competencies for direct service staff members who work with adults with severe mental illnesses: Specific knowledge, attitudes, skills, and bibliography. *Psychiatric Rehabilitation Journal*, 23(4), 378–392.
- Crits-Christoph, P., Chambless, D.L., Frank, E., Brody, C., & Karp, J.F. (1995). Training in empirically validated treatments: What are clinical psychology students learning?. *Professional Psychology: Research and Practice*, 26, 514–522.
- Davis, D., & Taylor-Vaisey, A. (1997). Translating guidelines into practice: A systematic review of theoretic concepts, practical experience, and research evidence in the adoption of clinical practice guidelines. *Canadian Medical Association Journal*, 157, 408–416.
- Dixon, L., McFarlane, W., Lefley, H., Lucksted, A., Cohen, M., & Falloon, I., et al. (2001). Evidence-based practices for services to families of people with psychiatric disabilities. *Psychiatric Services*, 52(7), 903–910.
- Drake, R.E., Goldman, H.H., Leff, H.S., Lehman, A.F., Dixon, L., & Mueser, K.T., et al. (2001). Implementing evidence-based practices in routine mental health service settings. *Psychiatric Services*, 52(2), 179–182.
- Drotos, C. (2001). Credentials losing credence. *Behavioral Health Management*, 21(4), 1.
- Dubois, D. (1999). Competency modeling. In D. Langdon, K. Whiteside & M. McKenna (Eds.), *Intervention resource guide: 50 performance improvement tools* (pp. 106–111). San Francisco: Jossey-Bass/Pfeiffer.
- Equal Employment Opportunity Commission, Civil Service Commission, Department of Labor, Department of Justice (1978). Uniform guidelines on employee selection procedures. *Federal Register*, 43(166), 38295–38309.
- Gilbert, T. (1996). *Human competence: Engineering worthy performance*. Washington, DC: International Society for Performance Improvement.
- Gill, K.J., Pratt, C.W., & Barrett, N. (1997). Preparing psychiatric rehabilitation specialists through undergraduate education. *Community Mental Health Journal*, 33, 323–329.
- Green, P. (1999). *Building robust competencies: Linking human resource systems to organizational strategies*. San Francisco, CA: Jossey-Bass.
- Hartman, M., Young, A., & Forquer, S. (2000). *Core competencies for practitioners providing care to individuals with severe mental illness*. Princeton, NJ: Center for Healthcare Strategies, Inc.
- Harvey, R. (1991). Job analysis. In M. Dunnette & L. Hough (Eds.), *Handbook of industrial and organizational psychology*, 2nd ed. (pp. 71–163). Palo Alto, CA: Consulting Psychologists Press.
- Herz, M.I., Liberman, R.P., Lieberman, J.A., Marder, S.R., McGlashan, T.H., Wyatt, R.J. et al. (2002). Practice guideline for the treatment of patients with schizophrenia. In *American Psychiatric Association practice guidelines for the treatment of psychiatric disorders: Compendium* (pp. 349–461). Washington, DC: American Psychiatric Association.
- Hoge, M.A. (2002). The training gap: An acute crisis in behavioral health education. *Administration and Policy in Mental Health*, 29(4/5), 305–317.
- Hoge, M.A., Jacobs, S., Belitsky, R., & Migdole, S. (2002). Graduate education and training for contemporary behavioral health practice. *Administration and Policy in Mental Health*, 29(4/5), 335–357.
- Hoge, M.A. & Morris, J.A. (Eds.). (2002). *Behavioral health workforce education and training*. [Special issue]. *Administration and Policy in Mental Health*, 29(4/5).
- Hoge, M.A., Stayner, S., & Davidson, L. (2000). Psychology internships in the treatment of severe mental illness: Implications for training in academic medical centers. *Journal of Clinical Psychology in Medical Settings*, 7, 213–222.
- Hoge, M.A., Thakur, N., & Jacobs, S. (2000). Understanding managed behavioral health care. *Managed Care and Mental Health*, 23(2), 241–253.
- Institute of Medicine (2000). *To err is human: Building a safer health system*. Washington, DC: National Academy Press.
- Institute of Medicine (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington: National Academies Press.
- Institute of Medicine (2003). *Health professions education: A bridge to quality*. Washington, DC: The National Academies Press.
- Joint Commission on Accreditation of Healthcare Organizations (2000). *Meeting the competency challenge in behavioral healthcare: The resource tool for behavioral healthcare human resource professionals who must meet the rigorous requirements of JCAHO*. Washington, DC: C & R Publications, Inc.
- Joint Commission on Accreditation of Healthcare Organizations (2002). *Hospital accreditation standards*. Oakbrook Terrace, IL: Joint Commission Resources, Inc.
- Kuehnel, T.G., & Liberman, R.P. (1997). *Competencies for psychiatric rehabilitation workers*. Camarillo, CA: Psychiatric Rehabilitation Consultants.
- Langdon, D. (2000). *Aligning performance: Improving people, systems and organizations*. San Francisco: Jossey-Bass/Pfeiffer.

- Lehman, W., Greener, J., & Simpson, D. (2002). Assessing organizational readiness for change. *Journal of Substance Abuse Treatment*, 22, 197–209.
- Lehman, A.F., Steinwachs, D.M., Dixon, L.B., Goldman, H.H., Osher, F., & Postrado, L., et al. (1998). Translating research into practice: The schizophrenia patient outcomes research team (PORT) treatment recommendations. *Schizophrenia Bulletin*, 24(1), 1–10.
- Lucia, A., & Lepsinger, R. (1999). *The art and science of competency models: Pinpointing critical success factors in organizations*. San Francisco, CA: Jossey-Bass/Pfeiffer.
- Marrelli, A. (1998). An introduction to competency analysis and modeling. *Performance Improvement*, 37(5), 8–17.
- Marrelli, A. (2001). How to implement performance improvement step-by-step. In M. Silberman (Eds.), *The consultant's tool kit* (pp. 210–218). New York: McGraw-Hill.
- Marrelli, A. (2001). *Introduction to competency modeling*. New York: American Express.
- McClelland, D. (1973). Testing for competence rather than intelligence. *American Psychologist*, 28, 1–14.
- McEvoy, J.P., Scheifler, P.L., & Frances, A. (1999). Treatment of schizophrenia 1999. *Journal of Clinical Psychiatry*, 60(11), 4–80.
- McLagan, P. (1997). Competencies: The next generation. *Training and Development*, 40–47.
- Milner, K., & Valenstein, M. (2002). A comparison of guidelines for the treatment of schizophrenia. *Psychiatric Services*, 53(7), 888–890.
- Mirabile, R. (1997). Everything you wanted to know about competency modeling. *Training and Development Journal*, 73–78.
- Moffic, H.S. (2000). Training psychiatric residents in managed care. *The Psychiatric Clinics of North America*, 23, 451–459.
- Morris, J.A., & Stuart, G. (2002). Training and education needs of consumers, families, and front-line staff in behavioral health practice. *Administration and Policy in Mental Health*, 29(4/5), 377–402.
- J.P. Pickett(Ed.) (2000). *American Heritage Dictionary of the English Language (4th ed.)*. Boston: Houghton Mifflin.
- Prahalad, C.K. & Hamel, G. (1990). The core competence of the corporation. *Harvard Business Review*, 79–91..
- R.R. Richards(Ed.) (1996). *Building partnerships: Educating health professionals for the communities they serve*. New York: Jossey-Bass.
- Rosenheck, R. (2001). Organizational process: A missing link between research and practice. *Psychiatric Services*, 52(12), 1607–1612.
- Rummler, G. (2004). Serious performance consulting. Tampa, FL: Presentation at the annual conference of the International Society for Performance Improvement.
- Rummler, G., & Brache, A.P. (1995). *Improving performance: Managing the white spaces on the organization chart (2nd ed.)*. San Francisco: Jossey-Bass.
- Shippmann, J., Ash, R., Battista, M., Carr, L., Eyde, L., & Hesketh, B., et al. (2000). The practice of competency modeling. *Personnel Psychology*, 53(3), 703–740.
- Society for Education and Research in Psychiatric-Mental Health Nursing (SERPN). (2002). Educational preparation for psychiatric-mental health nursing practice. Philadelphia: Author.
- Spencer, L., McClelland, D., & Spencer, S. (1994). *Competency assessment methods: History and state of the art*. Hay/McBer Research Press.
- Spencer, L., & Spencer, S. (1993). *Competence at work: Models for superior performance*. New York: John Wiley & Sons.
- Sternberg, R. (1998). Abilities are forms of developing expertise. *Educational Researcher*, 27(3), 11–20.
- Trochim, W., & Cook, J. (1993). *Workforce competencies for psychosocial rehabilitation workers: A concept mapping project*. Linthicum, MD: The International Association of Psychosocial Rehabilitation Services.
- Yager, J., Zarin, D.A., Pincus, H.A., & McIntyre, J.S. (1997). Practice guidelines and psychiatric education: Potential implications. *Academic Psychiatry*, 21, 226–233.
- Young, A., Forquer, S., Tran, A., Starzynski, M., & Shatkin, J. (2000). Identifying clinical competencies that support rehabilitation and empowerment in individuals with serious mental illness. *Journal of Behavioral Health Services & Research*, 27(3), 321–334.

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WORKFORCE COMPETENCIES IN BEHAVIORAL HEALTH: AN OVERVIEW

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This work was supported in part by Contract No. 03M00013801D from the Substance Abuse and Mental Health Services Administration.

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ABSTRACT: Competency-based training approaches are being used more in healthcare to guide curriculum content and ensure accountability and outcomes in the educational process. This article provides an overview of the state of competency development in the field of behavioral health. Specifically, it identifies the groups and organizations that have conducted and supported this work, summarizes their progress in defining and assessing competencies, and discusses both the obstacles and future directions for such initiatives. A major purpose of this article is to provide a compendium of current competency efforts so that these might inform and enhance ongoing competency development in the varied behavioral health disciplines and specialties. These varied resources may also be useful in identifying the core competencies that are common to the multiple disciplines and specialties.

KEY WORDS: assessment; behavioral health; competencies; training.

There have been growing concerns about the quality of health care in America. As the Institute of Medicine (2001) has focused its attention on potential strategies for improving the safety and effectiveness of services, it has called for a vigorous effort to develop a workforce that possesses a well-defined set of core competencies (Institute of Medicine, 2003a). In a similar vein, the organization that accredits medical residency programs has mandated that such programs demonstrate the knowledge and skill of their students on a specific set of common competencies (Accreditation Council for Graduate Medical Education (ACGME), 1999).

There are parallels to these trends in the field of behavioral health. For example, in its report to the President, the New Freedom Commission on Mental Health (2003) raised major concerns about the quality of mental health care in the United States. It identified a "workforce crisis" and called on training and education programs to offer a curriculum that "incorporates the competencies that are essential to practice in contemporary health systems." With respect to substance use disorders, the Strategic Plan for Interdisciplinary Faculty Development (Haack & Adger, 2002) noted the historic lack of attention on addictions issues in the training of the healthcare workforce, and called for four core competencies on substance use disorders to be incorporated into all health professions education.

Over the past decade, major efforts to identify and assess competencies in behavioral health have, in fact, begun. This article provides a review of the current status of those efforts. A total of 13 topic areas or initiatives in competency development are examined. These are organized into four categories: (1) substance use disorders (addiction counseling, interdisciplinary health professionals), (2) disciplines (marriage and family therapy, professional psychology, Psychiatric-Mental Health Nurse Practitioners (PMHNP), psychiatric rehabilitation, psychiatry, social work), (3) populations (children, serious and persistent mental illness); and (4)

special approaches to care (recovery, cultural competency, peer specialists). While not an exhaustive summary of all activities, this review captures some of the most prominent initiatives in the field.

Competency development in behavioral health can be described as a patchwork quilt of initiatives that have been conducted independently. We have asked a series of experts who have played a major role in these initiatives to each contribute an overview, identifying the segment of the workforce for which their competencies were intended, the organization(s) that sponsored the work, the progress that has been made in both competency development and assessment, future directions for the initiative, and instructions on how to access the competency models that were produced. While the resulting sections of this article each provide such information, if available, the sections are somewhat variable in content, reflecting the unique history, purpose, and processes employed in these diverse efforts.

SUBSTANCE USE DISORDERS

Addiction Counseling, Linda Kaplan

Addiction counseling is relatively young as professions go. Certification processes started in the late 1970s, and in 1981 three states in the Midwest established a small consortium to develop some common standards for certification. A report by Birch and Davis (1984) delineated the first set of national competencies for alcoholism and drug abuse counselors, which laid the foundation for the 12 core functions that were then used as the basis for certification standards.

The number of state credentialing boards for alcoholism and drug abuse counselors increased rapidly, and by 1989 almost all states had voluntary certification boards. The National Certification Reciprocity Consortium (today known as the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, or IC and RC) had about 43 member states by the late 1980s. Common standards were developed that included both written and oral exams, supervised work experience, and a set number of education/training hours. In 1990, the National Association of Alcoholism and Drug Abuse Counselors (NAADAC), concerned about the lack of a national standard and the multitude of acronyms used by the many state certification boards, developed a national certification process that required applicants to be state certified, pass a national exam, and have an academic degree. This was the first time in the addiction treatment field that academic degrees were paired with competencies as a basis for certification. Traditionally, the addiction

counseling field, which was developed by recovering counselors, had relied on assessing competencies as a basis for certification, rather than on academic preparation.

Over the past decade, major efforts to identify and assess competencies in behavioral health have begun.

In 1993, the Addiction Technology Transfer Center (ATTC) network was created by the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA) to improve the preparation of addiction treatment professionals. Soon, the ATTC National Curriculum Committee (Curriculum Committee) was formed to evaluate curricula and establish priorities for curriculum development. The Curriculum Committee developed the *Addiction Counseling Competencies* (ATTC, 1995), which contained 121 competencies. A national study was conducted validating the competencies that were necessary for addiction counseling (Adams & Gallon, 1997), which were developed without regard to education level.

The next step in the process was to articulate the knowledge, skills, and attitudes (KSA) under each of the competencies. Input from many stakeholder groups in the field was sought, and the competencies were sent to addiction experts for a field review. In 1996, a National Steering Committee was formed, which crosswalked the *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice* (ACC; ATTC, 1995) and the *International Certification and Reciprocity Consortium (IC and RC) Role Delineation Study* (IC and RC, 1996). This Steering Committee found that the ACC included the KSA that were required for effective practice, and endorsed the ACC as the basis for education and training of staff that treat people with substance use disorders.

In 1998 SAMHSA published the ACC as a Technical Assistance Publication (U.S. Department of Health and Human Services, 1998). The ACC is divided into two sections. The first contains the *Transdisciplinary Foundations*, organized in four dimensions, which cover the basic knowledge and attitudes for all disciplines working in the addiction field:

- *Understanding addictions.* Current models and theories; the context within which addiction exists; behavioral, psychological, physical health and social effects of psychoactive substances.
- *Treatment knowledge.* Continuum of care; importance of social, family, and other support systems; understanding and application of research; interdisciplinary approach to treatment.

- *Application to practice.* Understanding diagnostic and placement criteria; understanding a variety of helping strategies.
- *Professional readiness.* Understanding diverse cultures and people with disabilities; importance of self-awareness; professional ethics and standards of behavior; the need for clinical supervision and ongoing education.

There are eight dimensions in the second section, which focus on *The Professional Practice of Addiction Counseling*:

- *Clinical evaluation.* *Screening* to determine the most appropriate initial course of action; and *Assessment*, the ongoing process of gathering and interpreting all necessary information to evaluate the client and make treatment recommendations.
- *Treatment planning.* A collaborative process whereby the counselor and client develop treatment outcomes and strategies.
- *Referral.* A process that facilitates the client's use of needed support systems and community resources.
- *Service coordination.* Encompasses case management, client advocacy, and implementing the treatment plan.
- *Counseling.* A collaborative process that facilitates the client's progress toward mutually determined treatment goals and objectives through individual, group, couples, and family counseling.
- *Client, family and community education.* Process of providing clients, families, and community groups information on the risks related to psychoactive substance use, as well as treatment, prevention, and recovery resources.
- *Documentation.* Recording intake, treatment, and clinical reports, clinical progress notes, and discharge notes in an acceptable, accurate manner.
- *Professional and ethical responsibilities.* Includes responsibilities to adhere to accepted ethical standards and professional code of conduct and for continuing professional development; knowing and adhering to all federal and state confidentiality regulations, abiding by the code of ethics for addiction counselors, and obtaining clinical supervision and developing methods for personal wellness.

The addiction counseling competencies are in the process of being revised by the ATTC. In addition, competencies are being developed for clinical supervisors in addiction treatment.

The development of the ACC followed many of the seven steps outlined by Marrelli, Tondora, and Hoge (2005). However, there were lessons learned along the way:

- *Communication and Education Plan.* An important lesson learned was that involving key stakeholders in the process did not lead to the adoption of the competencies as the basis for certification, education, or staff development. Though stakeholders were involved and key groups did endorse the competencies, this did not lead to changes in practice. Only a few state certification boards are using the ACC as the basis for their education and training requirements. Many certification boards have not yet realigned their processes to conform to the ACC, and most academic institutions have not based their curricula on the ACC. A thorough plan that includes educating the field about the competencies and how they are to be used is necessary for them to be adopted.
- *Evaluate the Competency Model and Plan for Updates.* Though the intent has always been to make the competencies dynamic and incorporate new technologies, regular updates are difficult to plan and conduct. They are time-consuming and expensive.

Though old processes and traditions are hard to supplant, the addiction field is making significant progress toward the implementation of the addiction counseling competencies as the basis for professional KSA.

Interdisciplinary Health Professionals, Hoover Adger, Jr.

There have been numerous federal and non-federal initiatives to define alcohol and other drug-specific knowledge, attitudes, and skills, as well as core competencies for health professionals encountering individuals with substance use disorders (Davis, Cotter, & Czechowicz, 1988; Fleming, Barry, Davis, Kahn, & Rivo, 1994; Lewis, Niven, Czechowicz, & Trumble, 1987). These programs have played a major role in bringing about change in the curricula in schools of medicine, nursing, social work, psychology, and other disciplines. While many of the initial faculty development and educational efforts included primarily discipline-specific activities, a recent focus has been expanded to a much broader and richer interdisciplinary approach. This shift away from discipline-specific education and training has been facilitated by the growing interdisciplinary membership and influence of the Association for Medical Education and Research in Substance Abuse (AMERSA).

Since 1976, AMERSA has been working to expand education in substance use disorders for health care professionals. AMERSA has achieved national recognition for its role in supporting faculty development, curriculum design, implementation and evaluation, and the promulgation of an interdisciplinary approach to substance use disorder education and clinical services. Moreover, the organization has played an important role in

providing leadership in improved training for health care professionals in the management of problems related to alcohol, tobacco, and other drugs.

The addiction field is making significant progress towards the implementation of competencies as the basis for professional knowledge, skills, and attitudes.

In 1999, AMERSA entered into a cooperative agreement with the Health Resources and Services Administration's Bureau of Health Professions and the SAMHSA's Center for Substance Abuse Treatment. This agreement supported the initiation of a national interdisciplinary training program to improve health professionals' education in substance use disorders. This interdisciplinary project has three objectives, which include publishing a strategic plan on ways to improve health profession education in substance abuse, establishing a faculty development program to enhance curricula on this topic in professional schools and universities, and building an infrastructure to support expansion of faculty development across health professions.

A Strategic Planning Advisory Committee was convened with nationally recognized experts representing each of the disciplines involved in the project: dentists, dietitians, nurse-midwives, nurses, nurse practitioners, occupational therapists, pharmacists, physical therapists, physicians, physician assistants, psychologists, public health professionals, rehabilitation counselors, social workers, speech pathologists, and audiologists. Using a modified consensus development approach, the committee defined a set of core competencies for health professionals, irrespective of discipline. A resulting statement, "Core KSA in Substance Use Disorders for Health Professionals," broadly describes the minimum knowledge and skills related to substance use disorders for all health professionals. Its four elements are as follows:

- All health professionals should receive education in their basic core curricula to enable them to understand and accept alcohol and other drug abuse and dependence as disorders that, if appropriately treated, can lead to improved health and well-being.
- All health professionals should have a basic knowledge of substance use disorders and an understanding of their effect on the patient, family, and community. Each practitioner should have an understanding of the evidence-based principles of universal, selected, and indicated substance abuse prevention as defined by the Institute of Medicine.

- All health professionals should be aware of the benefits of screening for potential or existing substance-related problems, as well as of appropriate methods for intervention.
- All health professionals should have core knowledge of treatment, and be able to initiate treatment or refer patients for further evaluation and management. At a minimum, all health professionals should have the ability to communicate an appropriate level of concern and the requisite skills to offer information, support, follow-up, or referral to an appropriate level of services.

In addition, cross-disciplinary core knowledge, skill, and attitude competencies for health professionals in substance use disorders were identified by the Strategic Planning Advisory Committee. As one example, the *skill competencies* are as follows. All health care professionals should be able to

- Recognize early the signs and symptoms of substance use disorders.
- Screen effectively for substance use disorders in the patient or family.
- Provide prevention and motivational enhancement to assist the patient in moving toward a healthier lifestyle, or referral for further evaluation or treatment.

The entire report (Haack & Adger, 2002), which details the *Strategic Plan for Interdisciplinary Faculty Development* recommendations and supporting evidence, is available online at www.amersa.org or www.projectmainstream.net. In addition to the interdisciplinary core competencies for all health professionals, each of the disciplines involved has outlined prior activities and competencies that are specific to that discipline. Project curriculum and resource materials are also available from the website.

DISCIPLINE-SPECIFIC COMPETENCIES

Marriage and Family Therapy, William F. Northey, Jr.

The American Association for Marriage and Family Therapy (AAMFT) began its development of core competencies for the field of MFT in January 2003. The AAMFT Board of Directors charged the executive director with convening a task force that would define the domains of knowledge and requisite skills in each domain that comprise the practice of MFT. The product needed to be relevant to accreditors, trainers, and regulators (Northey, 2004). The model outlining these competencies would define knowledge and skill levels, the areas where such knowledge and skills would be obtained, and characteristics that might predispose

one for success as a marriage and family therapist. Competencies as defined would be based, to the extent possible, on a task analysis of clinical practice, clinical research, evidence-based family therapies, and emerging trends in family therapy. Attention would also be paid to the interface between MFT and the broader mental health delivery system, including the bridge between biological and/or genetic issues and pharmacological treatment, and the knowledge and skills MFTs would acquire and maintain in relation to these domains.

The AAMFT created a 50-member taskforce, a five-member steering committee, and assigned one primary staff member to develop the competencies. All of the members of the taskforce had published or presented on MFT education, training, or supervision. The steering committee was made up of progenitors of MFT evidence-based models, as well as regulators, educators, and researchers. The steering committee began its process by discussing ways to structure the core competencies. The committee reviewed extant models of competencies developed in a variety of fields (e.g., substance abuse, psychiatry, mediation, nursing) and reviewed research related to the development of exams used by regulatory bodies.

Workgroups highlighted the importance of close mentoring relationships as key to high level professional training.

The structure decided upon by the committee had two levels. The primary domains identified focused on the practice of MFT:

- *Admission to treatment.* All interactions between client and therapist up to the point when a therapeutic contract is established.
- *Clinical assessment and diagnosis.* Activities focused on the identification of the issues to be addressed in therapy.
- *Treatment planning and case management.* All activities focused on directing the course of therapy and extra-therapeutic activities.
- *Therapeutic interventions.* All activities designed to ameliorate the clinical issues identified.
- *Legal Issues, Ethics, and Standards.* All aspects of therapy that involve statutes, regulations, principles, values, and the mores of MFTs.
- *Research and program evaluation.* All aspects of therapy that involve the systematic analysis of therapy and how it is conducted effectively.

The subsidiary domains focused on types of skills or knowledge. These were: (1) conceptual, (2) perceptual, (3) executive, (4) evaluative, and (5) professional.

After the domains were defined, the steering committee and AAMFT senior staff vetted them, and each member of the steering committee was charged with developing competencies in each domain. The contributions of each were then collated, and the first draft was developed in April 2003, yielding 273 potential competencies. These 273 were then distilled and organized into the domains, resulting in 126 competencies. These 126 were then mapped upon the existing domains of knowledge used by accreditors and regulators to ensure that the current draft captured what was currently being used as the body of knowledge in the field.

The competencies were then sent to the entire 50-member taskforce, and each was asked to provide feedback on the 126 competencies. Refinement of and additions to the competencies resulted from the feedback, resulting in 136 total. This version was sent to other interested parties, including the major mental health professions, federal agencies in behavioral health, consumer and advocacy groups, and was made available to all members of the AAMFT via our website. The feedback from these groups resulted in the current version that contains 139 core competencies (AAMFT, 2004).

Throughout the development process, a concerted effort was made to capture aspects of competence that were unique to the profession of MFT and those competencies that were shared with other mental health professionals. In fact, a tripartite model was used to evaluate specific competencies on whether they were (1) common to all/most mental health professions; (2) common, but had MFTs added something unique to the competency; and (3) unique to MFTs. One of the competencies common to all mental health professions from the Legal Issues, Ethics, and Standards domain is: "MFTs develop safety plans for clients who present with potential self-harm, suicide, abuse, or violence." In contrast, a competency that is considered unique to MFTs is: "MFTs develop hypotheses regarding relationship patterns, their bearing on the presenting problem, and the influence of extra-therapeutic factors on client systems." Finally, an example of a competency that most mental health professionals do, but the profession believes MFTs add something unique is: "MFTs establish and maintain appropriate and productive therapeutic alliances with the clients." Since a significant portion of the services provided by MFTs involve couples and families, the competency takes on a slightly more complex meaning.

The final version was viewed through several lenses to ensure its validity. In addition to comparing it to the *Validation Report for Marriage and Family Therapists* conducted by the California Office of Examination Resources (2002) and the Association for Marriage and Family Therapy Regulatory Boards practice domains (Association of Marital and Family Therapy Regulatory Boards, 2004), the core competencies were also

mapped against the Commission on Accreditation for Marriage and Family Therapy Education Programs (2003) training standards, the IOM *Crossing the Quality Chasm Report* (Daniels & Adams, 2004; Institute of Medicine, 2001), and the report of the President's New Freedom Commission on Mental Health (2003).

The next major step in the development of the core competencies was an educators' summit that took place in July 2004. This meeting brought together educators, regulators, and accreditors to consider how to best implement the adoption and assessment of these core competencies for the field. It is expected that at least two publications will be produced from the project, one in the *Journal of Marital and Family Therapy*, and one in the *Family Therapy Magazine*. Future meetings with accreditors and regulators are also planned.

Professional Psychology, Frank L. Collins, Jr.

Over the past few years, a number of developments have occurred with respect to the identification, training, and assessment of competencies for health and human service providers in psychology. These efforts include conferences, workgroups, organizational projects, and commissions throughout North America and Europe. Recent books have focused on defining and selecting key competencies (Rychen & Salganik, 2001) and on competency-based education and training in psychology (Sumerall, Lopez, & Oehlert, 2000). In November 2002, a conference was held to bring together representatives from diverse education, training, practice, public interest, research, credentialing, and regulatory constituency groups to focus on competencies in professional psychology (Kaslow et al., 2004). Organizers of this conference hoped that this meeting might lead to the development of more specific definitions and descriptions of competency areas.

In an effort to build on what had already been done, and to ensure maximum buy-in from various constituency groups, the organizers of this conference developed an extensive survey and sought guidance from the field in identifying core competencies. Eight core competency domains were identified through the survey: (1) scientific foundations of psychology and research; (2) ethical, legal, public policy/advocacy, and professional issues; (3) supervision; (4) psychological assessment; (5) individual and cultural diversity; (6) intervention; (7) consultation and interdisciplinary relationships; and (8) professional development. The conference assigned delegates to workgroups addressing each of these topics, and to workgroups that focused on the assessment of competence and the specialty (non-core) competencies. Each workgroup had members with substantial knowledge about the competency area, as well as individuals with other complimentary expertise.

Psychiatry has embarked on a new competency movement that has resulted from internal dissatisfaction with variability and from external pressures.

Products from these workgroups included several papers, which were recently published in the *Journal of Clinical Psychology* (July 2004). Four additional papers will appear in the *Journal of Clinical Psychology* and *Professional Psychology: Research and Practice* within the next year. While it is beyond the scope of this paper to summarize all of the discussions, several cross-cutting concepts emerged. For example, workgroups reaffirmed the conceptualization of competence as including knowledge, skills, and attitudes. Several workgroups used this conceptualization to organize their efforts to identify critical subcompetencies within their competency domain. Equally important was the acknowledgement among the groups that there are cross-cutting competencies relevant to all aspects of competence at all levels of professional development. These included, for example, individual and cultural diversity, ethical practice, interpersonal and relationship skills, critical thinking, and knowledge of self. Clearly, some competencies (such as cultural diversity and ethics) are viewed as both core and subcompetencies. While this may seem inconsistent, it merely reflects the belief that these competencies are core, but must be incorporated within other core competency areas.

All groups placed a strong value on developmentally informed education and training. Several groups laid out a developmentally appropriate training sequence by describing progressively more complex and sophisticated content and methods for teaching the subcompetencies in their domain. Workgroups underscored the value of modeling, role-playing, vignettes, *in vivo* experiences, supervised experience, and other applied real world experiences as critical instructional strategies for teaching the competencies. The crucial role of establishing and maintaining a respectful and facilitative learning environment was affirmed. Workgroups also highlighted the importance of close mentoring relationships as key to high level professional training. Every workgroup endorsed the central role of integrating science and practice into all aspects of education and training, teaching evidence-based and informed practice, and the importance of establishing during training an internalized commitment to life-long continuous learning.

There was consensus that, as a profession, it is important to develop strategies to become equally effective at assessing knowledge, skills, and attitudes for each competency domain. To date, assessment of knowledge has been more successful than assessment of skills and attitudes (e.g., course examinations and the national Examination for Professional

Practice in Psychology). Therefore, the assessment of overall competence in both integrated and competency-by-competency formats is an area ripe for growth in education, training, and credentialing. Assessment techniques employed for licensure and other credentialing (e.g., board certification) might begin during education and training at developmentally appropriate times. This could result in a “culture shift” in psychology, so that methods of assessment are used continuously throughout a psychologist’s training and career.

This conference was supported by more than 30 professional organizations, with the Association of Psychology Postdoctoral and Internship Centers serving as the host and conference organizer. While this conference was an important starting point, it is critical that multiple and diverse constituency groups work together to struggle with the challenging and vexing questions that remain. In particular, agreement on the definitions and components of specific competencies are needed, along with methods for assessing such competencies through a developmental framework. For example, what behaviors should demonstrate competency in psychological assessment at the pre-internship level and post-doctoral level? As progress is made, it will help the field better communicate to the public and to policymakers the contributions that professional psychologists can make.

Psychiatric-Mental Health Nurse Practitioners, Judith Haber

Advanced Practice Psychiatric-Mental Health Nurses graduate from Master’s or Post-Master’s programs that, since 1954, have prepared graduates for the role of Psychiatric-Mental Health Clinical Nurse Specialist (PMHCNS), or more recently in the past 10 years, the role of PMHNP. The nursing field most recently completed entry-level competencies for graduates of PMHNP programs who focus their clinical practice on individuals, families, or populations that are at risk for developing mental health problems or have a psychiatric disorder. The PMHNP is a specialist who provides primary mental health care to patients seeking services in a wide range of settings. This involves the continuous and comprehensive assessment and treatment services necessary for the promotion of (1) mental health, (2) prevention, (3) treatment of psychiatric disorders, and (4) health maintenance.

The PMHNP Competencies reflect the work of a multi-organizational National Panel, co-chaired by Judith Haber and Kathleen Wheeler. The National Organization of Nurse Practitioner Faculties (NONPF) facilitated the work of the National Panel through two distinct phases that encompassed development and external validation of the PMHNP competencies (2002–2003). The process utilized models that were used for developing the *Nurse Practitioner Primary Care Competencies in Specialty Areas: Adult, Family, Gerontological, Pediatric, and Women’s Health* (U.S.

DHHS, 2002b). The National Panel included representatives from six national nursing organizations whose foci include advanced practice nursing education, psychiatric-mental health practice, and certification of the PMHNP. A subgroup of the NONPF Psychiatric-Mental Health Special Interest Group participated as NONPF representatives.

Initiated in 2002, Phase I of the project focused on the domains and competencies of PMHNP practice, which were developed from a role delineation study that was completed using an observational data collection method observing nurse practitioners in a range of situational contexts. Competence among the nurses ranged from novice to expert (interpretive situational base), and the results were intended to be used in conjunction with the Dreyfus model of skill acquisition (1980, 1986). This model depicts human acquisition of psychomotor, perceptual, and judgment skills as a generic progression through stages from novice to expert, and has been applied to nursing by Benner (1984) and Brykczynski (1999).

Domain is defined as a cluster of competencies that have similar intentions, functions, and meanings. They are used as an organizing framework. A *competency* is an interpretively defined area of skilled knowledge, identified and described by its intent, function, and meaning. Competencies are domain-specific. Seven domains provide the organizing framework for the PMHNP Competencies:

1. Health Promotion, Health Protection, Disease Prevention, and Treatment
 - 1A. Assessment
 - 1B. Diagnosis of Health Status
 - 1C. Plan of Care and Implementation of Treatment
2. Nurse Practitioner–Patient Relationship
3. Teaching-Coaching Function
4. Professional Role
5. Managing and Negotiating Health Care Delivery Systems
6. Monitoring and Ensuring the Quality of Health Care Practice
7. Cultural Competence

The domain-related competencies were developed to reflect the current knowledge base and scope of practice for PMHNPs. For example, domain 1A, Assessment, emphasizes that integral to the PMHNP role is the performance of a comprehensive physical and mental health assessment, including a psychiatric evaluation. Domain 1B, Diagnosis of Health Status, reinforces that PMHNPs are engaged in the diagnostic process, including critical thinking involved in formulating a differential diagnosis and the integration and interpretation of various forms of data. Domain 1C, Plan of Care and Implementation of Treatment, highlights that the

PMHNP plan of care is biopsychosocial in nature, and ranges from prescribing psychotropic and related medications to the conduct of individual, group, and family psychotherapy.

Phase II of the project focused on external validation of the PMHNP competencies. The Validation Panel involved 21 individuals who had not served on the National Panel and had expertise relevant to advanced practice psychiatric-mental health nursing. These areas of expertise included education, clinical practice, credentialing, regulation, accreditation, and employment of advanced practice psychiatric-mental health nurses. Using an evaluation tool, the Validation Panel systematically reviewed each PMHNP competency for relevancy (is the competency necessary) and specificity (is the competency stated clearly and precisely). Comment was also provided on the comprehensiveness of the competencies (is there any aspect of PMHNP knowledge, skill or personal attributes missing). The validation process demonstrated overwhelming consensus. Over 96% of the competencies remained after it was completed. Over 53% of the competencies underwent revision to enhance their specificity, and several competencies were added, resulting in a final set of 68 competencies. Completed in 2003, the PMHNP Competencies have been endorsed by 12 national nursing organizations and can be downloaded online at: www.nonpf.com (Wheeler & Haber, 2004).

Progress in competency assessment is underway and reflected in the work of the NONPF Educational Standards and Guidelines Committee, as well as in curriculum and practice demonstration projects nationwide. The objective of these projects is to develop valid and reliable competency-based evaluation tools that accurately assess PMHNP practice and outcomes. A variety of intra and interdisciplinary assessment modalities are being evaluated, including standardized formative and summative written exams, clinical performance exams, standardized simulations, interactive case studies, evidence-based practice projects, debates, capstone projects, electronic portfolios, and credentialing exams. In addition, an exploration is underway of recognized assessment modalities and tools effectively used by other mental health disciplines to avoid “reinventing the wheel” in the assessment of core mental health competencies. This may lead to a transcendent set of interdisciplinary assessment tools.

Competence is not only acquired through training, but also requires personal characteristics such as flexibility, common sense, problem-solving ability, and compassion.

Future directions include the need for further progress in competency assessment, and ongoing alignment of PMH Scope and Standards of

Practice documents with endorsed PMHNP competencies, educational curricula, program accreditation criteria, and credentialing processes. The Scope and Standards Committee of the American Psychiatric Nurses Association is currently revising the Scope and Standards of Practice for the psychiatric nursing specialty at the Registered Nurse and Advanced Practice Registered Nurse levels. A challenge for this committee will be to determine whether the PMHNP competencies developed by the National Panel also reflect the specialty competencies for the specialty's other advanced practice role, that of Psychiatric-Mental Health Clinical Nurse Specialist, thereby paving the way for adoption of core competencies reflecting the knowledge base and practice of all advanced practice psychiatric-mental health nurses.

Psychiatric Rehabilitation Practitioners, Kenneth J. Gill

The study of the competence of Psychiatric Rehabilitation Practitioners is focused on the skills and knowledge of persons who provide rehabilitation and community support services to those with severe and persistent mental illness. While most of these direct service staff have a bachelor's degree education or less, studies of the workforce have actually found a broad range in their educational preparation (Blankertz & Robinson, 1996). Despite the fact that formal credentials are usually lacking, the consensus among subject matter experts is that these staff require a fairly advanced skill and knowledge set (Coursey et al., 2000a, 2000b; International Association of Psychosocial Rehabilitation Services, IAPSRS, 2001; Pratt, Gill, Barrett, & Roberts, 1999).

There has been significant progress in the efforts to identify psychiatric rehabilitation competencies, which culminated in a report entitled, *Role Delineation of the Psychiatric Rehabilitation Practitioners* (IAPSRS, 2001). Panels of subject matter experts convened to define the practitioners' role and identify tasks and knowledge needed. Over 500 experts from the United States and Canada eventually had input. More than 70 tasks were identified, each with several statements about the required knowledge and skills. These tasks were divided into seven domains ranked in terms of importance, criticality, and frequency of use. They include: (1) interpersonal competence; (2) interventions; (3) assessment, planning, and outcomes; (4) community resources competence; (5) professional roles; (6) systems competence; and (7) diversity. The domains, tasks, knowledge, and skill statements, which are the primary findings of the role delineation study, are available online at: www.iapsrs.org/certification/pdf/role_delineation.pdf. This study will be updated within the next 2–3 years, and a completely new role delineation study will take place in approximately 5 years.

In conjunction with the Psychiatric Rehabilitation Certification program developed by IAPSRS and administered by its Commission on the Certification of Psychiatric Rehabilitation Practitioners, competency assessment has been primarily conducted by two methods. One method is ratings by supervisors who have direct knowledge of the practitioners' work. These ratings include only a sampling of tasks. A more rigorous and extensive method is a standardized multiple-choice examination. The exam meets current psychometric standards for reliability and content validity. Academic programs offering psychiatric rehabilitation courses and majors are now attempting to incorporate this content into their curricula, and developed methods for assessing the presence of these competencies in "lab" settings and actual clinical sites. Special issues of two journals, *Psychiatric Rehabilitation Skills* (Gill, 2001; Nemeč & Pratt, 2001) and *Rehabilitation Education* (Pratt & Gill, 2001) have been devoted to these educational issues.

The IAPSRS, recently renamed the United States Psychiatric Rehabilitation Association, is principally responsible for this work. IAPSRS funded various efforts as early as 1993 to study the psychiatric rehabilitation workforce, its characteristics and skills, and published the findings from a similar project in 1996, funded by the National Institute of Disability Rehabilitation Research (Blankertz & Robinson, 1996). A related effort, funded by the Center for Mental Health Services (CMHS) at SAMHSA, studied the competencies of staff who work with persons with severe and persistent mental illness (Coursey et al., 2000a, 2000b). This project identified similar competencies to those specified in the IAPSRS role delineation study.

The IAPSRS role delineation project defined a complex, multi-skilled role that includes many competencies. Even those with extensive education and experience in mental health or other helping professions do not typically possess this full range of knowledge and skills. While there is consensus on the complexity of the psychiatric rehabilitation role, the number of individuals actually prepared to assume it is rather limited. The IAPSRS study highlights that subject matter experts expect skilled practitioners who can work with persons who have complex and disabling disorders, as well as with families, significant others, stakeholders, and other providers. Yet, there are limited educational and training opportunities to develop such practitioners. This portion of the behavioral health and rehabilitation field seems particularly lacking in resources. Funding for workforce development activities and salaries remains very modest.

Direct care staff members from a variety of levels of education have been evaluated with the IAPSRS-sponsored competency assessment instrument. A fairly large proportion of test takers (28–42%) fail to establish competence when assessed. While there are now more than 40 institutions

of higher education that offer some form of psychiatric rehabilitation education, there is clearly not enough training in these competencies. Psychiatric rehabilitation educators have established a Consortium of Psychiatric Rehabilitation Educators who meet twice annually. This group also established an electronic listserv and website known as PSR-ED. They are tackling the issues of (1) incorporating these competencies within their courses, (2) developing instructional techniques to develop these competencies, and (3) devising methods for assessing whether students have acquired these competencies.

Psychiatry, Zebulon Taintor

Psychiatry is a diverse specialty and has displayed the usual American penchant for a system of checks and balances and separation of powers. Thus, there are many groups and organizations within the specialty that have contributed lists of competencies. These include:

- The American Psychiatric Association and its Council on Medical Education, Career Development committees and task forces on specific populations (e.g., people with severe mental illness) and services (e.g., prisoners). The APA setup a work group on competencies, which realized its most useful role would be to make those developing competency lists aware of each other's work and products.
- The American Association of Directors of Psychiatry Residency Training (AADPRT), which has developed competency lists and model curricula for psychiatry residencies.
- The Association of Directors of Medical Student Education in Psychiatry (ADMSEP), which has focused on the competencies to be developed in medical school.
- The Association for Academic Psychiatry, which has focused on all levels of psychiatric education.
- The Group for the Advancement of Psychiatry (GAP) with its many subject-specific committees, some of which have addressed competencies.
- The American College of Psychiatrists, which gives the Psychiatry Residents in Training Examination (PRITE) and thereby influences, through the questions it asks, the competencies focused on during training.

With the work of these groups as background, psychiatry, as part of medicine, has embarked on a new competency movement that has resulted both from internal dissatisfaction with the variability in skills in the profession and from external pressures from patients and the public.

The ACGME sets training requirements for all specialties and subspecialties approved by the American Board of Medical Specialties. Twenty-six

residency review committees within the ACGME structure review and accredit individual programs using the general requirements for all physician training and the specific requirements for each specialty. By 1999, the ACGME completed its response to the 1980 U.S. Department of Education mandate to address educational outcomes, including competencies. The result was a set of general competencies required for all physicians (Leach, 2001). These are available on the ACGME web site at: www.acgme.org/outcome/comp/compFull.asp, and include: (1) patient care, (2) medical knowledge, (3) practice-based learning and improvement, (4) interpersonal and communication skills, (5) professionalism, and (6) systems-based practice.

The Psychiatry Residency Review Committee (RRC), which sets the accreditation requirements for psychiatric residencies, has added to the six required general competencies an additional requirement of demonstrated competency in five types of psychotherapy. These include: (1) brief, (2) cognitive-behavioral, (3) psychotherapy and psychopharmacology in combination, (4) psychodynamic, and (6) supportive.

The workforce is poorly prepared to address the needs of children with SED.

These requirements became effective in January 2001, but the process really is just beginning. For example, the RRC offers no specification or detail on the psychotherapy competencies. It simply states that residency programs must now be able to provide details during accreditation visits as to how they verify that their graduates attain the general and specific competencies. The RRC is currently reluctant to add greater specificity, exemplified by its response to the family assessment and treatment competencies submitted for consideration by the *GAP Committee on the Family*. The RRC deemed these competencies exemplary, but too detailed for inclusion in the accreditation requirements for psychiatry. There is, however, a growing literature on the psychotherapy competencies (Andrews & Burruss, 2004; Dewan, Steenbarger, & Greenberg, 2004; Gabbard, 2004; Winston, Rosenthal, & Pinsker, 2004).

The RRC special requirements for psychiatry can be viewed on the ACGME web site at: www.acgme.org. There remains a strong emphasis in these accreditation guidelines on the use of timed rotations to assure development of skills in various areas, such as emergency psychiatry, consultation/liason, and the treatment of children and adolescents. It is attractive to think that training programs could be freed from these time constraints and offer flexibility while residents developed specific competencies at a self-paced rate of learning. However, the science of measuring competencies in psychiatry is just developing, and is untested in psychiatry

residency training. AADPRT, the training directors association, has written to the RRC asking that the next revision of the special requirements for psychiatry *not* substitute competencies for timed rotations.

It is critical to note that the American Board of Psychiatry and Neurology (ABPN) is the only organization that actually certifies individual psychiatrists. It has a list of competencies, which can be found at www.abpn.com/geninfo/competencies.html, and in two books that ABPN produced (Scheiber, Kramer, & Adamowski, 2003a, 2003b). The ABPN competency list, which incorporates the six core competencies from ACGME, carries great weight in the field, as it is the basis for the board certification exam. A general consensus is developing *against* generating multiple conflicting lists of competencies, and *for* support of the core ABPN list. However, inconsistencies exist, exemplified by the fact that the ABPN has not incorporated the psychotherapy competencies required by the RRC.

In the future, the RRC expects to revise the specific requirements for general psychiatry, having just completed the requirements for subspecialty training in addiction, forensic, geriatric, psychosomatic medicine, and sleep psychiatry. It is also focusing on child psychiatry, for which competencies have been suggested (Sexson et al., 2001). Work on competency development and assessment is expected to get increasing attention due to the ongoing ACMGE competency initiative, and further fueled by concerns about the 48% failure rate among psychiatrists on Part II of the ABPN examination in 2003.

Social Work, Anita L. Rosen

The task of summarizing the work related to competencies for the social work profession is somewhat daunting. No single organization is responsible for competency promulgation. In fact, a multiplicity of organizations is involved in examining and promoting competency in social work practice. In addition, a distinctive aspect of the social work profession is the wide range of settings, organizations, and populations where social workers practice. Compounding the issue is the psychosocial orientation of social work training and practice, which does not focus solely on mental health, but rather on a broad conceptualization of health, mental health, and the social and economic aspects of the lives of individuals, groups, and communities.

Social work in its various forms addresses the multiple, complex transactions between people and their environments. Its mission is to enable all people to develop their full potential, enrich their lives, and prevent dysfunction, through problem-solving and change. The profession is an interrelated system of values, theory, and practice. This orientation, combined with a broad range of service delivery settings and populations served,

means that there is often no one group or organization that “owns” social work or defines competent practice for the profession. In addition, there are differing views of how to define “competency” within the profession.

Given this disclaimer, there are a number of organizations that have attempted to define competencies and develop standards for competent psychosocial practice in social work. Three important organizations are: the National Association of Social Workers (NASW, www.naswdc.org), the major membership organization of the profession; the Association of Social Work Boards (ASWB, www.aswb.org), a coalition of boards that regulates social work and develops and maintains the social work licensing examination used across the country; and the Council on Social Work Education (CSWE, www.cswe.org), the accrediting body for the over 600 social work education programs in the United States.

NASW has developed practice standards in 12 areas such as palliative care, cultural competency, and clinical practice (www.naswdc.org/practice/default.asp). These standards generally refer to knowledge, skills, and ethics, and have been developed by cadres of experts, with input from practitioners. The standards are not competencies, but do provide guidelines for further explication, and are used by members, educators, and licensing bodies for defining the role and function of social work.

ASWB, in its role as developer of national licensing examinations, including one for clinical practice, conducts a thorough job analysis on a periodic basis through a rigorous, national sampling process that is then used by experts to develop examination questions. Four levels of examination to test competency have been developed, each covering a variety of content areas (e.g., human behavior, diversity, diagnosis and assessment, the therapeutic relationship).

CSWE has created the Educational Policy and Accreditation Standards for social work education, and requires the use of evidence and outcome measures by training programs, with the goal of helping assure that social work education prepares students for competent practice. The current standards were developed through a multi-year process with a diverse, expert committee, and substantial input from members. These standards are used as guidelines and are translated into competencies by individual social work education programs and faculty.

CSWE also has a project, funded by the John A. Hartford Foundation, called *Strengthening Aging and Gerontology Education for Social Work* (SAGE-SW, www.cswe.org/sage-sw/). SAGE-SW has developed a set of social work gerontology/geriatric competencies for education and practice, using a unique methodology (www.cswe.org/sage-sw/resrep/competenciesrep.htm). After developing a list of 65 competencies related to knowledge, skills, and professional ethics through a search of the literature and feedback from a panel of experts, a survey was mailed to a national sample of social

work practitioners and academics, both with and without interest in aging. Survey participants were asked to identify the competencies that all social workers needed, those needed only by advanced practitioners, and those needed by geriatric specialists. This list of competencies and the guidance given by the survey participants have been used and adapted by educators, practitioners, trainers, and national curriculum projects.

Other social work organizations, institutions, and coalitions have developed competencies or practice standards for specific areas of practice. For example, individual social work education programs that have U.S. Children's Bureau funding for Title IV-E Child Welfare Training have developed outcomes-based competencies for training students. A coalition of national organizations related to health care has developed standards for social work best practices in healthcare case management that incorporate outcome/practice evaluation. Social work competencies for interdisciplinary settings have also been developed. One such endeavor in palliative care from the Center to Advance Palliative Care can be found at: <http://64.85.16.230/educate/content/elements/socialworkercompetencies.html>.

The American Board of Examiners (ABE) in clinical social work (www.abecsw.org) provides the Board Certified Diplomate in Clinical Social Work credential. This organization has developed practice competencies in clinical social work, and has available online a position paper and bibliography related to competencies and clinical social work. Finally, the Institute for the Advancement of Social Work Research (IASWR, www.iaswresearch.org) has undertaken efforts to help promote the translation of research findings into education and practice, examine the availability of evidence as it relates to practice competence, and engage social work researchers in this process (see: www.charityadvantage.com/iaswr/images/iaswr%20aug%2003%20newsletter.pdf).

More than three-quarters of providers in the United States...have a bachelor's degree or less education, with little training about severe mental illness or its treatment.

Currently, the interest in and activities related to competent professional practice are gaining currency in social work. As the profession moves forward, there is need to foster collaboration of practice and academic organizations to develop and implement social work competencies, link evidence and outcome measures to the concept of competency, and attract federal funding to help social work assess the state of research knowledge for practice, and to conduct translational activities that help define competent education and practice.

POPULATION-FOCUSED COMPETENCIES

Children's Mental Health, Marsali Hansen

It is widely recognized that we need a workforce skilled in both quality clinical practice and a systems-of-care approach for children (Hansen, 2002; Tharinger et al., 1998). In 1999, the Child, Adolescent, and Family Branch of the CMHS in the SAMHSA published a series of monographs on *Promising Practices in Children's Mental Health*. Volume V of the series addressed training strategies, including core competencies (Meyers, Kaufman, & Goldman, 1999). The monograph highlighted the notion of competence with various definitions, but generally meaning a shared perspective of doing the right thing for the right reason at the right time. The authors emphasized the view that competence is not only acquired through training, but also requires personal characteristics such as flexibility, common sense, problem-solving ability, and compassion. Two sets of competencies that address these workforce concerns are cited in this SAMHSA monograph.

The first set of competencies was developed by Trinity College in Vermont for its master's program in Community Mental Health. The core competencies were developed by experts in the field and reviewed nationally. The materials highlight the specific knowledge, skills, and values required to function within a community-based system of care for children and adolescents with serious emotional disorders (SED). The skills incorporate the fundamental best practice of community mental health with the values and expectations articulated in systems-of-care documents (Hansen, 2002).

The following is an example:

- V. Demonstrates ability to design, deliver, and ensure highly individualized services and supports.
 - A. Routinely solicits personal goals and preferences.
 - B. Designs personal growth/service plans that fit the needs and preferences of the child/adolescent and family.
 - C. Encourages and facilitates personal growth and development toward maturation and wellness.
 - D. Facilitates and supports natural support networks.

The Commonwealth of Pennsylvania fostered the creation of the second set of core competencies identified in the SAMHSA monograph. The Pennsylvania Child and Adolescent Service System Program (CASSP) Training and Technical Assistance Institute (1995) that developed the competencies is funded by the Commonwealth and is part of Penn State University. As part of the development process, these competencies were

reviewed by academics, professional associations, policy experts, practitioners, family members, and others (Hansen et al., 1999).

These competencies serve as the foundation for all training efforts throughout Pennsylvania, and have been shared with other states. They are also used among family advocates as a set of performance expectations for professionals. Pennsylvania has a certification process for family therapists involved in a 3-year in-service training program. The competencies serve as a foundation for the certification. A statewide assessment of children's mental health providers is underway to identify gaps in workforce competence based on this document.

This competency set was designed to be relevant for all mental health professionals working with children, regardless of discipline. It is more clinically focused than the set of competencies developed in Vermont. The core competencies include both fundamental clinical expectations and the skills needed for practitioners' expanded roles within systems of care. The three sections focus on children (in developmental context), families, and communities. Examples include:

Child/young adult/assessment (100-VII-G):

1. Professionals will be able to demonstrate general knowledge of the types of assessments likely to be used with teens, including familiar tests, standards of current practice, and the pitfalls in interpretation and how to involve parents and families.

Family/intervention skills (200-11-B):

1. Professionals will be able to demonstrate the following specific skills in conducting the initial contact:
 - A. Ability to start where the family is and acknowledge the family's central role.
 - B. Ability to obtain an initial definition of the problem.
 - C. Ability to setup the initial session and establish a time, place, and who will be present.

These core competencies are designed to address the specific integration of system-of-care values, professional standards of practice, and models of clinical best practice across mental health disciplines. As the professions cry out for models of core competencies, Pennsylvania's document serves as an example of a comprehensive effort to present the expectations for best practice for children and adolescents with SED and their families. Such a model can serve as a foundation for other efforts within disciplines, professions, and child-serving systems, and for other statewide approaches.

At the national level, current efforts focus on the widely recognized crisis in children's mental health, a crisis that includes concerns about recruitment and retention, as well as the recognition that the workforce

is poorly prepared to address the needs of children with SED. These efforts embrace core competencies as a foundation for future developments. Training initiatives on many fronts are increasingly starting with sets of specific clinical expectations for individuals who work with children who have SED. These competency expectations, when combined and integrated with professional standards, will serve as a foundation for curriculum revisions that will better prepare students for entry into the workforce and, through continuing education, better prepare those individuals already in the workforce.

Serious and Persistent Mental Illness, Alexander S. Young

During the past decade, there have been remarkable advances in our understanding of how to provide care to people with SPMI. Clinical research has demonstrated that a wide range of well-defined pharmacologic and psychosocial interventions substantially improve outcomes in people with these disorders (Young & Magnabosco, 2004). Multi-disciplinary, team-based approaches have become widely accepted as an optimal structure for care. There is increasing agreement that care should be consumer-centered, and include attention to recovery, rehabilitation and consumer empowerment.

Researchers (Young & Magnabosco, 2004) have compared care in routine treatment settings with treatment practices that are known to be effective, and have found large discrepancies. Effective pharmacologic and psychotherapeutic interventions are used with only one-third of the individuals with depression and anxiety who could benefit from these treatments (Young, Klap, Sherbourne, & Wells, 2001). Evidence-based psychotherapies are often not delivered outside of academic and research settings. Among individuals with schizophrenia, many do not receive medications, such as clozapine, that could substantially improve their symptoms (Lehman, 1999). Effective psychosocial treatments, such as supported employment and family interventions, are provided to a small proportion of eligible individuals.

Projects have been conducted to improve care for people with severe and persistent mental illness, and have found that a substantial proportion of current providers and provider organizations do not possess necessary competencies (Corrigan, Steiner, McCracken, Blaser, & Barr, 2001; Drake et al., 2001; McFarlane, McNary, Dixon, Hornby, & Cimett, 2001; Young, Forquer, Tran, Starzynski, & Shatkin, 2000). For example, professionals often have negative attitudes toward rehabilitation, mutual support, and recovery, which can hinder the provision of client-centered care (Chinman, Kloos, O'Connell, & Davidson, 2002; Corrigan, McCracken,

Edwards, Kommana, & Simpatico, 1997). It has been estimated that more than three-quarters of providers in the United States caring for individuals in the public sector have a bachelor's degree or less education, with little training about severe mental illness or its treatment (CMHS, 2004). Even among the small proportion of doctoral-level professionals who work with this population, many have not been exposed to curricula or practicum experiences that are relevant to the care of people with serious mental illness (Hoge, Stayner, & Davidson, 2000).

In the United States, two projects have used a national consensus process to define core competencies. One was funded by the SAMHSA, and coordinated by the Center for Mental Health Policy and Services Research at the University of Pennsylvania. This project convened a national panel of 28 experts from a broad range of stakeholder groups, including academia, clinicians, consumers, family members, state mental health agencies, and managed care corporations. They reviewed empirical research, standards of care, and clinical guidelines. A set of 12 core clinical competencies and 52 subcompetencies was developed (Coursey et al., 2000a, 2000b), and is available at: www.uphs.upenn.edu/cmhpsr/cmhs_reports.htm.

A second project was funded by the Robert Wood Johnson Foundation through the Center for Healthcare Strategies, and coordinated by the UCLA-RAND Health Services Research Center and the Department of Veterans Affairs Desert Pacific Mental Illness Research, Education, and Clinical Center. The project reviewed existing literature and competency statements, and conducted focus groups and interviews with similar stakeholder groups as in the SAMHSA project. A national panel was convened, and a structured process led to the identification of 37 core competencies in seven domains that are critical for providing recovery-oriented care (Young, Forquer, Tran, Starzynski, & Shatkin, 2000). The competencies are available at: www.mirecc.org/product-frames.html. Both the UCLA-RAND and SAMHSA projects produced competency sets that cover a comprehensive range of important clinical domains such as the clinician–client relationship, assessment, rehabilitation, consumer empowerment, and caregiver support.

In the United Kingdom, a national competency development effort that focuses on severe mental illness was coordinated by the Sainsbury Centre for Mental Health, in conjunction with the National Health Service (U.K. Department of Health, 1999). This project was based on the concept of the “capable practitioner,” defined as clinicians who can adapt to change and new knowledge, and continuously improve their practice (Fraser & Greenhalgh, 2001). The project defined a set of competencies that enables clinicians to care for individuals with severe mental illness within the context of the National Service Framework for

Mental Health, which defines national care models, standards, and plans for service provision in the UK. The resulting competency set, which includes 67 competencies clustered in seven domains, is designed to inform training and curricula within the field (Lindley, O'Halloran, & Juriansz, 2001). It is available at: www.scmh.org.uk.

Many of the competencies identified have not been adopted or incorporated by training programs, licensing agencies, and certification boards.

Other work is relevant to this field of competency development. The work on psychosocial rehabilitation, described in an earlier section of this article, focused largely on caring for individuals with severe and persistent mental illness. Similarly, SAMHSA has supported the development of a number of “Evidence-Based Practice Implementation Resource Kits” (toolkits) designed to help providers and agencies implement evidence-based practices for this population (CMHS, 2003). These toolkits focus on illness management and recovery, medication management, assertive community treatment, family psychoeducation, supported employment, and management of co-occurring substance abuse. By offering standardized training for various types of personnel, these toolkits focus on competencies deemed essential for this work.

Now that several comprehensive competency sets have been developed, the focus of work has moved to development of interventions that improve the competency of providers. While there have been some successes (Young et al., in press), substantially more work is needed to evaluate the effectiveness of novel interventions and approaches to improving competency. When evaluating the quality of mental health care, provider competencies are one aspect of the structure of care. Therefore, competencies have a direct effect on health care processes—the care that consumers actually receive. As such, the value and accuracy of competency sets and models will be best understood by determining the extent to which provider performance can be improved, and evaluating how this improvement can lead to better care for consumers.

SPECIAL APPROACHES TO CARE

Work on competencies has begun in three critical areas that involve special approaches to care. These include the provision of recovery-oriented treatment, culturally competent care, and the delivery of services by trained peer specialists.

Recovery-Oriented Competencies, Janis Tondora and Maria J. O'Connell

Improving our understanding about the process and possibilities of recovery from severe mental illness, fueled by consumer advocacy efforts, has contributed to a recent national focus on improving the capacity of individual providers and the systems where they work to deliver recovery-oriented care (New Freedom Commission on Mental Health, 2003). However, with the many and varied definitions of recovery (Ralph, Kidder, & Phillips, 2000) and few models of care that operationalize principles of recovery into concrete, objective practices (Anthony, 2000), the development of recovery-oriented capacities has been challenging at best.

In the past few years, several organizations have attempted to clarify the meaning of recovery and recovery-oriented care through research, training, and dissemination efforts. This work has placed considerable emphasis on the competency of systems versus individuals. In June 2000, the Evaluation Center@HSRI published a compendium of recovery-related instruments that assess important aspects of the recovery process and recovery-related outcomes (Ralph, Kidder, & Phillips, 2000). In 2002, the National Association of State Mental Health Program Directors (NASMHPD) and the National Technical Assistance Center for state mental health planning (NTAC) published what is commonly known as the "What Helps, What Hinders" report on recovery (Onken, Dumont, Ridgway, Dornan, & Ralph, 2002). Drawing on 1000 pages of focus group transcripts from 115 consumers, this workgroup conceptualized an "emerging recovery paradigm" that focuses on the individual's unique identity, hope, strengths, and self-determination, while emphasizing holistic approaches to care, self-help, empowerment, choice, natural supports, community integration, active growth, normative roles, asset building, and self-efficacy. The second phase of this "What Helps, What Hinders" project involved the development of a 42-item self-report measure of recovery-oriented supports and an administrative-data profile containing 16 system performance indicators and 23 associated measures (Recovery Oriented System Indicators, ROSI; Onken, Dumont, Ridgway, Dornan, & Ralph, 2004). The ROSI is currently undergoing pilot testing and will be used to inform the development of a "report card" to assess recovery-oriented supports across state mental health systems.

A state-based effort has been conducted by the Connecticut Department of Mental Health and Addiction Services, in conjunction with the Yale Program for Recovery and Community Health. Drawn from an analysis of recovery elements identified through an extensive review of the literature and focus groups with consumers, the goals of this project have been to conceptualize the elusive construct of recovery, identify

measurable indicators of a recovery-oriented environment and recovery-oriented care, and provide competency-based training to behavioral health service providers, managers, and administrators (Davidson, O'Connell, Tondora, Kangas, & Evans, 2004; Davidson, O'Connell, Tondora, Staeheli, & Evans, 2004; www.dmhas.state.ct.us/recovery.htm).

Common principles of recovery and recovery-oriented systems of care were first identified (Davidson, O'Connell, Sells, & Staeheli, 2003). These were followed by identifying separate models of recovery pertaining to mental health and/or addictions, which helped practitioners learn to differentiate recovery-oriented practices from non-recovery oriented practices. The assessment of recovery-oriented competencies was conducted through the creation of the Recovery Self-Assessment (O'Connell, Tondora, Croog, Evans, & Davidson, in press). Based on the literature reviews and information gathered from the focus groups, this tool was developed to provide state programs with a method of gauging the degree to which constituents believed that their *programs* implement practices that are consistent with the principles of recovery. Efforts are now underway to train individual providers statewide in recovery practices through a Recovery Institute. International efforts have been underway to identify recovery-oriented competencies. For example, the New Zealand Mental Health Commission developed such a competency set through a project that was led by consumers, and gathered data through focus groups with consumers and written comments submitted by providers and government employees (O'Hagan, 2001). The final product includes 39 competencies in 10 domains, and can be accessed at: www.mhc.govt.nz/pages/publications.htm.

Work has also begun on formally assessing the recovery-oriented competencies of individual providers. Investigators at UCLA-RAND developed a paper-and-pencil instrument to measure 15 competencies that are critical to recovery-oriented care. The psychometric properties of this Competency Assessment Instrument (CAI) were evaluated in 341 clinicians at 38 clinical sites in two western states. The 15 scales were generally found to have good internal consistency, test-retest reliability, and validity (Chinman et al., 2003). The CAI and instructions for scoring are available at: www.mirecc.org/education-frames.html.

Cultural Competency, D. J. Ida

Quality services must, by definition, be culturally competent. In other words, it is not possible to provide competent services if one fails to adequately address the cultural and linguistic needs of diverse populations. The President's New Freedom Commission Report (2003) identified the

lack of quality services for African Americans, Asian-American/Pacific Islanders, Latinos, and Native Americans, and stated that:

The current mental health system has neglected to incorporate, respect, or understand the histories, traditions, beliefs, languages, and value systems of culturally diverse groups. Misunderstanding and misinterpreting behaviors have led to tragic consequences, including inappropriately placing individuals in the criminal and juvenile justice systems. There is a need to improve access to quality care that is culturally competent (p. 49).

Similar conclusions have been reached in the Institute of Medicine's report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2003b) and the Surgeon General's Report on *Culture, Race, and Ethnicity* (U.S. DHHS, 2001).

The need to increase the number of bicultural and bilingual service providers is reflected in the glaring discrepancy between the growing number of Latinos, African Americans, Asian-American/Pacific Islanders, and Native Americans, and the number of service providers from each of these communities. According to the 2000 Census, the four major ethnic groups comprised 30% of the population, and by the year 2025 will represent almost 40% of the U.S. population. They are, however, greatly underrepresented in the number of available providers. Ninety-four percent of psychologists, 88% of social workers, 92% of psychiatric nurses, 93% of marriage and family therapists, and 95% of school psychologists are white (not Hispanic; Center for Mental Health Services, 2004).

The solution to making the workforce responsive to the needs of communities of color is complex, multifaceted, and goes beyond efforts to hire culturally diverse and bilingual individuals. It occurs at all levels and involves training paraprofessionals as well as professionals and consumers. It involves changing not only who we train, but also the "what" and "how" of our training. It is teaching how culture defines the problem, and the way language influences how the problem is articulated.

In 2002, the U.S. Department of Health and Human Services, SAMHSA, and the CMHS awarded four grants as part of the *Reducing Racial and Ethnic Disparities through Workforce Training* initiative. The four award sites are Drexel University, the National Asian American Pacific Islander Mental Health Association (NAAPIMHA); Our Lady of the Lake University, and the University of Medicine & Dentistry of New Jersey/Robert Wood Johnson Medical School. Each site is implementing a training program designed to improve the quality of service to diverse populations. Drexel University and the Robert Wood Johnson Medical School provide training to service providers currently working with multi-ethnic populations in the Philadelphia and New Jersey communities, respectively. Our

Lady of the Lake University trains interns to provide bilingual and bicultural services to the Spanish speaking Latino population in San Antonio, Texas.

The focus of NAAPIMHA's training is to improve the quality of services for Asian-American and Pacific Islander consumers. It brought together experts from a range of groups to write the first national training curriculum to improve services for Asian-American and Pacific Islanders. The groups included the Asian Counseling and Referral Services in Seattle, the Asian Pacific Development Center in Denver, Hamilton Madison House in New York City, Hale Na'au Pono of the Wai'ane Community Mental Health Center on Oahu and RAMS, Inc., and the Asian American Psychiatric Inpatient Unit of the University of San Francisco General Hospital in San Francisco. The result was the *Growing Our Own* curriculum (NAAPIMHA, 2002), which is designed to train interns at the master's and doctoral level in psychology, counseling, and social work, as well as psychiatric residents. In addition, an effort is underway to train consumers to assist in teaching Module II of the curriculum, which is called *Connecting with the Consumer*.

At the state level, California is in the process of completing the *California Brief Multicultural Competency Training Program* to increase the cultural competency of their mental health workforce. The project was funded partially by the California Department of Mental Health and also by an unrestricted educational grant from Eli Lilly and Company. It is a collaborative effort that brought together the California Department of Mental Health, the California Institute for Mental Health/Center for Multicultural Development, the Tri-City Mental Health Center, the University of La Verne, and Portland State University to write a curriculum based on the *California Brief Multicultural Competence Scale* developed by Richard Dana of Portland State University. This scale is a 21-item self-report instrument to determine the training needs of service providers. This curriculum will be piloted in several counties this fall to assess the need for making any modifications before rolling it out to other parts of the state.

Two additional resources that are useful in identifying and teaching competencies are worthy of note. The SAMHSA Center for Mental Health Services Cultural Competence Standards (SAMHSA, 1998) identify the KSA that comprise the basic elements of cultural competence. Information on these competencies can be accessed at: www.uphs.upenn.edu/cmhpsr/. The DSM-IV Outline for a Cultural Formulation and a related training video (U.S. DHHS, 2002a) provides the practical framework for teaching the impact and role of culture in the assessment, diagnosis, and treatment of diverse populations, and is used in both the California and NAAPIMHA training programs to help clinicians accurately assess, diagnosis, and treat consumers.

Finally, as a special issue, the need to train interpreters is another important workforce competency issue, as the growing number of individuals with limited English proficiency far outweigh the availability of bilingual service providers. Frequently, family members, including children, or other untrained individuals are inappropriately used to provide interpreting services, seriously compromising the quality of services. The National Alliance of Multi-Ethnic Behavioral Health Associations (NAM-BHA), located in Washington, DC, recently completed the development of a curriculum to train interpreters to work specifically in the mental health arena. The training will be piloted in California and Texas, which have high concentrations of bilingual or monolingual non-English speaking populations.

No single organization is responsible for competency promulgation in social work.

Future efforts must continue to develop integrated models that train service providers across all disciplines of mental health, primary health, and addictions. Services must be culturally, linguistically, and developmentally appropriate to meet the needs across the lifespan of an individual. More research is also required to measure the core competencies, such as the ability to complete a cultural formulation and establish a therapeutic alliance with linguistically and culturally diverse populations.

Peer Specialists, Larry Fricks and Cheryl V. Finn

The President's New Freedom Commission Report (2003) on transforming mental health care in America proclaims a vision that all mental health consumers can recover. Recommendation 2.2 of the Report states:

Recovery-oriented services and supports are often successfully provided by consumers through consumer-run organizations and by consumers who work as providers in a variety of settings, such as peer-support and psycho-social rehabilitation programs... Because of their experiences, consumer-providers bring different attitudes, motivations, insights, and behavioral qualities to the treatment encounter... In particular, consumer-operated services for which an evidence base is emerging should be promoted (p. 37).

In pioneering Medicaid-billable consumer-operated services, Georgia has utilized consumer-providers, demonstrating both cost effectiveness and recovery outcomes that are transforming the system. In order to accomplish such a service implementation, it was critical to identify and foster the development of specific competencies for the consumer-provider workforce. In 2002, the Georgia Mental Health Consumer

Network (GMHCN) was awarded a 3-year CMHS State Networking Grant, which provided the initial funding to develop and implement the training and certification of peers for the new Medicaid-funded peer support services. To implement proposed consumer-directed services, there had to be assurances that the consumer “providers” had adequate training to perform job responsibilities as set forth in developing guidelines, and to establish a base of professionalism recognized within the system among consumers, professionals, administrators, and funding authorities. Partnering with the state Division of Mental Health, Developmental Disabilities and Addictive Disease (DMHDDAD; www2.state.ga.us/departments/dhr/mhmrsa/index.html), through its Office of Consumer Relations, a training and certification program for a consumer “provider” was established.

Initial qualifications and competencies were established to identify consumers eligible for admission into the training program. Focus groups were held to determine specific competencies that were necessary for peer specialists to be successful in these new roles. Included in the focus groups were representatives of the GMHCN, the DMHDDAD, and service provider organizations. Consideration was given to the categories of service where peer specialists could be employed, and from that discussion, more specific peer specialist roles and duties in each service were identified. With a fuller understanding of desired roles and duties, the group began to identify specific competencies that peer specialists must either possess or be trained to develop. The identified competencies were then incorporated in the Certified Peer Specialist (CPS) job description that is utilized for recruiting peers for employment and their performance evaluation as staff members.

First and foremost, candidates must be willing to self-identify as former or current consumers of mental health or co-occurring MI/SA services. They must be well grounded in their own recovery experience, with at least 1 year between initial diagnosis and application for training. They must possess a high school diploma or a GED, and be able to demonstrate basic reading comprehension and effective written communication skills. Finally, they must have demonstrated experience with leadership, including advocacy or implementation of peer-to-peer services.

Competencies taught and developed through the training program can be grouped into several distinct categories: (1) understanding mental illnesses, (2) recognizing the possibility of change, (3) developing commitment to change, (4) fostering action for change, (5) the Georgia Mental Health System, and finally (6) professional ethics. Peer specialists learn about the development of mental illness and the phases through which an individual progresses from despair to hope. They are taught principles of recovery and elements necessary to foster a “recovery

environment.” Group process and facilitation as well as effective listening and the art of asking questions are critical competencies that are emphasized throughout the training program. The importance of spirituality and cultural competence are also vital components of the program. Perhaps the most important skills to be developed through the training program are problem-solving and goal-setting, and the ability to articulate the difference between the two.

Forty hours of training is conducted in two 4-day sessions. Approximately 1 month after the training, these peers sit for their 1-day certification exam, which is both written and oral. Finally, upon successful completion of training and passing the exam, the newly CPS is asked to sign the Professional Code of Ethics for CPSs. Understanding the importance of professional ethics is the foundation for quality performance in the role of CPS.

Continuing education is held quarterly to reinforce specific skills or tools and to address issues that emerge from daily practice experience. Some emerging issues lead to the development of additional training modules that strengthen the training curriculum. Recently, the Office of Consumer Relations held a week-long training in mediation for the CPSs, to further develop their communication skills. This was followed by the employment of two full-time staff trained in mediation, to provide onsite technical assistance to any CPS needing help with conflict resolution.

A work force of approximately 200 CPSs is currently employed in Georgia’s public mental health system, promoting outcomes of independence and illness self-management by teaching recovery skills that can be replicated and evaluated. Approximately 2500 consumers will receive peer support services in the states’ 2004 fiscal year, with an expected Medicaid billing of \$6 million for their services. Training and certification activities continue, with the costs now fully supported by DMHDDAD through Mental Health Block Grant funds. Further information pertaining to the CPS Project can be obtained at: www.gacps.org.

The utilization of peers in service provision is growing rapidly across the country. South Carolina is already well underway with its own training and certification program modeled on the Georgia initiative. Hawaii is also moving in this direction, with staff from Georgia conducting initial training classes and providing technical assistance for developing a consumer-provider staff cohort. To further expand the growth of consumer-providers nationwide, a “Toolkit Manual” for replicating Medicaid-funded peer support services, and the training and certification of peer specialists was commissioned by CMHS and written by Georgia staff and other contractors.

The professions cry out for models of core competencies.

Another exciting new initiative is the Peer-to-Peer Resource Center, a National Consumer Self-Help Technical Assistance Center (TAC) sponsored by the Depression and Bipolar Support Alliance (DBSA; www.dbsalliance.org) and funded by the federal Center for Mental Health Services. The DBSA TAC considers peers a key workforce to promote self-directed recovery, independence and community integration for mental health consumers. In a newly piloted training and certification program, 25 consumers from around the country were taught skills to promote both illness self-management and supported employment in the summer of 2004. Specific competencies for supporting consumers seeking to return to or gain employment were included in this training program. Participants took both a pre-test and a post-test to determine the effectiveness of the training. The long-range goal of this training and certification program is replication nationwide and creation of a national network of trained and certified peer supporters working side-by-side with other mental health service providers. DBSA is also working with its Scientific Advisory Board to develop further evidence for the effectiveness of using CPSs.

DISCUSSION

A review of these highly varied efforts to identify and assess competencies in behavioral health yields an array of general conclusions. It appears that most of the work on this topic is relatively recent and remains in an early stage of development. The major focus in most initiatives has been on identifying the knowledge, skills, and attitudes required for practice, with some efforts to organize these requirements into manageable clusters or competency domains. To date, significantly less attention has been focused on developing and implementing strategies to assess the identified competencies among students and current members of the workforce.

There appear to be rather striking similarities in the content of competencies identified, at least in terms of the more general competency domains. Yet the work of the groups and organizations described above is occurring independently. Recognizing that inter-professional rivalries may impede collaboration, the question remains as to whether some level of collaboration around identifying, defining, and assessing *common* or *core* competencies would increase the resulting reliability, validity, and research base.

Several critical issues emerge from this review. First, it appears that consumer and family involvement in the process of identifying and assessing competencies needs to be significantly increased, as they do not appear to have played a major role in most of the work that has been done to date. Second, many of the competencies identified have not been adopted or incorporated by training programs, licensing agencies, and certification boards. Until this occurs, the work on competencies is likely to have limited impact on the field. Finally, there remains a question about whether the emerging competency sets, which have typically been identified by experts, are so comprehensive and idealistic as to be unachievable by the typical student or practitioner. To examine this question, the field must complement expert opinion with other data sources, such as observation of capable practitioners, to better define the competencies required to practice effectively.

These issues aside, the work that is underway in defining and assessing competencies is extraordinarily important. This work will be critical in guiding efforts to reshape and reform training and education for the diverse groups that comprise the behavioral health workforce. We must strive continually to define, with increasing precision, the knowledge, skills, and abilities that effective practice requires. Through the process of assessment, we must also ensure that those competencies are, in fact, developed.

REFERENCES

- AAMFT Core Competencies Taskforce. (2004). *The marriage and family therapy core competencies*. Alexandria VA: The American Association for Marriage and Family Therapy.
- Accreditation Council for Graduate Medical Education. (1999). The ACGME outcome project. Online at: www.acgme.org/outcome/comp/compFull.asp.
- Adams, R.J., & Gallon, S.L. (1997). *Entry-level addiction counselor competency survey: National results*. Portland OR: Northwest Regional Educational Laboratory.
- Addiction Technology Transfer Center Curriculum Committee. (1995). *Addiction counselor competencies: The knowledge, skills, and attitudes of professional practice*. Kansas City, MO: Author.
- Andrews, L.B., & Burruss, J.W. (2004). *Core competencies for psychiatric education*. Washington, DC: American Psychiatric Publishers.
- Anthony, W.A. (2000). A recovery-oriented service system: Setting some system level standards. *Psychiatric Rehabilitation Journal*, 24(2), 159–168.
- Association of Marital and Family Therapy Regulatory Boards. (2004). *Information for candidates: Examination in marital and family therapy*. New York: Professional Examination Service. <http://www.amftrb.org/PDF/info4candidate2004.pdf>.
- Benner, P.E. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley.
- Blankertz, L.E., & Robinson, S.E. (1996). Who is the psychosocial rehabilitation worker?. *Psychiatric Rehabilitation Journal*, 19(4), 3–13.
- Brykczynski, K.A. (1999). An interpretive study describing the clinical judgment of nurse practitioners. *Scholarly Inquiry for Nursing Practice: An Interpretive Journal*, 13(2), 141–166.
- California Office of Examination Resources. (2002). *Validation report: Marriage and family therapist*. Sacramento, CA: California Department of Consumer Affairs.

- Center for Mental Health Services. (2003). *Evidence-based practice implementation resource kits*. Washington DC: Substance Abuse and Mental Health Services Administration. <http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/>.
- Center for Mental Health Services. (2004). *Mental health, United States, 2002*. Rockville MD: Substance Abuse and Mental Health Services Administration DHHS Pub. No. SMA-3938.
- Chinman, M.J., Kloos, B., O'Connell, M., & Davidson, L. (2002). Service providers' views of psychiatric mutual support groups. *Journal of Community Psychology, 30*, 1–18.
- Chinman, M.J., Young, A.S., Rowe, M., Forquer, S., Knight, E., Miller, A. (2003). An instrument to assess competencies of providers treating severe mental illness. *Mental Health Services Research, 5*, 97–108.
- Commission on Accreditation for Marriage and Family Therapy Education. (2003). *Standards of accreditation* 10.3. Online at: www.aamft.org/about/COAMFTE/standards_of_accreditation.asp.
- Corrigan, P.W., McCracken, S.G., Edwards, M., Kormmana, S., & Simpatico, T. (1997). Staff training to improve implementation and impact of behavioral rehabilitation programs. *Psychiatric Services, 48*, 1336–1338.
- Corrigan, P.W., Steiner, L., McCracken, S.G., Blaser, B., & Barr, M. (2001). Strategies for disseminating evidence-based practices to staff who treat people with serious mental illness. *Psychiatric Services, 52*, 1598–1606.
- Coursey, R.D., Curtis, L., Marsh, D.T., Campbell, J., Harding, C., Spaniol, L., et al. (2000a). Competencies for direct service staff members who work with adults with severe mental illnesses: Specific knowledge, attitudes, skills, and bibliography. *Psychiatric Rehabilitation Journal, 23*(4), 378–392.
- Coursey, R.D., Curtis, L., Marsh, D.T., Campbell, J., Harding, C., Spaniol, L., et al. (2000b). Competencies for direct service staff members who work with adults with severe mental illnesses in outpatient public mental health/managed care systems. *Psychiatric Rehabilitation Journal, 23*(4), 370–377.
- Daniels, A.S., & Adams, N. (2004). *From policy to service: A quality vision for behavioral health*. Pittsburgh PA: American College of Mental Health Administration.
- Davidson, L., O'Connell, M., Sells, D., & Staeheli, M. (2003). Is there an outside to mental illness? In L. Davidson (ed.), *Living outside mental illness: Qualitative studies of recovery in schizophrenia* pp. 31–60). New York: New York University Press.
- Davidson, L., O'Connell, M., Tondora, J., Kangas, K., & Evans, A. (2004). The top ten concerns about recovery encountered in mental health systems transformation. Unpublished Manuscript.
- Davidson, L., O'Connell, M.J., Tondora, J., Staeheli, M., & Evans, A.C. (2004). Recovery from serious mental illness: Paradigm shift or (another) psychiatric shibboleth? Manuscript submitted for publication.
- Davis, A.K., Cotter, F., & Czechowicz, D. (1988). Substance abuse units taught by four specialties in medical schools and residency programs. *Journal of Medical Education, 63*(10), 739–746.
- Dewan, M.J., Steenbarger, B.N., & Greenberg, R.P. (2004). *The art and science of brief psychotherapy*. Washington, DC: American Psychiatric Publishers.
- Drake, R.E., Essock, S.M., Shaner, A., Carey, K.B., Minkoff, K., Kola, L., et al. (2001). Implementing dual diagnosis services for clients with severe mental illness. *Psychiatric Services, 52*, 469–476.
- Dreyfus, S.E., & Dreyfus, H.L. (1980). *Five-stage model of the mental activities involved in directed skill acquisition*. Berkeley, CA: Unpublished report supported by the Air Force of Scientific Research (AFSC), USAF (Contract F49620–79-C-0063).
- Dreyfus, H.L., & Dreyfus, S.E. (1986). *Mind over machine*. New York NY: Face Press.
- Fleming, M.F., Barry, K.L., Davis, A., Kahn, R., & Rivo, M. (1994). Faculty development in addiction medicine: Project SAEP, a one year follow-up study. *Family Medicine, 26*(4), 221–225.
- Fraser, S.W., & Greenhalgh, T. (2001). Coping with complexity: Educating for capability. *British Medical Journal, 323*, 799–803.
- Gabbard, G. (2004). *Long-term psychodynamic psychotherapy*. Washington, DC: American Psychiatric Publishers.
- Gill, K.J. (Ed.). (2001). Psychiatric rehabilitation curriculum in higher education [Special issue]. *Psychiatric Rehabilitation Skills, 5*(3).
- Haack, M., & Adger, H. (Eds.). (2002). Strategic plan for interdisciplinary faculty development: Arming the nation's health professional workforce for a new approach to substance use disorders. *Substance Abuse, 23*(3S).
- Hansen, M. (2002). The need for competence in children's public mental health services. In D.T. Marsh & M.A. Fristad (Eds.), *Handbook of serious emotional disturbance in children and adolescents* pp. 93–111). New York, NY: John Wiley and Sons.
- Hansen, M., Anderson, C., Gray, C., Harbaugh, S., Lindblad-Goldberg, M., Marsh, D.T. (1999). *Child, family, and community core competencies*. Harrisburg, PA: PA CASSP Training and Technical Assistance Institute.

- Hoge, M.A., Stayner, D., & Davidson, L. (2000). Psychology internships in the treatment of severe mental illness: Implications for training in academic medical centers. *Journal of Clinical Psychology in Medical Settings*, 7, 213–222.
- Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st Century*. Washington, DC: National Academies Press.
- Institute of Medicine. (2003a). *Health professions education: A bridge to quality*. Washington, DC: The National Academies Press.
- Institute of Medicine. (2003b). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, DC: National Academies Press.
- International Association of Psychosocial Rehabilitation Services. (2001). *Role delineation report of the psychiatric rehabilitation practitioner*. Morrisville, NC: Columbia Assessment Services.
- International Certification Consortium/Alcohol Reciprocity Abuse Other Drug. (1996). *Role delineation study for advanced alcohol and other drug abuse counselors*. Raleigh, NC: Columbia Assessment Services, Inc.
- Kaslow, N.J., Borden, K.A., Collins, F.L., Forrest, L., Illfelder-Kaye, J., Nelson, P.D., et al. (2004). Competencies conference: Future directions in education and credentialing in professional psychology. *Journal of Clinical Psychology*, 60(7), 699–712.
- Leach, D.C. (2001). The ACGME competencies: Substance or form? Accreditation Council for Graduate Education. *Journal of the American College of Surgeons*, 192(3), 396–398.
- Lehman, A.F. (1999). Quality of care in mental health: The case of schizophrenia. *Health Affairs*, 18, 52–65.
- Lewis, D.C., Niven, R.G., Czechowicz, D., & Trumble, J.G. (1987). A review of education in alcohol and other drug abuse. *JAMA*, 257(21), 2945–2948.
- Lindley, P., O'Halloran, P., & Juriansz, D. (2001). *The capable practitioner*. London England: Sainsbury Centre for Mental Health.
- Marrelli, A.F., Tondora, J., & Hoge, M.A. (2005). Strategies for developing competency models. *Administration & Policy in Mental Health*, 32(5), 573–601.
- McFarlane, W.R., McNary, S., Dixon, L., Hornby, H., & Cimett, E. (2001). Predictors of dissemination of family psychoeducation in community mental health centers in Maine and Illinois. *Psychiatric Services*, 52, 935–942.
- Meyers, J., Kaufman, M., & Goldman, S. (1999). *Promising practices: Training strategies for serving children with serious emotional disturbance and their families in a system of care*. In *Systems of care: Promising practices in children's mental health, 1998 Series* Volume V. Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.
- NAAPIMHA. (2002). *Growing our own*. Curriculum developed with funds from U.S. DHHS, SAMHSA, CMHS.
- Nemec, P.B., & Pratt, C.W. (2001). Graduate education in psychiatric rehabilitation. *Psychiatric Rehabilitation Skills*, 5(3), 477–494.
- New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America, final report*. Rockville, MD: U.S. Department of Health and Human Services/DHHS Pub. No. SMA-03–3832.
- Northey, W. (2004). Marriage and family therapy core competencies task force report to the board of directors. Report prepared by William Northey to the board of directors.
- O'Connell, M., Tondora, J., Croog, G., Evans, A., & Davidson, L. (in press). From rhetoric to routine: Assessing recovery-oriented practices in a state mental health and addiction system. *Psychiatric Rehabilitation Journal*.
- O'Hagan, M. (2001). *Recovery competencies for New Zealand mental health workers*. Wellington, New Zealand: Mental Health Commission.
- Onken, J.S., Dumont, J.M., Ridgway, P., Dornan, D.H., & Ralph, R.O. (2002). *Mental health recovery: What helps and what hinders? A national research project for the development of recovery facilitating system performance indicators*. Alexandria, VA: Report to the National Technical Assistance Center for State Mental Health Planning, National Association of State Mental Health Program Directors.
- Onken, S.J., Dumont, J.M., Ridgway, P., Dornan, D.H., & Ralph, R.O. (2004). *Update on the recovery oriented system indicators (ROSI) measure: Consumer survey and administrative data profile*. Washington, DC: Proceedings from 2004 Joint National Conference on Mental Health Block Grant and Mental Health Statistics.
- Pennsylvania CASSP Training and Technical Assistance Institute. (1995). *Core principles: Child and adolescent service system program (CASSP)*. Harrisburg, PA: PA Department of Public Welfare, Office of Mental Health and Substance Abuse Services.
- Pratt, C.W., & Gill, K.J. (2001). Psychiatric rehabilitation education: A government service provider and academic collaboration. *Rehabilitation Education*, 15, 191–199.

- Pratt, C.W., Gill, K.J., Barrett, N.M., & Roberts, M.M. (1999). *Psychiatric rehabilitation*. San Diego, CA: Academic Press.
- PSR-ED@yahoo (n.d.). Group web site devoted to psychiatric rehabilitation education. Contact: pnemec@bu.edu.
- Ralph, R.O., Kidder, K., & Phillips, D. (2000). *Can we measure recovery? A compendium of recovery and recovery-related instruments*. Rockville, MD: The Evaluation Center@HSRI and the Center for Mental Health Services.
- D.S. RychenL.H. Salganik(.) (2001). *Defining and selecting key competencies*. Seattle, WA: Hogrefe & Huber Publishers.
- Scheiber, S., Kramer, T., & Adamowski, S. (2003a). *Core competencies for neurologists: What clinicians need to know*. New York: Butterworth/Heinemann.
- Scheiber, S., Kramer, T., & Adamowski, S. (2003b). *Core competencies in psychiatric practice: What clinicians need to know*. Washington, DC: American Psychiatric Publishers.
- Sexson, S., Sargent, J., Zima, B., Beresin, E., Cuffe, S, Drell, M., et al. (2001). Sample core competencies in child and adolescent psychiatry training: A starting point. *Academic Psychiatry*, 25, 201–213.
- Substance Abuse and Mental Health Services Administration. (1998). *Cultural competence standards in managed care mental health services for four underserved/underrepresented racial/ethnic groups*. Washington, DC: Center for Mental Health ServicesDHHS Pub. No. SMA-00–3457.
- Sumerall, S.W., Lopez, S.J., & Oehlert, M.E. (2000). *Competency-based education and training in psychology: A primer*. Springfield, IL: Charles C. Thomas.
- Tharinger, D., Friedman, B., Hughes, J., La Greca, A., Silverstein, L., Vargas, L., et al. (1998). *Report of the task force on child and adolescent professional psychology to the board of professional affairs*. Washington, DC: American Psychological Association.
- U.K. Department of Health. (1999). *National service framework for mental health: Modern standards and service models*. London, England: Online at: www.publications.doh.gov.uk/nsf/index.htm.
- U.S. Department of Health and Human Services. (1998). *Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice (technical assistance publication series 21)*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.
- U.S. Department of Health and Human Services (2001). *Mental health: Culture, race, and ethnicity—a supplement to mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services, Administration Center for Mental Health Services, National Institutes of Health National Institute of Mental HealthDHHS Pub. No. SMA-01–3613.
- U.S. Department of Health and Human Services. (2002a). *Culture of emotions: A cultural competence and diversity training program/DSM-IV outline for cultural formulation*. Rockville, MD: Office of Minority Health. www.fanlight.com and www.omhrac.gov/cultural.
- U.S. Department of Health and Human Services. (2002b). *Nurse practitioner primary care competencies in specialty areas: Adult, family, gerontological, pediatric, and women's health*. Rockville, MD: Health Resources and Services Administration.
- Wheeler, K., & Haber, J. (2004). Development of psychiatric-mental health nurse practitioner competencies: Opportunities for the 21st Century. *Journal of the American Psychiatric Nurses Association*, 20(10), 1–10.
- Winston, A., Rosenthal, R.N., & Pinsker, H. (2004). *Introduction to supportive psychotherapy*. Washington, DC: American Psychiatric Publishers.
- Young, A.S., Chinman, M., Forquer, S.L., Knight, E.L., Vogel, H., Miller, A., et al. (in press). A consumer-led intervention that improves provider competencies as evaluated by research survey. *Psychiatric Services*.
- Young, A.S., Forquer, S.L., Tran, A., Starzynski, M., & Shatkin, J. (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.
- Young, A.S., Klap, R., Sherbourne, C.D., & Wells, K.B. (2001). The quality of care for depressive and anxiety disorders in the United States. *Archives of General Psychiatry*, 58, 55–61.
- Young, A.S., & Magnabosco, J.L. (2004). Services for adults with mental illness. In B.L. Levin, J. Petrila & K.D. Hennessy (Eds.), *Mental health services: A public health perspective* pp. 177–208). New York, NY: Oxford University Press.

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BEST PRACTICES FOR ASSESSING COMPETENCE AND PERFORMANCE OF THE BEHAVIORAL HEALTH WORKFORCE

Philip G. Bashook

ABSTRACT: The need for mechanisms to assess the competence and performance of the behavioral health workforce has received increasing attention. This article reviews strategies used in general medicine and other disciplines for assessing trainees and practitioners. The possibilities and limitations of various approaches are reviewed, and the implications for behavioral health are addressed. A conceptual model of competence is presented, and practical applications of this model are reviewed. Finally, guidelines are proposed for building competency assessment protocols for behavioral health.

KEY WORDS: assessment; behavioral health; competencies; workforce.

Assessment of health care providers' competencies occurs throughout the continuum of training and practice. Patients and clients, clinical experts, supervisors, and other health care providers informally evaluate these individuals every day. The expected competence of behavioral health care providers can be summarized in the phrase: *he/she should know his/her own limits of expertise, and should know what to do when those limits are reached.* Articulation of defined competencies by the Annapolis Coalition (Hoge, Tondora, & Marrelli, in press) translates knowing "one's own limits of expertise" as knowledge of the science of behavioral health care and how to use that knowledge in a caring and appropriate manner. One should also keep in mind that assessment of competence before entry into practice is quite different from assessment of performance in practice.

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This work was supported in part by Contract No. 03M00013801D from the Substance Abuse and Mental Health Services Administration.

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A general schema has been proposed to assess competence of physicians and other health care practitioners (Newble et al., 1994). Using this schema assessment of competence in the behavioral health workforce should begin by defining how the assessments will be used and what assessment results will be needed. Keeping this bigger picture in mind, an assessment plan might unfold by addressing each of these questions: who is to be assessed? What should be in the blueprint of competencies to be assessed along career paths (during training, pre-practice for certification/licensure, and during practice/employment)? What combination of assessment methods can provide the best measures for each of the competencies to be evaluated (Norman, Swanson, & Case, 1996), given the available resources and the intended uses of the assessments? The paper is organized into sections that follow this approach to the assessment planning process. It concludes with recommended best practices for assessment of competencies illustrated by examples for selected members of the behavioral health workforce.

THE BEHAVIORAL HEALTH WORKFORCE

The assessment challenge is to develop and use valid and reliable assessment methods that measure the competencies relevant to the setting and roles where each member of the behavioral health workforce functions. It is impractical in this paper to recommend an assessment plan for the more than 20 different types of behavioral health specialty disciplines, not to mention customizing the applications to the hundreds of settings where they practice. The elements of the behavioral health workforce have been described in previous work of the Annapolis Coalition and the Institute of Medicine (Hoge & Morris, 2002, 2004; Morris, Goplerud, & Hoge, 2004). This article reflects the broad breakdown of the workforce into those with graduate training, those with baccalaureate training, frontline providers, and consumers and families. Within these broad categories of course, extensive variation exists among the types of licensure and certification standards along the dimensions of educational level, credentialing authority, and state regulation. At present, very few formal structures exist for credentialing consumers and family members, who are increasingly acknowledged as significant parts of the workforce. The most significant exception to this observation is the emergence of peer support specialists. The peer support specialists are newly defined members of the behavioral health workforce who are current and/or former mental health consumers. They are trained to fulfill key roles in advocacy and consumer support of Medicaid-funded mental health

services. The certified peer specialists, originally only in the state of Georgia, complete competency-based training modules, and written and oral examinations (Sabin & Daniels, 2003). Since assessment principles described here for non-degreed staff most closely apply to this group of behavioral health providers, these individuals will not be discussed further here (see the website of the Georgia Certified Peer Specialist, 2004 Project for more details at <http://www.gacps.org>).

Assessment Technology

When considering which assessment technology to use, a significant challenge is judging the quality of the possible assessment methods. The goal is to generate as many quality measurements as possible about a trainee or practitioner across as many examples as possible of the trainee/practitioners knowledge, skills, abilities, and practice performances. Assessments for high-stakes decisions like graduation, certification, and licensure, for example, must be credible. This requires proof and documentation of the reliability and validity of the assessment results. The priority for assessments during training is to select the most feasible methods (i.e., the least expensive in terms of direct costs and labor) to obtain useful data for giving constructive feedback to trainees, and for making decisions about continuing or advancing the trainee in the program.

It is helpful to know the assessment jargon when weighing the value of one assessment method over another. Commonly used concepts for judging assessment methods are the psychometric requirements of reliability and validity, feasibility, and credibility. Each concept will be discussed briefly, followed by descriptions of commonly used assessment methods and the competencies each can best measure.

Psychometric Requirements. These are the estimates of the reliability and validity of an assessment method for a specific purpose. When measuring the competencies of an individual during training or in practice, the goal is for each assessment to be an accurate measure of the person's knowledge, skills, abilities, or performance. Accuracy means that the scores from the assessment are reliable and a valid measure of that person's performance. It is important to recognize that validity does not mean a method is valid per se, but refers to the validity of what the score means when used for a specific purpose with a specific group of people. Experts in psychometrics have developed statistical tests and procedures for calculating reliability estimates. They have also devised procedures for summarizing and interpreting an accumulation of studies necessary to

establish the validity of scores derived from an assessment method (Joint Committee on Testing Practices, 1999; Linn, 1994).

The research evidence suggests these instructor-made tests are rarely reliable, and may not cover the content adequately.

Reliability. Technically, reliability means an estimate of the measurement error for an assessment score (Brennan, 2001; Joint Committee on Testing Practices, 1999). The most useful reliability statistic in assessment is a calculation of the measurement error if the same assessment were repeated under similar conditions. This estimate of measurement error is called score reproducibility (Lunz, Stahl, & Wright, 1994). A highly reliable test of knowledge, for example in a standardized test format, would have a very low error rate and be expressed as having a reliability of 0.90 or greater (i.e., good score reproducibility). The reliability scale uses 0 as unreliable and 1.0 as perfect reliability. In performance assessments and assessments of skills for high-stakes decisions, acceptable reliabilities are above 0.85. Explanations for estimating reliability of written examinations can be found in Case and Swanson (2003). For performance assessments, see Lunz (1995) or Swanson, Norman, and Linn (1995).

In complex assessments like simulations, or when combining multiple assessment methods, it is necessary to separate out the estimated reliability of the score for each person from variations due to the method used, the difficulty of the clinical cases or situations presented, the severity or easy grading by assessors/raters, and different administrations of the assessment over time and location. These variables are referred to as facets when calculating reliability with the Rasch statistical model (Andrich, 1988; Lunz et al., 1994) or components when using generalizability theory (Shavelson & Webb, 1991).

Validity. The concept of validity refers to the accumulated evidence about how well an assessment of competencies measures what it is intended to measure (Joint Committee on Testing Practices, 1999). Validity is not a single statistical calculation, but rather a construct combining statistics, observations, and logical arguments to explain the quality of the validity evidence. In psychometric terms, validity refers to the consistency of scores on an assessment with a preconceived “psychological construct” that defines a person’s abilities or explains performance in practice. In the modern concept of validity, even statistical estimates of reliability are subsumed under construct validity, because reliability influences judgments about the veracity of assessment scores.

Content validity refers to selecting the appropriate range of topics and situations for the assessment. Content validity usually involves creating a blueprint for an examination or assessment and determining that the administered assessment items match the distribution of content defined in the blueprint. In performance assessments, content validity is established by experts selecting the situations or client cases to be used in an assessment, and confirming that the sample of cases is representative of the practice (LaDuca, 1994). Evidence for concurrent validity compares performance by the same people on one assessment (e.g., a simulated case problem) with a well-established score from another assessment (e.g., ratings from training supervisors), both administered contemporaneously as much as possible. A predictive validity study about simulated client cases, for example, might establish that a measurement of a person's abilities managing simulated client cases while in training has a high correlation with performance in actual practice.

Feasibility. Feasibility can be divided into the theoretical and practical problems of design, development, and production of an assessment method, as well as the administration, data analysis, reporting, and ongoing revisions and use of the method. In nearly all situations, feasibility becomes a question of available money, expertise, opportunity, resources, and time. The most efficient approach is to borrow a proven existing method, make minor changes to adapt it for use in the new setting, and hope that the method is as valid for the new setting and the different type of health provider as it was previously. This is the least costly approach, but leaves in question the validity of the results. There is extensive literature describing the transportability of assessment methods, which pivots on one question: will doing the assessments in a new setting or with different stimulus cases/items or raters still provide reproducible and valid measures of competencies the assessment was intended to measure? (Joint Committee on Testing Practices, 1999; Linn, 1994).

Practical concerns with using any assessment method, as noted above, are the time, expertise, and resources needed to use it properly and get useful results. Most clinical settings lack one or more of these. Training settings can often customize survey or rating forms by making minor changes to existing ones. This is quite easy and can be done at minimal cost. Creating custom forms should be sufficient to document a supervisor's ratings of trainees and give trainees feedback, but may not be credible or defensible for pass/fail decisions without additional corroborative evidence of reliability and validity.

In contrast, when resources are more plentiful, as with certifying boards, it is possible to produce a full battery of methods and even have a pool of test questions that can be used year to year. Practical concerns

are cost and sustaining the quality of the assessment method to assure credible results. A complete written examination for board certification (150 high-quality test questions per half-day exam) typically takes 12–18 months for initial planning to administration. The average cost is between \$1000 and \$1500 per item for development alone (\$225,000 per test), excluding test administration and the time of voluntary experts writing test questions. A practical examination like case-based orals takes less time because fewer cases are needed, but costs slightly more, since administration of the exam requires live expert examiners (\$1500 per case, or \$500–\$1000 per candidate). Budgeting for either assessment method needs to include experts meeting to construct and review items, consultants or staff with test construction expertise, editing and revising questions, pilot testing questions, and statistical analysis to document reliability and validity, obtain statistics about the quality of each test question, and administer the assessment to candidates (Browning, Bugbee, & Mullins, 1996).

Another practical matter is administering the assessment. Written exams, for example, are shifting from paper-and-pencil, to computer-based or web-enabled delivery of exams (Mancall, Bashook, & Dockery, 1996). Computers can vividly and accurately display pictures, video clips of clients, and actual clinical findings, allowing the user to zoom in on images, repeat video clips, and move easily from question to question. There are thousands of commercially run computer testing centers in all large cities and many smaller ones (e.g., <http://www.prometric.com>, <http://www.vue.com>). For-profit and nonprofit vendors also provide exam development expertise, candidate scheduling and registration, and verification of candidates during administration. Feedback from users reflects greater satisfaction with computer-delivered tests than paper-and-pencil administrations for high-stakes tests, and they appreciate the reduced time and cost, and added convenience of local travel to test sites. On the other hand, the costs are high for administration. A half-day to one-day exam can cost over \$80 per candidate seat at a commercial testing site. Clearly, this mode of test delivery is potentially feasible for large-scale testing by certifying or licensure boards. The candidates pay the testing cost through certification fees. In contrast, paper-and-pencil test delivery is most common during training.

Successful simulations force the trainee or practitioner to sort through a wide variety of options to clarify the important clinical problems and challenges.

Credibility. Credibility refers to the veracity of assessment results from the perspective of those who will use the results (e.g., the behavioral health community, colleagues in the same discipline, the public, govern-

ment regulatory agencies, and clients). A straightforward rule of thumb for judging credibility is deciding if the assessment results are a good measure of whether the person “knows their own limits and what to do when those limits are reached.” Credibility indicates how well the assessment results are supported by affirmative answers to the following questions:

- Are the content and competencies being assessed appropriate for the providers’ expected roles and responsibilities?
- What is the appropriate use of the assessment results? Training feedback? Training promotion? Employment? Certification? Licensure? Practice privileges?
- Was appropriate scientific rigor used in the design and execution of the assessment methods and the assessment process?
- Are the assessment methods appropriate for the type of provider?
- Were any adjustments made to accommodate the providers’ disabilities?
- Is the assessment fair to all those who take it?
- Are the raw findings in the assessment results kept confidential, as appropriate?

Assessment Methods

The commonly used assessment methodology can be classified into four categories according to what each is intended to measure. Table 1 describes each method and recommended uses for assessing competencies of behavioral health providers. Some of these descriptions build on the ACGME Toolbox of Assessment Methods© that is now a guide used in assessment of physicians in training (Bashook & Swing, 2000) and other sources (Bashook, 1994). Additionally, the methods can be grouped into four assessment categories according to what each is best at measuring: (1) assessment of knowledge, (2) assessment of decision-making, (3) assessment of practice performance and personal attributes, and (4) assessment of skills and tasks.

Assessment of Knowledge

This usually refers to assessing recall of facts, concepts, principles, and basic application in a standard examination format. There are three common exam formats: multiple choice questions (MCQs), essay questions, and short-answer questions.

TABLE 1
Assessment Methods and Recommended Uses^a

<i>Assessment Focus</i>	<i>Method</i>	<i>Description</i>	<i>Recommended Use</i>
Knowledge	Written exam—multiple choice questions	Many test questions in multiple choice with single response or matched answers	Assess knowledge of facts and concepts
Knowledge	Written exam—essay questions	Present challenging problem or question ask for written essay response	Assess intellectual synthesis of ideas, comprehension
Knowledge	Written exam—short answer questions	Present challenging problem or question and response in few words	Assess knowledge of facts and concepts, comprehension
Decision-making	Oral exam (standardized)	Case-based written, simulated, live patients, own case reports as focus of examiners' questions	Assess case specific decisions, know own limits
Decision-making	Key features cases	Written case focus on essential client management decisions	Assess decision-making different stages in client care
Performance and attitudes, skills/tasks	Global ratings	Raters judge general abilities usually retrospective after repeated observations	Assess performance on list of competencies synthesized by rater or multiple raters
Performance and attitudes	Supervisor's narrative reports	Documented summary of supervisor's judgments about person	Assess synthesized judgments about abilities, limitations

Performance and attitudes	Client surveys	Survey questions to clients asking about care satisfaction, judgments about providers, facilities, other services	Accumulated forms assess patterns or incidents, attitudes, actions, communications, professionalism
Performance and attitudes	Client record review	Use criteria and protocol to judge documented care	Assess decision-making, care follow-through
Performance and attitudes	Portfolios	Predefined expected products of practice, reflect about quality and impact	Assess judgments about quality, master professional and intellectual behaviors
Performance and attitudes	360-degree evaluation	Survey forms completed by multiple people in person's sphere of practice	Assess perceived judgment, professional behavior, communication skills
Performance and attitudes and skills/tasks	Standardized patient simulations (SPs)	Actors trained to follow protocol and simulate a client with clinical condition	Assess interview, communication, therapeutic alliance, interpersonal skills
Skills/tasks	Simulations and models	Imitate clinical situations by computerized and live cases	Assess attitudes, decisions, skills, abilities, and training
Skills/tasks	Checklist/rating scales	Ratings on specific behaviors, activities, tasks, or sequence of actions	Assess specific observable behaviors or actions

^aModified from ACGME Toolbox of Assessment Methods© (Bashook & Swing, 2000).

Multiple Choice Questions (MCQ). The typical standardized test that contains hundreds of questions often presents a brief synopsis of a client situation. The candidate is to select the best answer among four or five options. The individual taking the exam is judged by how many of the preferred responses are chosen. Questions are scored as correct or incorrect and tallied to decide a pass/fail decision or rank the person among peers. The questions are selected from a pool of questions based on a test blueprint that defines the content to be assessed. Experts on the content pre-select the correct answers. When properly designed, this type of written exam is considered the gold standard in knowledge assessment. Nearly all members of the behavioral health workforce are expected to pass standardized written examinations in the multiple-choice format at some point in their career.

These written exams are typically developed and administered by a certifying or licensure board. The MCQ exams are administered on paper or delivered on a computer as one or more half-day sessions, with around 150–200 questions per session. Some boards have one or even two full days of exams (300–600 test questions per exam). Well-constructed exams comply with accepted psychometric standards for reliability and validity (reliability can be as high as 0.98 for a diverse group of candidates). Credibility of results is high by all who rely upon test scores as evidence of the candidate's knowledge. Although expensive to create and administer, it is quite feasible to use this format for large-scale national testing of candidates.

Training instructors often assumes that constructing quality written exam questions will be easy. The research evidence suggests these instructor-made tests are rarely reliable (e.g., too few questions), and may not cover the content adequately (e.g., questionable validity). Also, design flaws with the MCQ technology contribute to unreliable scores. For example, one question gives hints to help the less capable answer other questions, or the questions contain grammatical errors that guide more astute test-takers (Case & Swanson, 2003; Joint Committee on Testing Practices, 1999).

Essay Questions. Essay questions present the test-taker with a challenging problem or scenario and ask him/her to explain how s/he would address the problem or scenario in a written essay response. Lengths of allowable responses can vary, and scoring is completed by content experts. The grading may be pass/fail or use various rating scales. Issues of reliability surface when multiple graders judge performance or one person must grade many essays. Reliability can be improved by training and monitoring the graders. The Educational Testing Service has

developed software to automate grading of essays and short-answer questions (Educational Testing Service, 2004).

Continuous quality improvement is a newer technology that some suggest could be used to measure practice performance.

Short Answer Questions. When using a short-answer question format, a brief synopsis of a client situation or problem is presented and the person responds with a phrase or one-sentence answer. Experts on the topic score answers. Grading answers can be automated using computer software (Educational Testing Service, 2004), which limits problems of inter-judge reliability. Short-answer questions are often used in written exams for limited numbers of trainees in place of the MCQ format because they are much easier to construct and do not require sophisticated technology to score.

Assessment of Decision-Making

At every stage in care, the practitioner must make judgments about critical actions that can affect a client. Decision-making and judgment cannot be assessed with standardized MCQs. They require assessing the use of knowledge in realistic practice situations (Page, 1995). The following assessment methods are effective for assessing decision-making if designed and used appropriately: case-based oral exams and key features cases.

Case-Based Oral Exams. This technology is used extensively in certification examinations for psychiatry (Juul & Scheiber, 1994), psychology, including specialties in psychology (see American Board of Professional Psychology, <http://www.abpp.org>), and other behavioral health disciplines requiring a professional degree. The candidate can be presented with case material in a variety of formats: written vignettes, images, their own client case reports, or live client situations. As the case unfolds, the candidates must explain their decisions about assessment, diagnoses, treatment planning, and/or managing the case. Examiners can question candidates on reasons for their decisions. Adding hypothetical variations to the presenting case tests the candidate's limits of expertise and actions they would take once those limits are reached (Mancall & Bashook, 1995). A typical examination lasts 30–60 min per session, with four to eight sessions. In this time frame, a well-constructed exam can question a candidate on 12–36 cases, and obtain from 50 to 100 measures of clinical decision-making. Estimated score reproducibility (reliability) has been

consistently above 0.90 for well designed and administered oral exams for certification (Lunz, 1995; Lunz et al., 1994).

Quality oral exams require extensive training of examiners (Des Marchais & Jean, 1993; McDermott et al., 1991), standardization of cases, pre-established scoring schema, and careful monitoring of administration to obtain reliable and valid results (Bashook, 2003; Mancall & Bashook, 1995). When designed properly, the case-based oral examination is a good predictor of practice performance (Solomon, Reinhart, Bridgham, Munger, & Starnaman, 1990).

Key Features Cases. This approach is a written examination where the person must make decisions for critical actions (key features) occurring at various stages in the case. Experts score responses based upon previously established criteria. Each case is counted as a single score (Page, Bordage, & Allen, 1995). Key features cases are currently used in physician licensure examinations in Canada (Page et al., 1995). This method has not been used in assessments of clinicians in the behavioral health workforce, but certainly could be incorporated into written exams during training and practice.

Assessment of Practice Performance and Personal Attributes

Assessing the performance of trainees involves assessments of observed behavior with clients over time, or in specific observed client encounters. Most commonly used methods are: global rating forms, supervisor's summary reports, client surveys, client record audits, portfolios, and 360-degree evaluations.

Global Rating Forms. A rater uses a form with multiple categories of performance to provide retrospective impressions/judgments about a person's performance. The rater can not only incorporate observed performance over time, but often include a synthesis of second-hand information from multiple sources. The rating scales usually include a place for judgments about overall competence and space for written comments. Scoring global rating forms includes separate tallies of rating scales with averages, frequency counts, the ratings by multiple raters, and qualitative evaluation of comments. There is some evidence that global ratings are superior for assessing performance compared to checklists (Regehr, MacRae, Reznick, & Szalay, 1998). This assessment method is used frequently in supervised clinical care situations, with supervisors or more senior practitioners rating junior practitioners or trainees. It is used in all behavioral health training programs leading to professional degrees and for behavioral health specialists.

Supervisor's Summary Reports. These reports are summaries produced biannually or annually (for employment), and provide documentation of a supervisor's evaluation of trainees or practitioners employed in a behavioral health facility. They serve as a compilation of the supervisor's judgments about the competencies of the person accumulated over months or a year. Often the reports are confidential. This report is ubiquitous, and used in both training and practice for all levels of the behavioral health workforce.

Client Surveys. Clients complete a questionnaire about specific encounters with a practitioner, the setting, and related care issues. Typical assessments include satisfaction with care, overall quality of care, competencies in interpersonal relations, therapeutic relationships, perceived expert knowledge, and professional practices. Accumulated across a number of clients, the summary of results and highlighted incidents (positive and negative reports from clients) can provide insight into how clients perceive a practitioner's professional demeanor, attitudes, and care (Weaver, Ow, Walker, & Degenhardt, 1993). Scoring is done by experts comparing findings against expected performance at the level of training and circumstances of practice situation.

Client Record Audits. This approach is customarily used to assess performance in practice with trained auditors performing a confidential review of case records and judging findings based on previously defined protocols and criteria. Audit information from multiple cases is easily converted into statistical descriptions to measure compliance with expected practices. Scores are useful for identifying strengths and weaknesses in practice performance when compared to similar practitioners. Some medical specialty certifying boards have introduced client record audits as part of the re-certification for their specialty (Bashook, 1994).

Roe points out, "A high level of competence is a prerequisite for good performance; it does not guarantee adequate performance."

Portfolios. The portfolio is a defined collection of products prepared by the student or practitioner that demonstrates progress in learning about or mastery of a competency. Products can be from training or practice experiences (e.g., clients encountered, ethical situations). For each product required in the portfolio, there are specifications based on what competencies will be assessed. In addition, the trainee or practitioner might be required to prepare a statement reflecting upon quality of the product, what was learned, and assessment of current competency.

Portfolios have been used to assess psychiatrists during residency training on attitudes, professionalism, and experience-related competencies that are not easily and systematically measured by other means (O'Sullivan, Cogbill, McClain, Reckase, & Clardy, 2002). Supervisors and instructors can score the portfolio against pre-determined standards. When properly designed, portfolios can be a reliable method to assess the more intangible attributes of competence, even in high-stakes assessments (Roberts, Newble, & O'Rourke, 2002).

360-Degree Evaluations. Often used in business, 360-degree evaluations are multiple ratings done retrospectively, concurrently, and separately by people in the sphere of influence of the person being evaluated (e.g., supervisors, colleagues, subordinates, clients, referring clinicians). All raters receive the same written survey containing rating scales and requesting judgments about a person's performance for a specific time period. The raters are strongly encouraged to add comments that illustrate the reasons for the ratings. Competencies often assessed include the person's clinical performance, interpersonal relationships, teamwork, knowledge application, communication skills, attitudes, and professionalism (Hall et al., 1999). The rating scales can be tabulated to produce a numeric score, and comments are organized to provide insight into the raters' perceptions about the person. A variation on the 360-degree evaluation is multiple peer ratings of performance that emphasize only the attributes that each peer is best at rating (Ramsey et al., 1993).

Using the 360-degree report requires caution in keeping information confidential, because comments are often sensitive, and exposure can be detrimental. This assessment method is used most effectively during employment situations for individuals who have some supervisory responsibilities, or training situations where the person has a significant role in team care.

Assessment of Skills and Tasks

Competencies involving specific skills or actions in client assessment, treatment, or care management can be assessed individually both in the context of care and during training. In order to give the skills or tasks a context, the assessment requires the presentation of a clinical case situation, even if only a brief description of the patient's characteristics. More elaborate case situations are used when the assessment attempts to mimic the realities of clinical practice as much as possible, and these commonly use role-playing simulations with live interactions or computers to create virtual reality environments. Typical assessment methods are: rating scales and checklists, role-playing computer simulations, and role-playing standardized patient examinations.

Rating Scales and Checklists. Rating scales and checklists are used during live or videotaped observations of a trainee or practitioner as a means of guiding the evaluation, and as documentation of what was observed. These assessment methods are very similar in how they are used, but differ in one respect. For checklists, the rater decides if the person being evaluated has or has not performed a specific action. If performed, the rater then checks the appropriate box on the form. With rating scales, the rater may judge not only completing a task, but also how well it was performed along a spectrum of excellent to poor or other range of quality performances. The additional step of judging the quality of a performance introduces greater variability in the ratings due to differences in interpreting the meaning of scale descriptions (e.g., what exactly does excellent or average mean). Personal biases about what behaviors should count more or less also influence the consistency of ratings across raters are, along with a tendency of raters to differ about how severe or easy they are when grading another's performance (rater severity). These variations in judgment are one reason rating scales may have a lower reliability than checklists, unless the rater is trained how to use the scales. There are statistical methods to correct for rater severity (Lunz et al., 1994). Also, training of raters improves consistency and validity of the raters' judgments (Winckel, Reznick, Cohen, & Taylor, 1994). It appears that global rating scales may provide more reliable measures of performance compared to checklists when the tasks are complex (Regehr et al., 1998). Typical uses include: completing a series of steps in a client workup such as mini-mental health status, or assessing completion of steps in a protocol for planning a client's discharge from a restricted care unit.

Role-playing Computer Simulations. Simulations used in assessment closely resemble reality. The focus is on the essential realistic clinical problems to be solved, while stripping away irrelevant distractions (Clyman, Melnick, & Clauser, 1995). Successful simulations, whether on computer, paper-and-pencil, or through role-playing, force the trainee or practitioner to sort through a wide variety of options as they clarify the important clinical problems and challenges to address and attempt to solve the problems. Simulations on computer have been developed to train surgeons, anesthesiologists, and other procedure-oriented doctors to manage new invasive technology like arthroscopy (Taffinder, Sutton, Fishwick, McManus, & Darzi, 1998).

Life-sized computerized adult and child mannequins have been used in an operating room simulation to train anesthesiologists in basic and advanced anesthesia treatments, including crisis situations (Gaba et al., 1998). These technologically advanced simulations, referred to as virtual reality (VR) environments, are commercially available at a cost of around

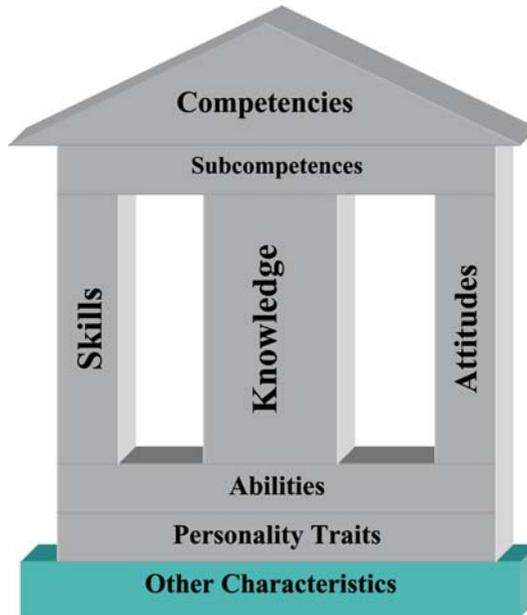
\$50,000 each, and include case-based software. There are additional expenses for creating tailor-made case scenarios, maintaining equipment and space, and employing technical staff to run the simulations. Some medical schools and hospitals have purchased VR equipment to train clinical staff, medical students, residents, and physicians. It is anticipated this technology will be widely adopted in medical curricula, because there are fewer opportunities to learn directly from patients and clients.

Role-playing Standardized Patient Examinations. During a standardized patient examination (SP), a trainee or practitioner is presented with a realistic scenario and must interact with a live person (the SP) in a role-playing simulation, as if the SP were a real client. The SP is an actor who has been previously trained to simulate a client with a realistic condition and appropriate emotional state. The trainee or practitioner's performance during the encounter can be evaluated against expected competencies defined in advance, and documented either by the SP or an observer. The SP encounter can last 10–30 min, followed by at least 10 min for the SP or an observer to rate the performance. Frequently, the encounters are observed and videotaped to protect the SP and the person being evaluated. SPs are widely used in training medical students and physicians in training, and for continuing medical education experiences (Guagnano, Merlitti, Manigrasso, Pace-Palitti, & Sensi, 2002). The SP examinations are most effective to evaluate the following competencies: workup/assessment of a client (medical, social, emotional, or other history, physical examination skills); communication skills, including giving bad news and counseling patients; and managing complex situations that could harm patients or staff when mishandled (e.g., suicidal patient, aggressive client behavior, paranoia).

Conceptual Frameworks for Assessment in Training and Practice

A distinction needs to be made between assessing competence and assessing performance in practice. Competence to practice is measured during training in controlled situations, at the time credentials or licenses are obtained, through objective examinations (written and oral). Assessment of performance during actual practice is measured either with assessments that are a snapshot of client care, or accumulated assessments over time (somewhat like video clips of practice with annotated ratings of the performance quality). Statistical analyses discern useful trends and outlying behaviors for improving quality of care, and look for patterns in the setting that need quality assurance interventions. In either the snapshot or video format, they are direct measures of practice, not implied capacities based on exams. Roe (2002) described a tradi-

FIGURE 1
Competence Architecture Model (Roe, 2002)



tional approach for assessment of psychologists' competencies prior to practice (during training) that is applicable to any occupation. Roe's model, the "competence architecture model" (2002), was intended as a guide for incorporating defined competencies for curricular design and program accreditation, but it works equally well for assessing competencies of anyone in the behavioral health workforce.

The model proposed by Roe can be visualized as a Greek temple (see Figure 1). He depicts expected competencies capping a building that has foundation layers of abilities, personality traits, and other personal attributes, all potentially measurable by assessment methods. Pillars of acquired learning are the traditional KSAs (knowledge, skills, and attitudes) where depth and breadth of learning are assessed. Practical learning supports the roof during supervised training. The knowing how and when that integrates the KSAs with the foundation layers become subcompetencies. Subspecialties combine KSAs with other abilities and personal attributes, all of which work together when performing a specific and demonstrable part of the clinical care. Typical subcompetencies include the evaluation of a client or the articulation of a treatment plan for a client. The roof of the model is made up of the competencies essential to practice. By combining assessments for the architectural ele-

ments below the roof of competence, one can infer whether a person has the appropriate competencies essential to practice.

The individual competencies defined by the Annapolis Coalition (Hoge et al., in press) are equivalent to subcompetencies in Roe's competence architecture model. In assessment, the preference is to measure each subcompetency separately and accumulate the results to make judgments about a person's overall competence. For example, a subcompetency is the ability to perform an appropriate and focused intake interview with a client and/or family.

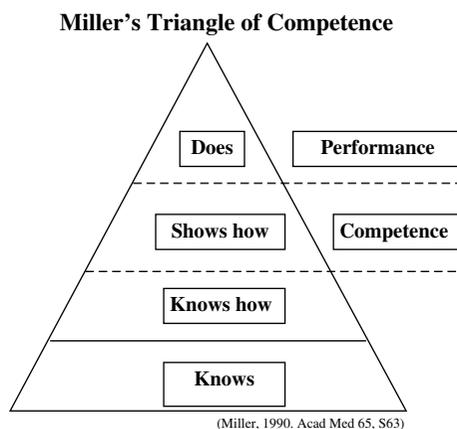
A variety of assessment methods could be used to generate an aggregate score composed of multiple measurements of this ability. A systematic assessment could include a knowledge test about essential steps and theory in history taking, live or simulated observations of the student or practitioner interviewing a client, documented accumulated ratings on intake interviewing skills observed and judged by faculty, supervisors or senior trainees over weeks or months of supervised practice, and measures of the person's attitudes about clients' cultural differences assessed using validated attitude scales. An aggregate score that combines these measures would require adjustments for statistical reliability of each measure. Interpreting the score must be tempered by qualitative adjustments for the person's communication style, personality attributes, assumed relative validity of each measure, and limits and circumstances when each measure was taken.

Accumulating valid measures for each subcompetency is essential, but as Roe points out, "A high level of competence is a prerequisite for good performance; it does not *guarantee* adequate performance." This model provides the framework used in this paper when explaining how to design assessment of competencies for entry into practice.

Miller's Triangle (1990) provides a useful framework for structuring assessment of performance in practice. The triangle is like an inverted pyramid, with four progressive stages of assessment: "knows," "knows how," "shows how," and "does" (see Figure 2). All four stages clearly define progressive capabilities, and build on abilities in the lower stages. Also, Miller's Triangle visualizes the well-established principle that assessment of a person's knowledge is important, but not sufficient to predict they will apply the knowledge in practice (Kennedy, Regehr, Rosenfield, Roberts, & Lingard, 2003).

Considering the roles, responsibilities, and settings of behavioral health practice requires adding two more components to the Miller Triangle: (1) systems-related influences on practice (e.g., facility-specific regulations, policies, patient expectations, governmental regulations, and access to other health professionals), and (2) individual-related influences (e.g., mental and physical health of the practitioner, relationships

FIGURE 2
Miller's Triangle of Competence Assessment (Miller, 1990)



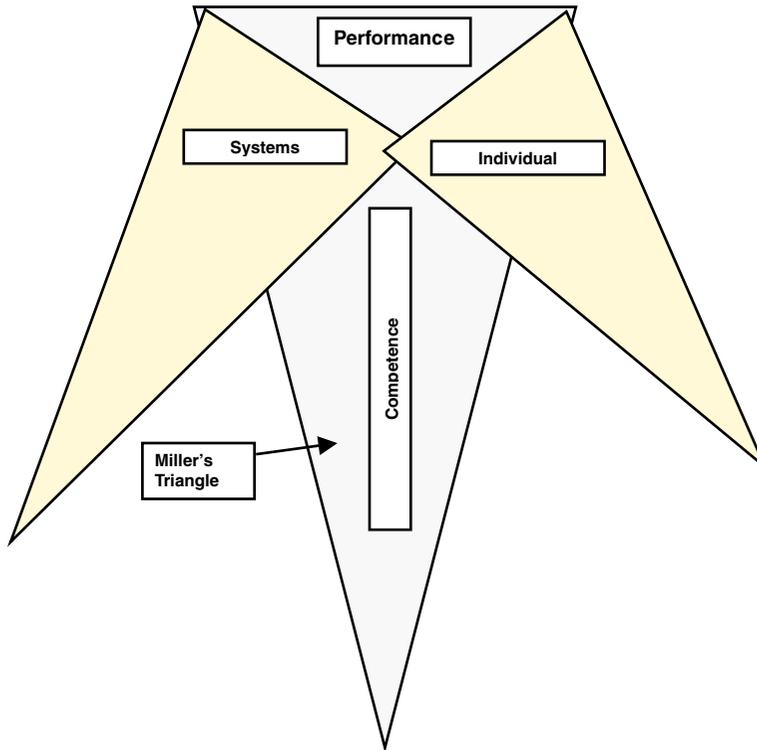
with others like patients, other practitioners, and their family, and state of mind at time of performance practice assessment). Rethans and colleagues (2002) refer to this more complex model of assessment and competence as the “Cambridge Model,” after the conference where it was proposed (see Figure 3).

Measurement of practice performance is complex because of variability in forces external to the individual. The Institute of Medicine (2000, 2001) reported about safe health care, and emphasized that quality performance by individual practitioners depends directly upon the health care systems where they work. The following is a short list of the common systems-related factors that can influence practice performance, and must be considered when interpreting results from an assessment program for behavioral health providers:

- Case mix and quantity of clients
- Differences in priority setting by individuals
- Institutional policies and regulations
- Legal, ethical, and other limits in how one can practice
- Expertise and teamwork of available clinical team members
- Options for referral to practitioners with greater expertise
- How care will be paid for and limitations in insurance coverage

Also, the validity of predicting quality of practice performance from objective assessments like exams for re-licensure or renewal of certification (the “knowing how” in the Miller model) depends to a large extent

FIGURE 3
The Cambridge Model for Assessment of Performance
(Rethans et al., 2002)



upon how well these assessment methods are adjusted to account for the variabilities inherent in daily practice.

Looked at from the perspective of the practitioner, maintenance of competence in practice requires a purposeful self-directed learning agenda that combines opportunities to participate in continuing education activities and on-the-job learning. Often, client needs and expectations, as well as a wish to manage care situations most effectively, drive most practitioners' learning agendas (Bashook, 1993). A method to assess this competence in practice has not been well developed.

Another product of the Cambridge Conference meeting was a framework for implementing a practice performance assessment program (Lew et al., 2002). The proposed framework outlines three broad domains to address in planning, and specifies the questions and decisions to consider. It offers guidance for creating defensible procedures that should address the concerns of all stakeholders. The domains are:

1. *Purposes and Outcomes.* What are the purposes of the assessment? Whose purposes are being met? Are they unambiguously stated and made available prior to implementing the program?
2. *Planning the Practice Assessment Program.* What steps are taken to assure fairness and defensibility of the process and results? Is the plan clearly described, including who are the assessors, what methods are used, what is known about the technical characteristics of the methods?
3. *Processes.* How will the program be administered and communicated to the stakeholders and assessors? How will methods be developed and used? What are the security issues? What are the policies and rules regarding the amount of time for the assessments and appeals procedures? What are the feasibility issues like cost and resource needs to produce credible and useful performance data?

The framework is partly based upon the extensive experience of the United Kingdom's General Medical Council peer review program, which assessed physicians' practice performance. The UK program withstood court litigation to remove doctors' licenses (Southgate et al., 2001), and uses a portfolio method combining interviews, tests of competence, and self-reports, which generates more than 700 judgments about the doctor's practice performance.

A less ambitious suggestion for assessing performance practice is to provide tools for the individual practitioner to create a self-directed learning portfolio (Roberts et al., 2002) and report progress to certifying and licensure boards using web-based software (Bashook & Parboosingh, 1998). This approach would fit into one component of the maintenance of certification programs by the physician specialty boards in the U.S. and Canada (American Board of Medical Specialties, 2003; Royal College of Physicians and Surgeons of Canada, 2004). It also takes into consideration on-the-job learning directly related to personal and institutional influences the practitioner brings to the workplace (see Figure 2). It is important to realize that some practice roles cannot be assessed with any assurance until the person has begun working in a practice setting and has opportunities to demonstrate their capabilities over time, under real conditions (Cunnington & Southgate, 2002).

Accumulation of continuing education credits in place of direct performance assessments has no value when assessing practitioners' maintenance of competence.

Continuous quality improvement is a newer technology that some suggest could be used to measure practice performance (see Institute for Healthcare Improvement, <http://www.ihl.org>). It is based on the principles of quality control used in engineering systems as adapted to human behavior and health systems. Most recently, quality improvement initiatives have focused on patient safety themes, which supports the Institute of Medicine report about “errors in medicine” and health care system deficiencies (Institute of Medicine, 2000, 2001). The assessment pays direct attention to individual behaviors that are influenced by the systems where they work, which in turn influence quality. It seems to work in medical settings with defined expectations for patient care decision-making and outcomes.

Once in practice, the person may have the competence and know-how and perform admirably when the opportunities arise, yet still have few situations to perform all they can do. Demonstrating pre-practice competence does not necessarily mean the person will find him or herself in a practice environment designed to support competence, and so may not function competently in practice. The reality of practice places constraints on how competencies are routinely used, and the practice setting adds additional restrictions that necessitate conformity to team preferences or institutional policies and practices, whether or not these preferences, policies, or practices have as a basis empirical knowledge.

These variations in settings, roles, and responsibilities will influence the individual practitioner’s abilities to maintain the initial competencies assessed at entry into practice. Complicating the equation are the growing trends that require practitioners to demonstrate continuing or maintenance of competence by periodic reassessments for re-registration of a license or renewal of certification (Bashook & Parboosingh, 1998). These reassessments often occur at intervals of two or three years for licensure, and 5–10 years for renewal of certification. It’s important to recognize that accumulation of continuing education credits in place of direct performance assessments has no value when assessing practitioners’ maintenance of competence (Cunnington & Southgate, 2002). An alternative is to adopt the maintenance of certification programs being implemented in Canada and the United States (American Board of Medical Specialties, 2003; Royal College of Physicians and Surgeons of Canada, 2004).

Some behavioral health providers without professional degrees, or advanced certified training do not have these re-registration and renewal requirements. However, all groups are reassessed for continuing competence through employment evaluations, practice opportunities, and attempts to advance through adding specialized expertise with additional certifications.

Recommended Best Practices in Assessment of Providers

In considering which methods to adopt, it is important to realize that no single assessment method can evaluate all competencies, and more than one method may measure the same competencies (see Table 1). Ideally, the best approach is to develop an assessment blueprint that identifies multiple assessment methods tailored to the competencies to be measured, and accounts for feasibility of using the methods when considering the career stage of a practitioner (year in training, or practice roles in clinical settings). An example is a peer assessment program for family physicians in Canada that uses written exams, case-based and chart-stimulated oral exams, and standardized patient cases (Norman et al., 1993).

Schuwirth and colleagues (2002) proposed guiding principles that would combine practice performance assessment methods into results that all stakeholders would consider coherent, credible, and defensible. In their view, the combination of assessment methods should provide a whole portrait of the practitioner. The essential ingredients include: having large samples of behavior to assess, irrespective of the assessment methods used; organizing the sequence and intensity of assessments into a structure, but not an overly regimented or prescriptive structure; and using multiple assessment methods to reduce risk of bias due to any one method. Also, it's important to keep in mind that ways of assessing competencies are not static, and need to be revised to be consistent with current priorities in the discipline, public expectations, current scientific knowledge, and improvements in assessment methodology.

With these caveats noted, the following are some suggested best practices citations that build upon the published literature (see American Board of Professional Psychology, <http://www.abpp.org>; Bashook, 1994). For examples of assessment practices with other health care providers, see Landon, Normand, Blumenthal, and Daley (2003); Browning et al. (1996); Swanson et al. (1995); and Foulkes et al. (1993). These recommended best practices are grounded in the conceptual framework for assessments in training, the "competence architecture model" (Roe, 2002); and the framework for assessment in practice, the "Cambridge Model of Assessment" (Rethans et al., 2002). All suggestions are tempered by considerations of the reliability, validity, feasibility, and credibility of the assessment methods.

Within each of the traditional behavioral health disciplines, there are templates for assessment practices, some much more detailed than others. This is also true for some practice areas that have traditionally put less emphasis on academic credentials and more on life experiences, such as addictions counseling and the newly created peer support spe-

cialist category. There are also educational programs being developed targeted towards families and primary consumers, for which assessment strategies are in their earliest stages of development. Readers seeking detailed information should access professional association websites or seek information related to intervention strategies with specific population targets (e.g., assertive community treatment for persons with serious and persistent mental illnesses).

Best Assessment Practices: Professional Degreed Practitioners

The Example of Psychiatrists. The medical student who plans to enter psychiatry after completing the M.D. degree is continuously evaluated over the four-year medical school curriculum in a carefully constructed and progressive assessment process that resembles the competence architecture model. All accredited medical schools in the U.S. and Canada must have defined graduation competencies and a comprehensive system of evaluating medical students (see <http://www.lcme.org/standard.htm>). After graduating medical school, assessments for residents in psychiatry for four years (general psychiatry) or five to six years (child and adolescent psychiatry) shift emphasis from evaluating knowledge and basic clinical skills and tasks to evaluation of core psychiatric competencies (Scheiber, Kramer, & Adamowski, 2003). The accumulated results of these assessments during residency determine whether the graduate is qualified to become a candidate for certification by the American Board of Psychiatry and Neurology. Advanced certification after training in child and adolescent psychiatry and other psychiatric specialties involves a similar two-stage assessment process.

Best Assessment Practices: Trained Therapists with College Degrees

The Example of Creative Arts Specialists. The Art Therapy Credentials Board (2004) has developed a certifying process for art therapists that includes training requirements and a written case-based knowledge examination. The exam uses MCQ items with cases to cover the six major content domains of the discipline: (1) psychological and psychotherapeutic theories and practice, (2) art therapy assessment, (3) art therapy theory and practice, (4) recipient populations, (5) art therapy media, and (6) professionalism and ethics. Assessments of performance in practice would greatly enhance the credibility of the certificates. These assessments could be obtained at reasonable cost and effort through systematic reports using a portfolio assessment method.

Best Assessment Practices: Non-Degreed Staff

Example of Certification in Alcohol and Other Drug Abuse. The International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse (2004) has established certification standards for alcohol and other drug abuse counselors. Most American states and more than a dozen countries have adopted these standards. The training requirements include 240 h of formal didactic instruction in workshops, courses, institutes, in-service, and distance education. Supervised practical training requires 300 h, covering 12 core functions with assessment of targeted skill development and demonstrated application of knowledge within an alcohol or drug counseling setting.

In addition, entry to certification requires 6000 h (three years) of supervised experience in providing alcohol or other drug abuse counseling services. An associate's degree and other behavioral science course work can substitute for some of these training and course requirements. Besides the reports of successfully completing the supervisor's evaluations, the candidate must pass a written examination (MCQ format) designed by a team of international experts in alcohol and substance use. Finally, a case-based oral examination (write-up of a single client that the candidate has managed) must be passed. Peers who have advanced certification evaluate this case in a structured oral examination.

Clearly, this certification program closely follows the "competence architecture model," having the counselor build competency with didactic foundational course work, plus extensive focused and supervised skill and practice development, in addition to supervised training in practice.

CONCLUSION

The recommended best practices for assessment of the behavioral health workforce can be summarized in the following guidelines:

1. Define the content and competencies to be assessed in an assessment plan or blueprint as the first step in creating a valid assessment program.
2. Provide evidence that the implemented assessment methods measure what was intended in the plan with supporting data, statistical analysis, and logical explanations. The assessment evidence should:
 - Assure that the assessment is reliable, showing the amount of error or variability that could occur if the same assessment were repeated with the same group of trainees or practitioners.

- Present accumulated evidence of the validity of assessment results for a specific group of people in specific circumstances to demonstrate that the results can be interpreted to measure what they are purported to measure. It is the scores on the assessment, not the method, that is valid.
 - Demonstrate the feasibility of an assessment method with realistic estimates of cost in time and effort to develop, test, implement, and obtain valid results when using the method.
 - Demonstrate the credibility of an assessment where all stakeholders who rely upon the assessment results consider the methods and the findings plausible, consistent, and useful for the intended purposes.
3. Use the “competence architecture model” (Roe, 2002) as a guide for combining assessment methods appropriate for evaluating trainees during training or at the completion of training (e.g., initial certification or licensure).
 - Assessments used during training for purposes of feedback for trainees do not need the same high reliability and rigorous validity standards as in high-stakes assessments such as those involving credentialing and licensure.
 - Assessments for licensure and certification (initial and renewal) should include a well-engineered blueprint and evidence of validity and reliability that is credible to defend against challenges.
 4. Use the “Cambridge Model” (Rethans et al., 2002) as a guide for combining assessment methods appropriate for evaluating performance in practice (e.g., continuing quality improvement of practice, renewal/maintenance of certification, re-registration of license).
 - Sample multiple behaviors and practice events using a variety of assessment methods.
 - Avoid overly structured assessment program that trivialize what is to be assessed (Schuwirth et al., 2002).
 5. Construct new assessment methods using the following sequence: (1) content and testing experts work together to develop the new method to assure content accuracy and technical integrity, (2) pilot test and revise assessment cases or test items as needed, and (3) perform psychometric analyses of results every time the methods are used (Browning et al., 1996).

There is a growing global emphasis on assessing the competence of all health care providers, especially physicians, as reflected in standards for accreditation requiring assessment of competencies (World Federation

for Medical Education, 1998). This trend continues into initial specialty certification, with time-limited certification that requires physicians to renew their certification through a process called “maintenance of certification/competence” (Bashook & Parboosingh, 1998; Cunnington & Southgate, 2002). This practice is the norm in medicine throughout North America (American Board of Medical Specialties, 2003; Royal College of Physicians and Surgeons of Canada, 2004), and is rapidly taking hold in Europe and other regions of the world (see European Union of Medical Specialists, <http://www.uems.net>). It is common for trends that start in medicine to influence other health care disciplines. Therefore, assessment plans, which demonstrate maintenance of competence, are soon likely to be an important priority for all behavioral health disciplines. The medical model of competence and performance assessment is one option, but the behavioral health workforce should consider alternatives tailored to their specialized roles, responsibilities, and settings.

A start could be periodic cross-disciplinary meetings to exchange information and experience about assessment programs. Also valuable would be a grant funding mechanism to foster creating better assessment tools and methodology specific to common competencies in behavioral health care. No matter how this effort is achieved, building and using quality assessment methods will not occur without significant planning, support, and cooperation among all who have a stake in behavioral health care.

REFERENCES

- American Board of Medical Specialties. (2003). *ABMS annual report and reference handbook*. Available from: <http://www.abms.org>.
- Andrich, D. (1988). *Rasch models for measurement*. Newbury Park CA: Sage Publications.
- Art Therapy Credentials Board. (2004). *Art therapy credentials board: Booklet of information and study guide for certification examination*. Available from: <http://www.atcb.org/>.
- Bashook, P.G. (1993). Clinical competence and continuing medical education: Lifelong learning to maintain competence. In C. Coles & H.A. Holm (Eds.), *Learning in medicine* (pp. 21–41). Oslo, Norway: Scandinavian University Press.
- Bashook, P.G. (1994). Beyond the traditional written and oral examinations: New certification methods. In J. Shore & S. Scheiber (Eds.), *Certification, recertification, and lifetime learning in psychiatry* (pp. 117–138). Washington, DC: American Psychiatric Press.
- Bashook, P.G. (2003). *Structured case-based orals are a valid and reliable measure of physician's clinical decision-making*. Chicago, IL: American Educational Research Association.
- Bashook, P.G., & Parboosingh, J. (1998). Continuing medical education: Recertification and the maintenance of competence. *British Medical Journal*, *316*, 545–548.
- Bashook, P.G., & Swing, S. (2000). *Toolbox of assessment methods*©, version 1.1. Evanston, IL: Accreditation Council for Graduate Medical Education /American Board of Medical Specialties. Available at <http://www.acgme.org>.
- Brennan, R.L. (2001). An essay on the history and future of reliability from the perspective of replications. *Journal of Educational Measurement*, *38*(4), 295–317.
- Browning A.H., Bugbee A.C., & Mullins M.A. (Eds.) (1996). *Certification: A NOCA handbook*. Washington, DC: National Organization for Competency Assurance.
- Case, S.M., & Swanson, D.B. (2003). *Constructing written test questions for the basic and clinical sciences*. Philadelphia, PA: National Board of Medical Examiners. Available at <http://www.nbme.org>.

- Clyman, S.G., Melnick, D.E., & Clauser, B.E. (1995). Computer-based case simulations. In E.L. Mancall & P.G. Bashook (Eds.), *Assessing clinical reasoning: The oral examination and alternative methods* (pp. 139–149). Evanston, IL: American Board of Medical Specialties.
- Cunnington, J., & Southgate, L. (2002). Relicensure, recertification, and practice-based assessment. In G.R. Norman, D.I. Newble & C.P.M. Vander Vleuten (Eds.), *International handbook of research in medical education* (pp. 883–912). Amsterdam: Kluwer Academic Publishers.
- Des Marchais, J.E., & Jean, P. (1993). Effects of examiner training on open-ended, high taxonomic level questioning in oral certification examinations. *Teaching & Learning in Medicine*, 5(1), 24–28.
- Educational Testing Service. (2004). *Graduate record examination (GRE)*. Available from: <http://www.gre.org/tiindex.html>.
- Foulkes, J., Bandaranayake, R., Hayes, R., Phillips, G., Rothman, A., & Southgate, L., (1993). Combining components of assessment. In D. Newble, B. Jolly & R. Wakeford (Eds.), *The certification and recertification of doctors: Issues in the assessment of clinical competence* (pp. 134–150). Great Britain: Cambridge University Press.
- Gaba, D.M., Howard, S.K., Flanagan, B., Smith, B.E., Fish, K.J., & Botney, R. (1998). Assessment of clinical performance during simulated crises using both technical and behavioral ratings. *Anesthesiology*, 89, 8–18.
- Georgia Certified Peer Specialist Project. (2004). *Georgia Certified Peer Specialist Project*. Georgia Mental Health Consumer Network, Division of Mental Health, Developmental Disabilities and Addictive Diseases. Available from: www.gacps.org.
- Guagnano, M.T., Merlitti, D., Manigrasso, M.R., Pace-Palitti, V., & Sensi, S. (2002). New medical licensing examination using computer-based case simulations and standardized patients. *Academic Medicine*, 77(1), 87–90.
- Hall, W., Violata, C., Lewkonja, R., Lockyer, J., Fidler, H., & Toews, J., et al. (1999). Assessment of physician performance in Alberta: The physician achievement review. *Canadian Medical Association Journal*, 161(1), 52–57.
- Hoge, M.A. & Morris, J.A. (Eds.) (2002). Behavioral health workforce education and training. [Special issue]. *Administration and Policy in Mental Health*, 29(4/5), 297–303.
- Hoge, M.A. & Morris, J.A. (Eds.) (2004). Implementing best practices in behavioral health workforce education: Building a change agenda [Special issue]. *Administration and Policy in Mental Health*, 32(2), 83–205.
- Hoge, M.A., Tondora, J., & Marelli, A.F. The fundamentals of workforce competency: Implications for behavioral health. *Administration and Policy in Mental Health*(in press).
- Institute of Medicine. (2000). *To err is human: Building a safer health system*. Washington, DC: National Academy Press.
- Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st Century*. Washington, DC: National Academy Press.
- International Certification & Reciprocity Consortium/Alcohol & Other Drug Abuse. (2004). *Standards for certified alcohol and other drug abuse counselors*. Available from: <http://www.icrcaoda.org/>.
- Joint Committee on Testing Practices (1999). *Standards for educational and psychological testing*. Washington, DC: American Educational Research Association, American Psychological Association National Council on Measurement in Education.
- Juul, D., & Scheiber, S.C. (1994). The part II psychiatry examination: Facts about the oral examination. In J.H. Shore & S.C. Scheiber (Eds.), *Certification, recertification, and lifetime learning in psychiatry* (pp. 71–90). Washington, DC: American Psychiatric Press.
- Kennedy, T., Regehr, G., Rosenfield, J., Roberts, W., & Lingard, L. (2003). *Degrees of gap between knowledge and behavior: A qualitative study of clinician action following an educational intervention*. Chicago, IL: American Educational Research Association.
- LaDuca, A. (1994). Validation of professional licensure examinations: Professions theory, test design, and construct validity. *Evaluation & the Health Professions*, 17(2), 178–197.
- Landon, B.E., Normand, S.L., Blumenthal, D., & Daley, J. (2003). Physician clinical performance assessment: Prospects and barriers. *Journal of the American Medical Association*, 290(9), 1183–1189.
- Lew, S.R., Page, G.G., Schuwirth, L.W., Baron-Maldonado, M., Lescop, J.M., & Paget, N., et al. (2002). Procedures for establishing defensible programmes for assessing practice performance. *Medical Education*, 36(10), 936–941.
- Linn, R.L. (1994). Performance assessment: Policy promises and technical measurement standards. *Educational Researcher*, 23, 4–14.
- Lunz, M.E. (1995). Statistical methods to improve decision reproducibility. In E.L. Mancall & P.G. Bashook (Eds.), *Assessing clinical reasoning: The oral examination and alternative methods* (pp. 97–106). Evanston, IL: American Board of Medical Specialties.

- Lunz, M.E., Stahl, J.A., & Wright, B.D. (1994). Interjudge reliability and decision reproducibility. *Educational Psychological Measurement, 54*(4), 913–925.
- E.L. Mancall/P.G. Bashook (Eds.) (1995). *Assessing clinical reasoning: The oral examination and alternative methods*. Evanston, IL: American Board of Medical Specialties.
- Mancall, E.L., Bashook, P.G., & Dockery, J.L. (1996). *Computer-based examinations for board certification: Today's opportunities and tomorrow's possibilities*. Evanston, IL: American Board of Medical Specialties.
- McDermott, J., Scheiber, P.T., Juul, D., Shore, J., Tucker, G., & McCurdy, L., et al. (1991). Reliability of the part II board certification examination in psychiatry: Inter-examiner consistency. *American Journal of Psychiatry, 148*(12), 1672–1674.
- Miller, G.E. (1990). The assessment of clinical skills/competence/performance. *Academic Medicine, 65*, S63–S67.
- Morris, J.A., Goplerud, E.N., & Hoge, M.A. (2004). Workforce issues in behavioral health. Institute of Medicine, Unpublished manuscript.
- Newble, D., Dauphinee, D., Macdonald, M., Mulholland, H., Dawson, B., & Page, G., et al. (1994). Guidelines for assessing clinical competence. *Teaching and Learning in Medicine, 6*(3), 213–220.
- Norman, G.R., Davis, D.A., Lamb, S., Hanna, E., Caulford, P., & Kaigas, T. (1993). Competency assessment of primary care physicians as part of a peer review program. *Journal of American Medical Association, 270*(9), 1046–1051.
- Norman, G. R., Swanson, D.B., & Case, S.M. (1996). Conceptual and methodological issues in studies comparing assessment formats. *Teaching & Learning in Medicine, 8*(4), 208–216.
- O'Sullivan, P., Cogbill, K., McClain, T., Reckase, M., & Clardy, J. (2002). Portfolios as a novel approach for residency evaluation. *Academic Psychiatry, 26*(3), 173–178.
- Page, G. (1995). Assessing reasoning and judgment. In E.L. Mancall & P.G. Bashook (Eds.), *Assessing clinical reasoning: The oral examination and alternative methods* (pp. 19–27). Evanston, IL: American Board of Medical Specialties.
- Page, G., Bordage, G., & Allen, T. (1995). Developing key-feature problems and examinations to assess clinical decision-making skills. *Academic Medicine, 70*(3), 194–201.
- Ramsey, P.G., Wenrich, M.D., Carline, J.D., Inui, T.S., Larson, E.B., & LoGerfo, J.P. (1993). Use of peer ratings to evaluate physician performance. *Journal of American Medical Association, 269*(13), 1655–1660.
- Regehr, G., MacRae, H.M., Reznick, R.K., & Szalay, D. (1998). Comparing the psychometric properties of checklists and global rating scales for assessing performance in an OSCE format examination. *Academic Medicine, 73*(9), 993–997.
- Rethans, J.J., Norcini, J.J., Baron-Maldonado, M., Blackmore, D., Jolly, B.C., & LaDuca, T., et al. (2002). The relationship between competence and performance: Implications for assessing practice performance. *Medical Education, 36*(10), 901–909.
- Roberts, C., Newble, D.I., & O'Rourke, A.J. (2002). Portfolio-based assessments in medical education: Are they valid and reliable for summative purposes? *Medical Education, 36*(10), 899–900.
- Roe, R.A. (2002). What makes a competent psychologist? *European Psychologist, 7*(3), 192–202.
- Royal College of Physicians and Surgeons of Canada. (2004). *Maintenance of certification*. Available from: <http://rcpsc.medical.org/>.
- Sabin, J.E., & Daniels, N. (2003). Strengthening the consumer voice in managed care: VII. The Georgia peer specialist program. *Psychiatric Services, 54*(4), 497–498.
- Scheiber, S.C., Kramer, T.A.M., & Adamowski, S.E. (2003). *Core competencies for psychiatric practice*. Arlington, VA: American Psychiatric Publishing.
- Schuwirth, L.W.T., Southgate, L., Page, G.G., Paget, N.S., Lescop, J.M.J., & Lew, S.R., et al. (2002). When enough is enough: A conceptual basis for fair and defensible practice performance assessment. *Medical Education, 36*(10), 925–930.
- Shavelson, R.J., & Webb, N.M. (1991). *Generalizability theory: A primer*. Newbury Park CA: Sage Publications.
- Solomon, D., Reinhart, M., Bridgham, R., Munger, B., & Starnaman, S. (1990). An assessment of an oral examination format for evaluating clinical competence in emergency medicine. *Academic Medicine, 65*(S43–S44).
- Southgate, L.J., Cox, J., David, T., Hatch, D., Howes, A., & Johnson, N., et al. (2001). The general medical council's performance procedures: Peer review of performance in the workplace. *Medical Education, 35*(Suppl 1), 9–19.
- Swanson, D.B., Norman, G.R., & Linn, R.L. (1995). Performance-based assessment: Lessons from the health professions. *Educational Researcher, 24*(5), 5–11.
- Taffinder, N., Sutton, C., Fishwick, R.J., McManus, I.C., & Darzi, A. (1998). Validation of virtual reality to teach and assess psychomotor skills in laparoscopic surgery: Results from randomised controlled studies using the MIST VR laparoscopic simulator. In J.D. Westwood, H.M. Hoffman, D. Stredney &

- S.J. Weghorst (Eds.), *Medicine meets virtual reality* (pp. 124–130). Amsterdam: IOS Press.
- Weaver, M.J., Ow, C.L., Walker, D.J., & Degenhardt, E.F. (1993). A questionnaire for patients' evaluations of their physicians' humanistic behaviors. *Journal of General Internal Medicine*, 8, 135–139.
- Winckel, C. P., Reznick, R.K., Cohen, R., & Taylor, B. (1994). Reliability and construct validity of a structured technical skills assessment form. *American Journal of Surgery*, 167(4), 423–427.
- World Federation for Medical Education. (1998). International standards in medical education: Assessment and accreditation of medical schools' educational programmes: A WFME position paper. *Medical Education*, 32, 549–558.

STRATEGIES FOR DEVELOPING COMPETENCY MODELS

Anne F. Marrelli, Janis Tondora, and Michael A. Hoge

ABSTRACT: There is an emerging trend within healthcare to introduce competency-based approaches in the training, assessment, and development of the workforce. The trend is evident in various disciplines and specialty areas within the field of behavioral health. This article is designed to inform those efforts by presenting a step-by-step process for developing a competency model. An introductory overview of competencies, competency models, and the legal implications of competency development is followed by a description of the seven steps involved in creating a competency model for a specific function, role, or position. This modeling process is drawn from advanced work on competencies in business and industry.

KEY WORDS: behavioral health; competency; modeling.

There have been growing questions about the competency of the healthcare workforce in the United States. The pace of change within the healthcare field has raised concerns about whether providers have the necessary knowledge, skills, and abilities to navigate current systems of care. These concerns have been exacerbated by data on the frequency of patient injuries and deaths as a result of errors in care (Institute of Medicine, 2000, 2001).

Competency-based approaches to training, assessment, and staff development are increasingly viewed as a central strategy for improving the effectiveness of those who provide care (Institute of Medicine, 2003). The adoption of such approaches is occurring in behavioral health, as

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This work was supported in part by contract No. 03M00013801D from the Substance Abuse and Mental Health Services Administration.

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evidenced by the release of numerous reports that identify competencies for various segments of the mental health and addictions treatment workforce (Coursey et al., 2000; National Panel for Psychiatric Mental Health Nurse Practitioner Competencies, 2003; U.S. Department of Health and Human Services, 1998).

The identification and application of the competencies required for effective job performance has become a complex and sophisticated endeavor as experience with this approach has furthered in business and industry. The purpose of this article is to draw on that reservoir of knowledge and describe a seven-step process for competency modeling. It is intended to offer a conceptual introduction to competency modeling by briefly explaining each step in the process. It is not possible, given space constraints, to provide sufficient guidance for readers to undertake competency modeling without further instruction or support. However, this article should serve as a useful orientation to the process, as well as a beginning guide for efforts to plan further development of competency models within the field of behavioral health. We begin with a brief review of key concepts, discuss relevant legal issues, and then describe the seven strategies.

OVERVIEW OF COMPETENCY CONCEPTS

A competency is a measurable human capability that is required for effective performance. A competency may be comprised of *knowledge*, a single *skill* or *ability*, a *personal characteristic*, or a cluster of two or more of these attributes. Competencies are the building blocks of work performance. The performance of most tasks requires the simultaneous or sequenced demonstration of multiple competencies (Hoge, Tondora, & Marrelli, in press). An example of a competency appears in Table 1.

Knowledge is awareness, information, or understanding about facts, rules, principles, guidelines, concepts, theories, or processes needed to successfully perform a task (Marrelli, 2001; Mirabile, 1997). The knowledge may be concrete, specific, and easily measurable, or more complex, abstract, and difficult to assess (Lucia & Lepsinger, 1999). Knowledge is acquired through learning and experience.

A *skill* is a capacity to perform mental or physical tasks *with a specified outcome* (Marrelli, 1998). Similar to knowledge, skills can range from highly concrete and easily identifiable tasks, such as filing documents alphabetically, to those that are less tangible and more abstract, such as

TABLE 1
Example of a Competency: Managing Performance

Definition	Using effective selection procedures to hire successful employees. Setting clear performance goals and expectations for employees and regularly monitoring their progress. Providing coaching and feedback to employees to maximize their performance. Analyzing the underlying causes of performance problems and taking action to resolve the problems.		
Descriptors	<ul style="list-style-type: none"> • Makes sound hiring decisions based on the requirements of the job. • Clearly defines performance expectations for employees. • Provides employees with the resources they need to accomplish their goals. • Regularly monitors employee work and goal achievement. • Promptly addresses performance problems. • Recognizes the achievements of employees on a regular basis. • Applies the organization's performance management process. • Provides employees with regular feedback to improve their performance. 		
	<i>Low Proficiency</i>	<i>Moderate Proficiency</i>	<i>High Proficiency</i>
Selects employees based on initial impressions developed from reading the resume and an interview.	Identifies the competencies required to perform the job and uses the competencies as a guide in selecting employees.		Selects employees based on a careful analysis of the competencies required for the job. Bases interview questions (or other selection techniques) on the required competencies.
Distributes assignments without providing adequate information to employees to successfully complete the tasks.	Explains assignments clearly to employees.		Clearly defines all assignments and associated performance expectations and checks to ensure the employee has understood.

TABLE 1 *(Continued)*

When giving assignments, does not consider the resources the employee will need.	When giving assignments, asks employees if they have the resources they need.	When giving assignments, reviews with employees the resources they will need and ensures the resources are available or provided.
Infrequently meets individually with employees to monitor progress and provide feedback.	Meets individually with employees at least every month to monitor progress and provide feedback.	Meets individually with employees at least every two weeks to monitor progress and provide feedback.
Delays addressing performance problems until they have escalated.	Promptly addresses performance problems. Provides feedback to the employee and develops an action plan for improvement.	Looks beneath symptoms to identify the root causes of performance problems and works with the employee to develop an effective solution.
Does not recognize employee accomplishments.	Recognizes and rewards employees for good performance.	Continuously recognizes and rewards employees, both formally and informally.
Fails to match assignments with employee strengths or development needs.	Organizes and assigns work to achieve objectives, and uses the strengths of each team member.	Organizes work to achieve objectives, leverage strengths of employees and provide development opportunities.
Implements some but not all components of the organization's performance management process.	Consistently implements the organization's performance management process.	Uses the organization's performance management process to monitor and maximize performance and develop employees.

managing a quality improvement project (Hoge, Tondora, & Marrelli, in press; Lucia & Lepsinger, 1999).

An *ability* is a demonstrated cognitive or physical capability to successfully perform a task with a *wide range of possible outcomes* (Marrelli, 1998). An ability is often a constellation of several underlying capacities that enable us to learn and perform. These are often time-consuming and difficult to develop, and usually have a strong component of innate capacity. For example, the ability of analytical thinking comes more naturally to some than to others, and can be quite challenging for many individuals to develop.

Competency experts note that many *personal characteristics* may be required for or may influence effective performance. These characteristics, such as attitudes, values, and traits, often have an emotional or personality component. Marrelli (1998, 2001) has argued that it is useful to define these personal characteristics as “enabling behaviors.” These include work habits, ways of interacting with others, or manners of conducting oneself that contribute to effective work performance. Examples of enabling behaviors are managing work priorities and assignments to meet schedule commitments, developing rapport with others, and treating others with respect (Marrelli, 1998, 2001). Enabling behaviors can emerge through learning, experience, innate predisposition, or a combination of these determinants. For example, developing rapport with others appears to be an almost instinctive behavior for some, while others have to consciously learn how to develop rapport and then practice assiduously before they can achieve it routinely.

A *competency model* is an organizing framework that lists the competencies required for effective performance in a specific job, job family (i.e., group of related jobs), organization, function, or process. Individual competencies are organized into competency models to enable people in an organization or profession to understand, discuss, and apply the competencies to workforce performance (Hoge, Tondora, & Marrelli, in press).

The vast majority of expenditures on mental health care and substance use disorders treatment are expenditures on personnel.

The competencies in a model may be organized in a variety of formats. No one approach is inherently best. Rather, organizational needs will determine the optimal framework. A common approach is to identify several “core” or “key” competencies that are essential for all employees, and then identify several additional categories of competencies that apply

only to specific subgroups. Some competency models are organized according to the type of competency, such as leadership, personal effectiveness, or technical capacity. Other models may employ a framework based on job level, with a basic set of competencies for a given job family and additional competencies added cumulatively for each higher job level within the job family.

LEGAL IMPLICATIONS

Before considering the steps in the competency modeling process, it is important to briefly examine the legal implications in the application of competency models. If a model will be used to make employment decisions, the process of identifying the competencies must adhere to rigorous standards. Employment decisions include hiring, promotion, selection of employees for training opportunities that may lead to promotion, reassignment, evaluation, compensation, termination, and in many cases, certification. The organization's ability to successfully defend these decisions depends heavily on the reliability and validity of the competency model, and the organization may be asked to demonstrate that the model was created and utilized according to acceptable professional standards. The federal *Uniform Guidelines on Employee Selection Procedures* (Equal Employment Opportunity Commission, 1978) provides detailed guidance on the requirements for validation. As an example of appropriate implementation, in a competency-based selection process, the required competencies for the position are used as the selection criteria.

If a completed competency model is to be used in employment selection decisions, it is important to distinguish between the competencies that are "essential" for job performance and those that are "non-essential." As an example, the federal Americans with Disabilities Act (ADA) is designed to ensure that qualified persons with disabilities have the same access to employment as those without disabilities. The competencies assessed in selection procedures must be demonstrably related to the "essential" job functions. Information about the definition of "essential" can be found in the ADA regulations (Equal Employment Opportunity Commission, 1991; Marrelli, 1994).

If the competencies will be used for employee development, strategic workforce planning, or career planning, less rigor in the competency modeling process is required because there is less legal risk to the organization in these applications. In these situations, the level of rigor will be determined by the importance to the organization of the accuracy and thoroughness of the identified competencies.

THE PROCESS OF DEVELOPING COMPETENCY MODELS

A thorough competency modeling process has seven steps. Each of these is described below. While presented in a logical sequence, in practice, the process can be somewhat less orderly due to the interrelationship among these steps.

Step One: Defining the Objectives

The first and most important step in a competency modeling effort is to clearly and specifically define the objectives. There are four essential questions to be answered in this process.

A competency may be comprised of knowledge, a single skill or ability, a personal characteristic, or a cluster of two or more of these attributes.

Why is there a need to develop a competency model? Consider carefully the problems to be solved, the benefits to be gained, and the opportunities to be pursued through the development and application of a competency model. Because competency modeling requires a significant investment of time and money, a strong need should drive the decision to conduct such a project.

What is the unit of analysis? Is the objective to identify the competencies required for effective performance for a job family, a specific job, or a more narrow function? Will the results apply to a single work group, a department, or an entire organization? Or will they apply to a consortium of several organizations, or all the members of a profession?

What is the relevant timeframe? Does the concern with the competencies need to be addressed now, or is it necessary to identify these competencies in the future? Many organizations choose to identify both the competencies currently needed and the competencies that will likely be needed in the foreseeable future. The ability to predict future needs will vary greatly depending on the rate of change and the type of factors that influence the field being studied.

How will the competency model be applied? Will it be used for strategic workforce planning, employee selection, promotion, performance management, training and development, certification, succession planning, compensation, rewards and recognition, or career planning? Many of the decisions made about methodology and the resulting competency model will depend on the intended applications. Table 2 contains a sample statement of the objective for a competency modeling project.

TABLE 2
Sample Statement of Objectives

Need	The job requirements of clinical supervisors have changed significantly over the past several years due to internal organizational factors, state and federal regulations, and health care system changes. Further changes are expected over the next three to five years. Frequent problems in the quality of patient care have also arisen because some clinical supervisors have not adequately monitored the work of their staff.
Objective (unit of analysis and time-frame)	Identify the competencies that are essential for effective performance for clinical supervisors in the State's 10 mental health centers now and in the next three years.
Application	<p>The identified competencies will be used:</p> <ul style="list-style-type: none"> • In the selection of new clinical supervisors to ensure they demonstrate the competencies required for successful job performance. • To manage and evaluate the performance of clinical supervisors. • To identify the development needs of current clinical supervisors and create development programs to meet these needs.

Step Two: Obtain the Support of a Sponsor

A sponsor is necessary for each competency modeling project to provide the information, resources, support, and authorization required to ensure its success. A key element of the support that the sponsor will provide involves gaining the commitment and participation of the employees, managers, professionals, or others from whom data will be collected. Thus, sponsors must have influence and jurisdiction over the relevant units of analysis, and might be a chief executive, department head, program manager, or the board or management of a professional association.

Convincing the sponsor that the competency modeling project is a worthwhile investment of organizational resources can be accomplished by preparing answers to the following questions:

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- What specific organizational needs will the competency model address?
 - How will the model address these needs?
 - What additional potential applications will the model have?
 - How will the model be developed? Why is this approach being used?
 - How will employees, managers, professionals, and other stakeholders be involved?
 - How long will it take to develop and apply the model?
 - What actions will be taken to ensure the success of both the model development and its application? What are some of the potential barriers, and what are the plans for addressing them?
 - What are the tangible and intangible costs of developing the model?

It is crucial to be clear in explaining what is needed, including authorization to conduct the project, staff time, facilities, equipment and supplies, other resources, and most especially, the sponsor's commitment to ensure the full cooperation and participation of the employees, managers, and other stakeholders involved in or affected by the project. It is best to provide this information both orally and in writing.

Step Three: Develop and Implement a Communication and Education Plan

A key element of success in any competency project is convincing those who will participate or be affected of its value. Buy-in, commitment, and the cooperation of these stakeholders are vital.

Work with people who know the organization well in order to identify all the stakeholders in the project. These include the individuals and groups who will benefit, be negatively impacted, be inconvenienced, or affected in any way from the competency study. Assess the probable level of support that can be expected from each individual or stakeholder group by informally classifying them into one of three categories:

- *Committed.* These stakeholders will participate willingly in data collection or pilot testing, provide funding or other resources, and will influence others to support the study.
- *Compliant.* These stakeholders will do what they are asked, but will not go beyond what is required of them.
- *Resistant.* Active resisters may strongly oppose the study by refusing to cooperate with requests to supply information or people, delaying requested actions, or even attempting to stop the study. Passive resisters may outwardly appear to comply with project requirements, but actually attempt to undermine the study (Lucia & Lepsinger, 1999).

Plan a communication strategy to address probable concerns. For example, organizational leaders may fear their autonomy in selecting and assessing their employees will be replaced by a competency model that dictates criteria for making these decisions. To decrease their anxiety, emphasize in the communications that the completed competency model will provide tools and guidelines for decision-making, rather than rigid requirements.

Create a schedule for communicating with each stakeholder group, planning the amount and type of information to be provided. Inform all stakeholders about the study in the early planning phases, and communicate at periodic intervals throughout the study to keep everyone informed of the progress being made and what they can expect next. The stakeholders who will be directly involved in the study, such as those who will be interviewed or will complete a survey, will need more detailed and frequent communications.

Benchmarking interviews with other organizations is especially useful in achieving a broader view of the job.

The communication plan should specify the media to be used. Possibilities include in-person briefings, conference calls, e-mail bulletins, voicemail bulletins, posters, staff meetings, town halls, newsletters, videos, memos, and more. The effectiveness of each media will vary with the message, the organizational culture, and the stakeholders. The impact of the communication will also vary with the person who delivers the message, so the delivery also needs to be carefully planned. For example, a memo from a senior manager will receive much more attention than a memo from the competency project leader.

Step Four: Plan the Methodology

In Step Four, the methodology is designed that will lead to development of the competency model. This involves selecting the sample of individuals who will contribute data for the project, as well as the methods to be used for obtaining the data. For the sake of simplicity, we will hereafter refer principally to a “job,” but the discussion also applies to other units of analysis, such as a job family, specialization within a job, or a specific function.

Sample Selection

Using Multiple Groups. It is essential to collect data about required competencies from both job incumbents and others familiar with the work. Self-reports about competencies from incumbents can be flawed, as people sometimes report that their job requires more socially prestigious competencies than those actually needed. For example, employees might report that “problem-solving” is a key competency, when in reality what they need is the “ability to follow directions.”

The managers or supervisors who directly oversee the work of the target job should always be included in the sample, along with job incumbents. If those in the target job supervise others, include the supervisees in the sample, as they can provide information about the competencies needed to be an effective supervisor. If the target job involves a high level of interaction with clients or patients, it is important to include them as a source of data, since they can provide a useful perspective on the competencies they value in the job incumbents. For some job roles, it is also appropriate to include colleagues or team members to obtain their unique perspective.

Focus on High Performers. The accuracy of the competency model will depend heavily on the accuracy of the data collected. Data accuracy is dependent on the people from whom data is collected. These individuals should be highly knowledgeable about what is needed for effective performance. In developing a competency model, the goal should be to identify the competencies required for *excellent* performance, not average or poor performance. The people most likely to provide accurate data about the competencies required for excellent job performance are those who perform the job the best—the high, top, or exemplary performers (Gilbert, 1996; Kelley & Caplan, 1993). Traditional job analysis and other common approaches to identifying competencies include all employees in their data collection, often without differentiating among the data provided by low, average, and high performers. The problem with this approach is that low and average performers may not fully understand what is required to do an exceptional job.

Some methods of competency identification compare the information provided by low and high performers and assume that the competencies identified by the high performers, but not by the low or average performers, are the competencies that should be included in the competency model. However, only identifying the *differentiating* competencies is a flawed approach because it is important to include all the competencies required for high performance, not just those that differentiate between low and high performers. Failure to do so can lead to serious consequences when the model is applied.

Desirable Characteristics of the Sample. It is important to ensure that the people selected to identify competencies have strong analytical and verbal abilities. A high level of analytical thinking is required, as many of the competencies needed to perform a job duty are not readily apparent. For many jobs, analytical ability is not necessary to perform competently. Therefore, we cannot assume for all jobs that a competent or high performing job incumbent or manager will have the required analytical ability to identify all competencies. The ability to express oneself well in oral speech or in writing is another important attribute in identifying competencies so that the input is clear and concise.

Selecting a Representative Sample. The accuracy of the data collected about competencies will depend heavily on how closely the sample represents the population of interest. The high performers, their managers or supervisors, and others selected should be proportionately similar to the entire population in terms of job responsibilities, functional area, tenure, ethnicity, gender, geographic location, or other characteristics relevant to the job. If a competency study addresses several levels of a job role, it is necessary to ensure that the sample includes employees from all levels.

Selecting Data Collection Methods

At least two different methods of collecting data should be used in a competency identification project. Every method of data collection has relative strengths and weaknesses, so multiple methods can complement each other and compensate for the weaknesses in singular approaches. If the resulting data obtained from one method is similar to the data collected in a second approach, there is greater credibility and greater assurance that required competencies have been accurately identified. Multiple methods are also useful in assuring that a competency is not missed all together.

The ideal subject matter expert is a superior performer who previously functioned in the job, but has been promoted to a higher level.

The factors to consider in selecting the data collection methods include:

- *Validity.* Is there evidence that a particular method will more accurately reflect the required competencies for the job role being studied?
- *Reliability.* Will the method provide reliable data, such that similar results would be obtained in repeated administrations?
- *Application.* How will the identified competencies be applied? When the competencies will be used in hiring, promotion, evaluation, or

compensation of employees, more evidence for the validity of the method is required than for development, strategic workforce planning, or recognition programs.

- *Efficiency*. How much time and other resources will the method require in instrument development, administration, and analysis of results?
- *Practicality*. Will the method be practical given the constraints of the project, such as the geographical dispersion or staggered schedules of employees?
- *Acceptance*. Will the job incumbents, managers, and other stakeholders in the study accept the method as a reasonable way to collect data? Are they likely to participate and cooperate with this method?

Seven different data collection methods follow. For each method, we summarize the advantages and disadvantages. Space limitations do not permit us to provide guidelines for the use of each method. This information can be found in the sources included in the annotated bibliography provided at the conclusion of the paper.

Literature Review. A preliminary approach for defining job content and identifying required competencies is to conduct a review of the literature to learn about previous studies of the job or similar jobs. Quite often, no previous studies have been conducted. However, if they do exist, they can be extremely helpful in providing an introduction to the job and a preliminary list of competencies to consider. The literature review supplements, but does not replace, other data collection methods. It simply provides a quick overview.

Sources of published literature include books, professional journals, association magazines, theses, and dissertations. Unpublished studies may be available from professional associations, consulting firms, colleges and universities that offer training programs for the target job, and through the Internet. The quality of these studies will vary widely, and they need to be critically evaluated before use.

Focus Groups. In focus groups, a facilitator works with a small group of job incumbents, their managers, supervisees, clients, or others to define the job content or to identify the competencies they believe are essential for performance. A series of focus groups is often conducted to allow many people in the organization to provide input.

There are different approaches to conducting focus groups. Typically, the facilitator will use a prepared protocol of questions to guide a structured discussion. For example, if the purpose of the focus group is to identify required competencies, the facilitator may go through each element of work behavior and ask the participants to describe the competencies that these require. Sometimes the participants are asked to individually list the competencies they think are important. They then

work as a group to identify additional competencies and reach consensus regarding a final list. Another approach is to base the discussion on previously collected data, such as the findings from a questionnaire. In this situation, the facilitator will methodically lead the group through the results, asking them to confirm the data or explain their perspective if they differ.

Expert panels are a special type of focus group where persons who are considered highly knowledgeable about the job and its requirements meet to develop a list of the competencies required for success. The members of expert panels are typically those who write about or do research in the relevant discipline, such as published academics.

Focus group advantages:

- They can facilitate support for the competency study and its application, because many people can be involved in the panels and provide input.
- A large amount of data can be collected quickly and relatively inexpensively.
- Participants build on each other's ideas to provide an in-depth and broad perspective that is not possible in individual interviews.
- The rapport that group members build with each other and the facilitator often encourages participants to contribute more information than they would when working alone.

Focus group disadvantages:

- Focus groups can be difficult to organize because they require that numerous people with varying schedules and commitments be present at the same place and time.
- A skilled facilitator is required to encourage a productive discussion where all participate.
- The quality of the information produced is heavily dependent on the analytical ability and depth of experience of the group members.
- Focus groups often identify competencies that reflect the values and traditions of an organization or those that are socially desirable, but not actually required for the target job.
- Group members are often not as candid in a group setting as they are when questioned individually.
- Group members who are not good collaborators can frustrate the group and slow progress.
- The more extroverted group members can dominate the conversation.
- The quality of the data can be negatively impacted by "group think," such as confining thinking to a certain perspective.
- The large amount of qualitative data typically collected can be time-consuming and difficult to analyze.

Structured Interviews. In structured interviews, carefully planned questions are asked individually of job incumbents, their managers, or others familiar with the job. Benchmarking interviews with other organizations are especially useful in achieving a broader view of the job or determining which competencies are more universally deemed necessary for a particular job. However, it is important to be cautious in applying the information collected from other organizations. There are many variables such as work environment, culture, and differences in job responsibilities that may limit the relevance of the information.

Structured interview advantages:

- A skillful interviewer can establish rapport with the interviewee and encourage a frank and full discussion. Interviewees usually are more candid in an individual setting than in focus groups, and thus may provide a more accurate and comprehensive perspective of the job.
- Skilled interviewers can probe for either more detailed information or to clarify the interviewee's responses.
- The words of the interviewee's responses are augmented by gestures, tone of voice, and posture that can reveal feelings and attitudes about selected competencies.

Structured interview disadvantages:

- Skilled interviewers are needed to ensure productive interviews. It can require extensive training for novices to develop good interviewing skills.
- The knowledge of the interviewees about the job can vary significantly. It can be difficult to assess the accuracy of the information they provide, especially when interviewees present conflicting perspectives.
- Individual interviews are very time-consuming and expensive to conduct, and require many interviews to obtain adequate information about a job. Each interview will typically require three hours—one hour to conduct the interview, and an additional two hours to document the results.
- Analysis of the qualitative data obtained in interviews is also labor-intensive and difficult.
- There is the potential for considerable bias in the way the questions are asked by the interviewer, how they are heard and answered by the interviewee, and in how the interviewer filters and documents the responses. Situational variables such as the time of day, deadlines, and degree of privacy can also affect the data.
- Some interviewees are uncomfortable in an individual, face-to-face setting, and will provide less information than they would through a more anonymous method such as a survey.

Behavioral Event Interviews. In behavioral event interviews (BEI), top performers are interviewed individually about what they did, thought, said, and felt in challenging or difficult situations. The competencies that were instrumental in their success are extrapolated from their stories. Often, average and low performers are also interviewed to provide a comparison. The interviewer will ask questions such as, “Tell me about a time when you had an extremely challenging client,” or, “Give me an example of a situation at work in which you had to make a difficult decision.”

Behavioral event interview advantages:

- The interviews provide an in-depth perspective of the job’s challenges and the competencies needed to master them.
- When average and low performers are interviewed as well as high performers, BEIs clearly discriminate between the competencies required for top performance and the baseline competencies needed for acceptable performance.
- BEIs are an excellent method for identifying the interpersonal and management competencies that are often difficult to define.
- The very specific descriptions of effective and ineffective behaviors produced in BEIs can be used to develop behavioral examples for competency models or case studies, role-plays, or other simulations for training.

Behavioral event interview disadvantages:

- BEIs are time and labor intensive. Up to a full day can be required to conduct an interview and then analyze the data.
- A highly trained and skilled interviewer is essential to obtain accurate information. The interviewer must have strong analytical ability and experience in competency identification to accurately infer the competencies.
- BEIs are not practical for analyzing a series of jobs because of the time, expense, and expertise required for administration and data analysis.
- BEIs focus solely on current and past behaviors, which may be different from those needed in the future.
- Because BEIs focus on critical incidents, the competencies needed for the more routine aspects of work may be missed.
- The data collected may not be widely accepted by stakeholders because it is provided by a small number of interviewees.

Surveys. In surveys, job incumbents, their supervisors, and perhaps senior managers complete a questionnaire administered either in print or electronically. The survey content is based on previous data collection efforts such as interviews, focus groups, or literature reviews. The respondents are typically asked to assign ratings to each listed job element or competency. For example, respondents may be asked how critical a competency is to effective job performance, how frequently the competency is used on the job, the degree to which the competency differentiates superior from average performers, and if the competency is needed on entry to the job or can be developed over time. Survey respondents are usually asked to provide in writing any additional information that they feel is important.

Survey advantages:

- Considerable data can be collected quickly and inexpensively.
- Information can be easily collected from geographically-dispersed respondents.
- Respondents may complete the survey at a time and place that is convenient for them.
- Surveys permit the input of many people in the organization and thus facilitate acceptance of the competency study.
- The survey questionnaires can be easily customized for subgroups of respondents.
- The anonymity of surveys encourages candid responses.
- The multiple-choice or rating-type questions result in quantitative data that can be easily summarized and analyzed.

Survey disadvantages:

- The data collected is often limited to the job content or competencies included in the survey. For example, respondents may be asked to list additional job competencies that they believe are important, but there is no opportunity to probe their responses as you might in interviews and focus groups.
- There is no mechanism to check for respondents' understanding of the questions.
- Response rates are typically low, so it can be challenging to secure an adequate representative sample.
- It is difficult to summarize and analyze the responses to open-ended questions.

Competency-based approaches are increasingly viewed as a central strategy for improving the effectiveness of those who provide care.

Observations. In this data collection method, the research team visits high-performing incumbents and observes them at work. The more complex the job and the greater the variety in job tasks, the more time is required for an observation. For a very routine job where the same task is repeated over and over throughout the day, an observation of a couple hours might suffice. For very complex jobs, observation of a week or more may be required. If the job changes based on work cycles, seasons, or other factors, the observations may have to be conducted over a period of weeks or months. The observation process may include asking employees to explain what they are doing and why. Sometimes observations of average and low performers are also conducted to establish a basis for comparison. The competencies required for effective performance are then inferred from the observations by experts in competency identification.

Observation advantages:

- Because observations provide a sample of what the job is like in “real life,” they are often used in competency studies to provide preliminary information. This serves as an excellent orientation to the job for the research team.
- If representative samples of employees are observed, the validity of the competencies identified is high because actual job behavior is viewed.
- Observations can provide a full perspective of the job when incumbents’ interactions with colleagues, managers, and clients are observed.
- Both verbal and non-verbal behavior can be observed.
- Many employees in an organization tend to have greater confidence in competencies identified through observations.

Observation disadvantages:

- The primary disadvantage is that these are very time-consuming and expensive, especially for complex jobs.
- If only a relatively small proportion of job incumbents are observed, the validity and credibility of the results can be low.
- Extensive experience in competency work and strong analytical ability is required to accurately infer the competencies from the observations.
- There is considerable opportunity for bias by the observer in filtering and documenting the job behavior. Training of observers is important to minimize bias.

- Job incumbents may feel anxious when they are being observed and may modify their usual behavior. However, after a few hours of observation, behavior typically returns to normal.

Work Logs. In the work log method of data collection, job incumbents enter into logs or diaries their daily work activities with stop and start times for each activity. Depending on the complexity and variety of the job, incumbents may be asked to make log entries for several days, weeks, or months. Here is a sample excerpt from a work log for a Clinical Supervisor:

Monday, May 17, 2003

8:30–8:45 Reviewed critical incident reports from prior week.

8:45–9:00 Read and responded to team member requests for schedule changes and time off.

9:00–10:00 Met with a clinician on the team to review clinical case-load, high-risk cases, and written documentation.

10:00–11:00 Participated in team case review conference. Three clients discussed.

11:00–12:00 Observed treatment provided by new counselor and provided feedback.

Work log advantages:

- Work logs provide an excellent overview of a target job and its everyday work activities and outputs. They offer a picture of the rhythm of the employee's day that can be especially valuable.
- Most individuals find work logs easy to understand and complete.
- Work logs are a good substitute for observations if these are not feasible due to logistics or expense, or if incumbents are not comfortable being observed.

Work log disadvantages:

- Employees need to have a strong incentive for completing the work logs because it can be tedious to continuously enter the information.
- Reporting errors are common because people may not enter information accurately or completely.
- It is time-consuming and challenging to summarize and analyze the data collected.

Competency Menus and Databases. Lists of competencies for jobs or job families that are found in many different organizations can be purchased from publishers and consulting firms. These competencies are organized into menus or databases. While such databases are not currently available

for behavioral health treatment staff, there are several databases of competencies for leaders, managers, and administrative support positions that may be relevant to the field.

Some of these competency lists are available in electronic databases. The user selects the desired competencies for the target job from a list of those that are potentially applicable, and the software program creates a customized list. Some competency menus are available in a printed card format with one competency listed on each card. Users select the cards containing the relevant competencies and behavioral descriptors.

Menu and database advantages:

- These are inexpensive, quick, and easy to use.
- Menus can provide a preliminary list of competencies to be incorporated in surveys, focus groups, or interviews.

Menu and database disadvantages:

- The validity of competencies derived with this method can be poor, as they may fail to accommodate for significant differences in work environment, culture, and specific job responsibilities among organizations for the same job or family of jobs. They must be combined with other methods.

Complementary Data Collection Methods

As we noted above, if multiple data collection methods are applied within a single study, the methods can complement each other and offset the inherent disadvantages of each. For example, a large group survey is a good way to test the validity of focus group results, which are typically based on small sample sizes. Surveys are also a good way to confirm the results of observations.

Another excellent combination of data collection methods is the structured interview and survey. The job content and competencies identified in the interviews subsequently can be used to construct the survey questionnaire. A large group of respondents can then be asked through the survey to rate the importance of each job element or competency. Interviews can also be used following surveys to collect more in-depth information from a sample of the survey respondents.

Plan the Data Recording and Analysis

Before collecting data, it is necessary to plan how data will be recorded so that it is accurately and consistently documented by all who partici-

pate in data collection. This must be done simultaneously with development of the plan for data analysis to ensure that the recording strategies will support the planned analyses. Data collection and analysis almost always take more time than estimated. Thus, allow extra time in the competency project schedule for these activities.

Pilot Testing. It is important to pilot test the selected data collection methods and refine them as needed before full administration. This is necessary to ensure that the data collection methods and recording procedures yield the type, depth, and breadth of information desired.

Step Five: Identify the Competencies and Create the Competency Model

In this step, three inter-related tasks are accomplished. The content of the job is broadly defined. This information is then used to identify the specific competencies required for effective performance. Once these individual competencies are identified, they are organized into a framework that constitutes a competency model.

Job Definition

Because competencies are specific to job content, the competencies required for success in a job cannot be identified until the content of the job has been delineated. An important preliminary step in understanding the job is to review available job documentation to acquire a basic knowledge of the responsibilities of the job, its place in the organization or profession, and the education and experience required for job incumbents. Job documentation includes job descriptions, recruitment materials, previous studies of the job, policies and procedures, organization charts, technical reference or training manuals, work samples such as reports or memos, regulatory materials, and performance records. It is also productive to meet with a human resources representative familiar with the job, and with a manager or supervisor one level above the target job. The gathering of such information will probably begin in an informal way in the early phases of planning the competency project.

The shelf life of competency models varies with the job or discipline and the rate of change.

The preliminary review should lead to a detailed definition of the job role content, describing each of the key elements of the job. "Job analysis" and "job modeling" are two terms frequently used for this type of process. There is a divergence of opinion among practitioners on the most effective approach. For example, some job study methods focus on identifying job

duties and tasks, and then quantifying the importance, frequency, and criticality of each. Other methods emphasize work processes and products.

We suggest that a comprehensive job study method be used to define the job where six elements related to work behavior are described (Langdon, 2000; Langdon & Marrelli, 2002):

- Input (resources, triggers for action)
- Processes (the actions taken to create the outputs)
- Outputs (deliverables such as products or services)
- Consequences (desired results for the client, organization, and individual)
- Feedback (communication about the work)
- Conditions (rules, regulations, policies)

This approach results in the full definition of the job role that is essential to subsequently and accurately identifying the specific competencies required for effective performance in that role. The “Further Reading” section at the conclusion of this article lists several resources for learning more about job study methods.

Identification of Competencies

Competency identification directly follows the definition of job content. For example, if the job-study approach focused on the six elements of work, then the identification of competencies is based on a methodical examination of the competencies required to address each of the six elements, beginning with inputs and ending with work conditions. If the job study method focused on duties and tasks, then the identification begins with the first task in the first duty and continues through the last task in the last duty.

The initial list of competencies required for effective job performance is developed by conducting a content analysis of the data collected. The themes and patterns that repeatedly appear in the data will be noted. This is best accomplished by working with the interviewers, observers, focus group facilitators, and others who collected the data.

There are many approaches to developing the initial competency list, including the following:

- Identify the knowledge, skills, abilities, and personal characteristics required to execute each element or perform each duty. As the competencies are named, note them on index cards, adhesive-backed notes, or in an electronic spreadsheet or database.
- Group very similar knowledge, skills, abilities, and personal characteristics to create a competency category (e.g., “works well under pressure,” “tolerance for stress,” and “maintains productivity in difficult situations,” would be placed into one group).

- Set aside the categories for which there are just a few notes, and focus on the frequently mentioned categories.
- Give each competency category a preliminary label. Each category becomes a preliminary competency.
- If identifying competencies for multiple levels within a job role, such as treatment providers and their supervisors, create a separate list of competencies for each level. Identify the competencies common to all the levels, and note the competencies specific to each level.
- Compare the findings from this process with the initial literature review and available benchmarking information.
- Create an initial list of required competencies.
- Write a tentative definition for each competency.
- If there are repeated differences between superior and average performers, create two separate lists of competencies. One list will consist of the competencies that distinguish superior performers from others. The second list will consist of the competencies that both superior and average performers demonstrate.

Assemble the Competency Model

Cluster similar knowledge, skills, abilities, and personal characteristics together to avoid creating an extensive list of competency categories. Remember that the objective is not to create an exhaustive list of competencies for research purposes. The goal is to create a list of the most critical competencies for practical, everyday application in training and personnel management. This set of competencies, with a clear definition for each, constitutes the competency model. In most cases, to remain manageable, the number of competencies should be 20 or fewer.

Review by Subject Matter Experts

Draft lists of competencies and their definitions should be reviewed by subject matter experts (SMEs) and revised based on their feedback. These SMEs should have extensive experience with the target job and knowledge of the job content. There should be diversity among reviewers in perspectives, experience, and familiarity with the different work units or functions encompassed in the competency project. The ideal SME is a superior performer who previously functioned in the job, but has been promoted to a higher level, creating a broader perspective of the job and its requirements. Other potential SMEs are managers of the current job and current incumbents who are superior performers.

To be successful, the project must be carefully planned and supported by the leadership of an organization or profession.

Provide SMEs the list of competencies and instructions before meeting with them, and plan on meeting for several hours. If schedules prohibit extended or multiple meetings, SMEs can be asked to review the competencies independently and supply feedback in a specified format. However, this situation is far from ideal, which makes it imperative to ensure that the SMEs have a good understanding of how to review the competencies.

Suggested steps when meeting with an SME are as follows:

- Explain what a competency model is and how it will be used.
- Review the target job, its responsibilities, and place in the organization.
- Summarize the process followed in developing the preliminary list of competencies.
- Explain that the SME role is to verify that competencies have been correctly identified.
- Describe the process SMEs will use to review the competencies and provide feedback.
- If conducting the review in person, discuss each competency individually, asking the SMEs for their feedback on the competency and its definition. Ask probing questions to verify the importance of the competency and the appropriate wording of the competency label and its definition.

Develop Behavioral Examples

To complete the competency model, behavioral examples should be developed for each competency at three or more levels of proficiency. These behavioral examples can be based on the information collected while defining the job content and identifying the competencies. Alternatively, job incumbents and their supervisors can be asked, as a separate process, to provide examples of how the competencies are applied on the job. The purpose of these behavioral examples is to illustrate how the competencies are actually demonstrated. If competencies have been identified for multiple levels of a job, it will usually be necessary to draft different behavioral examples for each, even for those competencies that are common to the different levels. Although two levels may require the same competency, the manner in which it is demonstrated may vary with each level.

The completed competency model will include a list of competencies, organized by type (e.g., core, personal effectiveness, technical), with a definition and several behavioral examples at three or more levels of proficiency for each competency. It is good practice to have a second group of subject matter experts review the model for accuracy before it is finalized.

Step Six: Apply the Competency Model

The value of a competency model lies in its application. The value is maximized if it is applied in all aspects of human resource management. In a fully-integrated, competency-based human resource system, the competencies identified as required for effective performance for a target job are used to select, develop, manage, reward, and compensate employees. The employees know precisely what competencies are required for success and how they will be evaluated. Below are the key areas of application and some of the tools that can be created to foster the use of the competency models, once developed.

Strategic Workforce Planning

- Develop assessment tools to determine if the current workforce possesses the competencies necessary to effectively meet organizational goals.

Selection

- Develop criteria for screening and evaluating resumes based on the competencies.
- Develop content specifications for written tests, performance tests, or other selection instruments.
- Create interview questions that are designed to elicit examples of how candidates have demonstrated each competency in their past work experience. Prepare accompanying interview guides and rating scales.

Training and Development

- Use the competencies to design a curriculum for training and other workforce development activities.
- Create a multi-rater feedback instrument to assess employee needs for competency development.
- Produce development planning guides that provide employees with specific suggestions for how to build or strengthen each competency.

Performance Management

- Develop guides for managers to help them conduct discussions with their employees about their performance of the competencies.
- Create rating guides to assist managers in the assessment of each competency.
- Develop a performance appraisal process and forms that incorporate the competencies.

Succession Planning

- Design tools to help senior leaders assess the critical competency gaps in the pool of succession candidates.
- Develop instruments to assess the competencies of managers who appear to have high potential for advancement.
- Create guides describing senior-level career paths and the competencies required for each step in those paths.

Rewards and Recognition

- Design a recognition program based on the demonstration of highly-valued competencies or clusters of competencies.
- Create a guide for managers with suggestions on rewarding the demonstration of specific competencies by their employees.

Compensation

- Design a competency-based compensation program where employees' salaries are increased as they provide evidence of proficiency in selected competencies.

Step Seven: Evaluate and Update the Competency Model

After the competency model has been developed and applied, it is important to evaluate both the competency model development process and the value of the resulting model to the organization. The evaluation should examine how the competency modeling process could be improved, as well as the utility of the model that was developed. Standard program evaluation techniques can be applied in this process.

Competency modeling is a continuous process. To be valuable, the list of required competencies must be revised as organizational strategies, environmental conditions, job design, regulations, professional practices, or other key factors change. The shelf life of competency models varies

with the job or discipline and the rate of change. In addition, individual competencies within a model will have varying shelf lives. For example, technical competencies usually become outdated long before personal effectiveness or leadership competencies require revision.

A schedule for reviewing the currency of a competency model should be established. At the time of review, if there have been no significant changes to the target job or the organization, then interviews, focus groups, surveys, or SME groups can be used to revise and update the model. If the target job or the organization has changed significantly since the model was developed, a new competency study will need to be conducted. The existing model may be useful as a departure point for the development of a new model.

CONCLUSION

From this review, it should be clear that the development and use of competencies is a complex endeavor. To be successful, the project must be carefully planned and supported by the leadership of an organization or profession, and concerted efforts must be made to communicate with those involved or potentially affected. Multiple methods of data collection are optimally used to define the job and to build a competency model, with attention to assuring the reliability and validity of the information gathered. This work sets the stage for application of the model, which should occur in an integrated fashion at multiple levels of the organization. The utility of the model should be evaluated, and it must be revised as the demands of a job change.

The cost of this approach, in terms of both time and expense, can be significant. However, the potential benefits are significant as well. The development and application of competency models is a proven approach for investing in human resources in order to achieve a more effective and productive workforce. Since the vast majority of expenditures on mental health care and substance use disorders treatment are expenditures on personnel, there is a compelling rationale for using a competency-based approach for the training and development of all segments of the behavioral health workforce.

REFERENCES

- Coursey, R.D., Curtis, L., Marsh, D.T., Campbell, J., Harding, C., & Spaniol, L., et al. (2000). Competencies for direct service staff members who work with adults with severe mental illnesses in outpatient public mental health/managed care systems. *Psychiatric Rehabilitation Journal*, 23(4), 370–377.

- Equal Employment Opportunity Commission, Civil Service Commission, Department of Labor, & Department of Justice. (1978). Uniform guidelines on employee selection procedures. *Federal Register*, 43(166), 38295–38309.
- Equal Employment Opportunity Commission (1991). Equal employment opportunities for individuals with disabilities: Final rule. *Federal Register*, 56(144), 35726–35753.
- Gilbert, T. (1996). *Human competence: Engineering worthy performance*. Washington, DC: International Society for Performance Improvement.
- Hoge, M.A., Tondora, J., & Marrelli, A.F. (in press). The fundamentals of workforce competency: Implications for behavioral health. *Administration and Policy in Mental Health*.
- Institute of Medicine (2000). *To err is human: Building a safer health system*. Washington, DC: National Academy Press.
- Institute of Medicine (2001). *Crossing the quality chasm: A new health system for the 21st Century*. Washington, DC: National Academies Press.
- Institute of Medicine (2003). *Health professions education: A bridge to quality*. Washington, DC: The National Academies Press.
- Kelley, R., & Caplan, J. (1993). How bell labs creates star performers. *Harvard Business Review*, 71(4), 128–139.
- Langdon, D. (2000). *Aligning performance: Improving people, systems and organizations*. San Francisco: Jossey-Bass/Pfeiffer.
- Langdon, D., & Marrelli, A.F. (2002). *A performance-based model for competency identification: The workshop*. Bellingham, WA: Performance International.
- Lucia, A., & Lepsinger, R. (1999). *The art and science of competency models: Pinpointing critical success factors in organizations*. San Francisco: Jossey-Bass/Pfeiffer.
- Marrelli, A.F. (1994). The Americans with disabilities act and selection. *Human Resources Bulletin*, 1(2), 1–4.
- Marrelli, A.F. (1998). An introduction to competency analysis and modeling. *Performance Improvement*, 37(5), 8–17.
- Marrelli, A.F. (2001). *Introduction to competency modeling*. New York: American Express.
- Mirabile, R. (1997). Everything you wanted to know about competency modeling. *Training and Development*, 73–78.
- National Panel for Psychiatric Mental Health Nurse Practitioner Competencies (2003). *Psychiatric mental health nurse practitioner competencies*. Washington, DC: National Organization of Nurse Practitioner Faculties.
- U.S. Department of Health and Human Services (1998). *Addiction counseling competencies: The knowledge, skills and attitudes of professional practice*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

FURTHER READING

Behavioral Event Interviews

- Angelides, P. (2001). The development of an efficient technique for collecting and analyzing qualitative data: The analysis of critical incidents. *International Journal of Qualitative Studies in Education*, 14, 429–442.
- Keatinge, D. (2002). Versatility and flexibility: Attributes of the critical incident technique in nursing research. *Nursing & Health Sciences*, 4(1–2), 33–39.

Focus Groups

- Barbour, R.S., & Kitzinger, J. (1999). *Developing focus group research: Politics, theory, and practice*. Thousand Oaks, CA: Sage.
- Bloor, M., Frankland, J., Thomas, M., & Robson, K. (2001). *Focus groups in social research*. Thousand Oaks, CA: Sage.
- Fern, E.F. (2001). *Advanced focus group research*. Thousand Oaks, CA: Sage.

Job Studies

- Brannick, M.T., & Levine, E.L. (2002). *Job analysis: Methods, research, and applications for human resource*

management in the new millennium. Thousand Oaks, CA: Sage.

Hartley, D.E. (1999). *Job analysis at the speed of reality*. Amherst, MA: Human Resource Development Press.

Langdon, D. (2000). *Aligning performance: Improving people, systems and organizations*. San Francisco: Jossey-Bass/Pfeiffer.

Literature Reviews

Cooper, H.M. (1998). *Synthesizing research: A guide for literature reviews*. Thousand Oaks, CA: Sage.

Fink, A. (1998). *Conducting research literature reviews: From paper to the internet*. Thousand Oaks, CA: Sage.

Pan, M.L. (2004). *Preparing literature reviews*. Glendale, CA: Pyczak.

Observations

Jorgensen, D.L. (1989). *Participant observation: A methodology for human studies*. Thousand Oaks, CA: Sage.

Sharpe, T.L., & Koperwas, J. (2003). *Behavior and sequential analyses: Principles and practice*. Thousand Oaks, CA: Sage.

Structured Interviews

Holstein, J., & Gubrium, J.F. (2003). *Inside interviewing: New lenses, new concerns*. Thousand Oaks, CA: Sage.

Wengraf, T. (2001). *Qualitative research interviewing: Biographic narrative and semi-structured methods*. Thousand Oaks, CA: Sage.

Surveys

Fink, A. (2002). *How to ask survey questions* (2nd ed.) Vol. 2. Thousand Oaks, CA: Sage.

Fink, A. (2002). *How to design survey studies* (2nd ed.) Vol. 6. Thousand Oaks, CA: Sage.

Fink, A. (2002). *How to manage, analyze and interpret survey data* (2nd ed.) Vol. 9. Thousand Oaks, CA: Sage.

Fowler, F.J. (2001). *How to ask survey questions* (3rd ed.). Thousand Oaks, CA: Sage.

Punch, K.F. (2003). *Survey research: The basics*. Thousand Oaks, CA: Sage.

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MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION REPORT ON CO-OCCURRING DISORDERS.

The Mental Health Services Oversight and Accountability Commission was created to provide oversight, accountability, and leadership on issues related to mental health including the implementation of the Mental Health Services Act, which was passed by voters in 2004 as Proposition 63.

Two key tenets of the Mental health Services Act are: 1) Effective services for people with serious mental illnesses must include “whatever it takes” for recovery, and 2) Those services must be integrated. “Whatever it takes” refers to funding for a wide array of clinical and supportive services beyond mental health care, notably including such things as housing and treatment for co-occurring conditions (COD). “Integrated” refers to services that are concurrently delivered by a coordinated team of caregivers, often sharing single sites. Among the most important services to be provided in an integrated manner with mental health services is treatment for alcohol and other forms of chemical dependency.

At a recent conference, the commission heard a detailed presentation on the extensiveness of co-occurring disorders – which are a combination of diagnoses affecting people who have mental illness and also have substance abuse.

This report builds upon the presentations and discussion at that hearing and includes important recommendations for changes in state policy.

KEY FINDINGS

1. Approximately one half of the people who have one of these conditions - a mental illness or a substance abuse disorder - also have the other condition. The proportion of co-morbidity may be even higher in adolescent populations.
2. Availability of integrated treatment for mental health and substance abuse problems is currently the exception rather than the rule.

3. Numerous studies demonstrate that integrated care is necessary for successful treatment of co-occurring disorders (COD). Other care models, such as sequential or parallel care, have very limited effectiveness.
4. The “AB 34” programs and other Adult System of Care programs in the mental health system appear to be the only significant publicly funded programs that offer integrated care in mental health or substance abuse treatment facilities. Virtually all other programs provide treatment for only mental health or substance abuse. Most private insurance coverage and other treatment for mental health or substance abuse is similarly separated.
5. Insufficient support for integrated COD programs leads to a paucity of both treatment facilities and properly trained clinicians. Both are essential to provide the full spectrum of necessary care. The lack of such facilities and experts restricts access to service not just for outpatient care, but also for inpatient mental health units with COD capability.
6. Kaiser Permanente provides unlimited substance abuse treatment, even when it is neither funded nor required to do so because their data indicates that the cost of providing the substance abuse services is more than offset by the savings in physical health care.
7. People with co-occurring disorders are disproportionately represented in the criminal justice system largely as a consequence of this lack of access to mental health and substance abuse services.
8. Law enforcement officials and judges frequently find that individuals are incarcerated simply due to the lack of available treatment options for mental health and substance abuse.
9. People with mental illness in prison do not receive adequate or appropriate care. Prison health officials are not sufficiently trained in offering rehabilitative and recovery oriented services which would prepare an individual with mental illness for success after discharge.
10. People with co-occurring mental illnesses and substance abuse have high recidivism rates in the prison system.
11. A pilot program begun in 2000 showed that the recidivism rate can be significantly reduced by offering such care to parolees with severe mental illnesses.

RECOMMENDATIONS

1. Public and private health plans which have programs that are funded by the Mental Health Services Act should be required to ensure integrated mental health and substance abuse services are available for all clients who need them.
2. Programs standards should be created for provision of integrated mental health and substance abuse services, and should be linked to program eligibility including MHSA reimbursement. Standards should include acceptable clinical staffing patterns and levels to ensure competency to address related medical, psychiatric, and substance-abuse needs. Standards should include the requirement of a COD screening instrument for all MHSA plans. Standards should require the co-location of substance abuse professionals in every program that provides services to individuals with COD and the co-location of mental health specialists in every state licensed and or certified substance abuse treatment program.
3. MHSA funding should be used to co-train physicians who specialize in addiction medicine or psychiatry to ensure that physicians in either specialty have expertise in treating both substance abuse and mental illness. In addition, training in substance abuse treatment should be required for every mental health professional working with those with COD.
4. An individual seeking treatment for co-occurring disorders should find no wrong door. He or she should receive integrated treatment from either type of specialist.
5. All public and private health plans should be required to provide comprehensive substance abuse services. (They are already required to provide comprehensive mental health services.)
6. All MHSA plans should be required to have a housing component that includes structured housing for those with Co-Occurring Disorders.
7. MHSA plans and others that deal with COD services should include explicit and detailed plans for coordination among agencies that provide either substance programs and or mental health mental health programs. The coordination should address both funding and provision of service. Resources should be combined whenever possible. This includes, but is not limited to, directly combining resources from the Substance Abuse and Crime Prevention Act (SACPA) and the MHSA.

8. Eligibility criteria for MHSA funding and other funded COD services should be detailed and explicit. It should include all inclusionary and exclusionary criteria. These criteria -- including any "medical necessity" criteria — should be specifically designed to address the needs of individuals with COD, and should not improperly deny treatment to those with Co-Occurring Disorders.
9. The Department of Corrections and Rehabilitation should consider developing programs to offer comprehensive "whatever it takes" integrated services for parolees with co-occurring mental illnesses and substance abuse disorders.
10. All prison health officials and staff with responsibilities for inmates with severe mental illness, as well as county jail officials and staff designed to move those who are mentally ill or suffer from Co-Occurring Disorders from custody into Community Treatment should receive special training in recovery-oriented services.



MENTAL HEALTH SERVICES OVERSIGHT AND ACCOUNTABILITY COMMISSION REPORT ON CO-OCCURRING DISORDERS.

The Mental Health Services Oversight and Accountability Commission was created to provide oversight, accountability, and leadership on issues related to mental health including the implementation of the Mental Health Services Act, which was passed by voters in 2004 as Proposition 63.

Two key tenets of the Mental health Services Act are: 1) Effective services for people with serious mental illnesses must include “whatever it takes” for recovery, and 2) Those services must be integrated. “Whatever it takes” refers to funding for a wide array of clinical and supportive services beyond mental health care, notably including such things as housing and treatment for co-occurring conditions (COD). “Integrated” refers to services that are concurrently delivered by a coordinated team of caregivers, often sharing single sites. Among the most important services to be provided in an integrated manner with mental health services is treatment for alcohol and other forms of chemical dependency.

At a recent conference, the commission heard a detailed presentation on the extensiveness of co-occurring disorders – which are a combination of diagnoses affecting people who have mental illness and also have substance abuse.

This report builds upon the presentations and discussion at that hearing and includes important recommendations for changes in state policy.

KEY FINDINGS

1. Approximately one half of the people who have one of these conditions - a mental illness or a substance abuse disorder - also have the other condition. The proportion of co-morbidity may be even higher in adolescent populations.
2. Availability of integrated treatment for mental health and substance abuse problems is currently the exception rather than the rule.

3. Numerous studies demonstrate that integrated care is necessary for successful treatment of co-occurring disorders (COD). Other care models, such as sequential or parallel care, have very limited effectiveness.
4. The “AB 34” programs and other Adult System of Care programs in the mental health system appear to be the only significant publicly funded programs that offer integrated care in mental health or substance abuse treatment facilities. Virtually all other programs provide treatment for only mental health or substance abuse. Most private insurance coverage and other treatment for mental health or substance abuse is similarly separated.
5. Insufficient support for integrated COD programs leads to a paucity of both treatment facilities and properly trained clinicians. Both are essential to provide the full spectrum of necessary care. The lack of such facilities and experts restricts access to service not just for outpatient care, but also for inpatient mental health units with COD capability.
6. Kaiser Permanente provides unlimited substance abuse treatment, even when it is neither funded nor required to do so because their data indicates that the cost of providing the substance abuse services is more than offset by the savings in physical health care.
7. People with co-occurring disorders are disproportionately represented in the criminal justice system largely as a consequence of this lack of access to mental health and substance abuse services.
8. Law enforcement officials and judges frequently find that individuals are incarcerated simply due to the lack of available treatment options for mental health and substance abuse.
9. People with mental illness in prison do not receive adequate or appropriate care. Prison health officials are not sufficiently trained in offering rehabilitative and recovery oriented services which would prepare an individual with mental illness for success after discharge.
10. People with co-occurring mental illnesses and substance abuse have high recidivism rates in the prison system.
11. A pilot program begun in 2000 showed that the recidivism rate can be significantly reduced by offering such care to parolees with severe mental illnesses.

RECOMMENDATIONS

1. Public and private health plans which have programs that are funded by the Mental Health Services Act should be required to ensure integrated mental health and substance abuse services are available for all clients who need them.
2. Programs standards should be created for provision of integrated mental health and substance abuse services, and should be linked to program eligibility including MHSA reimbursement. Standards should include acceptable clinical staffing patterns and levels to ensure competency to address related medical, psychiatric, and substance-abuse needs. Standards should include the requirement of a COD screening instrument for all MHSA plans. Standards should require the co-location of substance abuse professionals in every program that provides services to individuals with COD and the co-location of mental health specialists in every state licensed and or certified substance abuse treatment program.
3. MHSA funding should be used to co-train physicians who specialize in addiction medicine or psychiatry to ensure that physicians in either specialty have expertise in treating both substance abuse and mental illness. In addition, training in substance abuse treatment should be required for every mental health professional working with those with COD.
4. An individual seeking treatment for co-occurring disorders should find no wrong door. He or she should receive integrated treatment from either type of specialist.
5. All public and private health plans should be required to provide comprehensive substance abuse services. (They are already required to provide comprehensive mental health services.)
6. All MHSA plans should be required to have a housing component that includes structured housing for those with Co-Occurring Disorders.
7. MHSA plans and others that deal with COD services should include explicit and detailed plans for coordination among agencies that provide either substance programs and or mental health mental health programs. The coordination should address both funding and provision of service. Resources should be combined whenever possible. This includes, but is not limited to, directly combining resources from the Substance Abuse and Crime Prevention Act (SACPA) and the MHSA.

8. Eligibility criteria for MHSA funding and other funded COD services should be detailed and explicit. It should include all inclusionary and exclusionary criteria. These criteria -- including any "medical necessity" criteria — should be specifically designed to address the needs of individuals with COD, and should not improperly deny treatment to those with Co-Occurring Disorders.
9. The Department of Corrections and Rehabilitation should consider developing programs to offer comprehensive "whatever it takes" integrated services for parolees with co-occurring mental illnesses and substance abuse disorders.
10. All prison health officials and staff with responsibilities for inmates with severe mental illness, as well as county jail officials and staff designed to move those who are mentally ill or suffer from Co-Occurring Disorders from custody into Community Treatment should receive special training in recovery-oriented services.

- o Applied use of theory
- o Working with families
- o How to find and use resources
- Changes to the requirements for persons who earned a degree outside of California (note: other changes to these requirements are pending in the legislature)

Previously Proposed Changes

- Adding instruction in areas needed for practice in a public mental health environment (including case management, systems of care for the severely mentally ill, etc.) which may be provided in credit level coursework or through extension programs.
- Infusing the culture and norms of public mental health work and principles of the Mental Health Services Act (including recovery, consumer empowerment and participation, a greater emphasis on culture, etc.) throughout the curriculum.
- Increasing the total unit requirement from 48 to 60.
- Requiring coursework currently permitted to be taken outside of the degree program to be taken within the degree program. Many of these courses are currently required prior to sitting for the licensing examinations. They would now be required prior to registration as an intern.
- Providing more flexibility in the curriculum requirements (i.e., fewer requirements for specific hours or units for particular coursework) to allow for innovation in curriculum design.
- Adding three units and 75 contact hours to the practicum requirement.
- Addressing the impact of socio-economic status on behavior and treatment.

These requirements would be phased in over a period of time to ensure that schools are able to make the changes.

Attachments

Non-Qualifying Degrees

Concept Draft for MFT Curriculum

Current MFT Educational Requirements

**Concept Draft for MFT Curriculum
September 2007**

- Text that is underlined only is either a non-substantive change, or is a substantive change that was presented for consideration at the June 2007 meeting
- Text that is both **underlined and highlighted** is a substantive change being presented for consideration at the September 2007 meeting

The following text is proposed to be added to Sections 4980.37, 4980.38, 4980.39, 4980.40, 4980.41:

This section shall become inoperative effective January 1, 2018.

§4980.36. DEGREE PROGRAM

(a) This section applies to applicants for licensure or registration who graduated on or after **June 30, 2014**.

(b) Applicants for licensure or registration shall possess a doctor's or master's degree conferred by a school, college or university accredited by the Western Association of Schools and Colleges, Commission on the Accreditation of Marriage and Family Therapy Education, or approved by the Bureau for Private Postsecondary and Vocational Education¹ in one of the following disciplines:

- (1) marriage, family, and child counseling
- (2) marital and family therapy
- (3) psychology
- (4) clinical psychology
- (5) counseling psychology
- (6) counseling with an emphasis in marriage, family, and child counseling
- (7) counseling with an emphasis in marriage and family therapy

(c) A ~~qualifying~~ doctor's or master's degree program that qualifies for licensure or registration shall do all of the following:

- (1) Integrate marriage and family therapy principles throughout its curriculum.
- (2) Integrate the principles **of mental health recovery** and methods of service delivery in recovery model practice environments throughout its curriculum.
- (3) Allow for innovation and individuality in the education of marriage and family therapists.
- (4) Encourage students to develop those personal qualities that are intimately related to effective practice such as integrity, sensitivity, flexibility, insight, compassion, and personal presence.
- (5) Permit an emphasis or specialization that may address any one or more of the unique and complex array of human problems, symptoms, and needs of Californians served by marriage and family therapists.
- (6) Integrate the understanding of various cultures and the social and psychological implications of socio-economic position throughout its curriculum.
- (7) ~~Encourage students~~ **Provide students with the opportunity** to meet with various consumers and family members of consumers of mental health services ~~so as to understand to enhance understanding of their experience of mental health illness, treatment, and recovery.~~

¹ This will be changed to reflect whatever is the final outcome regarding reform of the BPPVE and recent board actions to sponsor legislation recognizing regional accreditation agencies.

- (d) ~~In order to qualify for licensure, a~~ A doctor's or master's degree program that qualifies for licensure or registration shall contain no less than 60 semester or 90 quarter units of instruction that includes, but is not limited to all of the following.
- (1) Diagnosis, assessment, prognosis and treatment of mental disorders, including severe mental disorders, evidence based practices, and psychological testing.
 - (2) At least 12 semester or 18 quarter units in theories, principles, and methods of a variety of psychotherapeutic orientations directly related to marriage and family therapy, and marital and family systems approaches to treatment and how these theories can be applied therapeutically with individuals, couples, families, adults, children, adolescents, and groups to improve, restore, or maintain healthy relationships.
 - (3) Developmental issues from infancy to old age. This instruction shall include:
 - (A) The effects of developmental issues on individuals, couples, and family relationships.
 - (B) The psychological, psychotherapeutic, and health implications of developmental issues and their effects.
 - (C) Aging and its biological, social, cognitive, and psychological aspects.
 - (D) A variety of cultural understandings of human development.
 - ~~(E) The understanding of human behavior within the social context of socioeconomic status and a representative variety of the various cultures found within California.~~
 - (F) The understanding of human behavior within the social context of socioeconomic status.
 - (G) The understanding of human behavior within the social context of a representative variety of the cultures found within California.
 - (4) The broad range of matters that may arise within marriage and family relationships and life events within a variety of California cultures including:
 - (A) Child abuse assessment and reporting
 - (B) Spousal or partner abuse assessment, detection, intervention strategies, and same gender abuse dynamics
 - (C) Cultural factors relevant to abuse of partners and family members.
 - (D) Childbirth
 - (E) Child rearing, parenting and stepparenting
 - (F) Marriage
 - (G) Divorce
 - (H) Blended families
 - (I) Long term care
 - (J) End of life
 - (K) Grief

Instruction shall include the psychological, psychotherapeutic, community, and health implications of these matters and life events.
 - (5) Cultural competency and sensitivity, including a familiarity with the racial, cultural, linguistic, and ethnic backgrounds of persons living in California.
 - (6) An understanding of the effects of socioeconomic status on ~~behavior~~, treatment and available resources.
 - (7) Human sexuality including the study of physiological-psychological and social-cultural variables associated with sexual identity, sexual behavior and sexual disorders.

- (8) Provide specific instruction in substance Substance abuse, co-occurring disorders, and addiction which shall include each including all of the following areas.
- (A) The definition of alcoholism and other chemical dependency, and evaluation of the affected person, substance use disorders, co-occurring disorders and addiction.
 - (B) Medical aspects of alcoholism and other chemical dependency substance use disorders and co-occurring disorders.
 - (C) The effects of psychoactive drug use.
 - ~~(C)~~ (D) Current theories of the etiology of substance abuse and addiction.
 - ~~(D)~~ (E) The role of persons and systems that support or compound the substance abuse and addiction.
 - ~~(E)~~ (F) Major treatment approaches to alcoholism and chemical dependency identification, evaluation and treatment of substance use disorders, co-occurring disorders and addiction, including best practices.
 - ~~(F)~~ (G) Legal aspects of substance abuse.
 - ~~(G)~~ (H) Populations at risk with regard to substance abuse use disorders and co-occurring disorders.
 - ~~(H)~~ (I) Community resources offering screening, assessment, treatment and follow-up for the affected person and family.
 - (I) The process of referring affected persons.
 - (I) Recognition of substance use disorders, co-occurring disorders and addiction and appropriate referral.
 - (J) The prevention of substance abuse use disorders and addiction.
 - (K) For purposes of this paragraph, "addiction" is defined as a chronic pattern of behavior that continues despite the direct or indirect adverse consequences that result from engaging in the behavior. This includes, but is not limited to substances and behaviors including computer-related, shopping, gambling, sex, eating, and work.
 - (L) For purposes of this paragraph, "co-occurring disorders" is defined as a mental illness and substance abuse diagnosis occurring simultaneously in an individual.
- (9) California law and professional ethics for marriage and family therapists. This course shall include, but not be limited to, the following areas of study:
- (A) Contemporary professional ethics and statutory, regulatory, and decisional laws that delineate the profession's scope of practice.
 - (B) The therapeutic, clinical, and practical considerations involved in the legal and ethical practice of marriage and family therapy, including family law.
 - (C) The current legal patterns and trends in the mental health professions.
 - (D) The psychotherapist/patient privilege, confidentiality, the patient dangerous to self or others, and the treatment of minors with and without parental consent.
 - (E) A recognition and exploration of the relationship between a practitioner's sense of self and human values and his or her professional behavior and ethics.
 - (F) Differences in legal and ethical standards for different types of work settings.
- (10) Psychopharmacology.
- (11) No less than nine semester or thirteen quarter units of practicum in a supervised clinical placement that provides supervised fieldwork experience including a minimum of 225 hours of face-to-face experience counseling individuals, couples, families, or groups. The practicum shall provide training in all of the following areas:
- (A) applied use of theory and psychotherapeutic techniques

- (B) assessment
- (C) diagnosis
- (D) prognosis
- (E) treatment of individuals and premarital, couple, family, and child relationships, including all of the following:
 - (i) dysfunctions
 - (ii) healthy functioning
 - (iii) health promotion
 - (iv) illness prevention
 - (v) working with families**
- (F) professional writing including documentation of services, treatment plans, and progress notes
- (G) how to find and use resources**

Educational institutions are encouraged to design the practicum required by this paragraph to include marriage and family therapy experience in low-income and multicultural mental health settings.

- (e) A degree qualifying for licensure or registration shall include instruction in the following areas:

- (1) Case management
- (2) Systems of care for the severely mentally ill
- (3) Public and private services and supports available for the severely mentally ill
- (4) Community resources for victims of abuse
- (5) Disaster and trauma response
- (6) Advocacy for the severely mentally ill
- (7) Collaborative treatment**

The instruction required in this subdivision may be provided either in credit level coursework or through extension programs offered by the degree granting institution.

- (f) The board has the authority to make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation or approval.
- (g) Each applicant shall submit to the board a certification from the educational institution stating that the institution's required curriculum for graduation and any associated coursework completed by the applicant satisfies the requirements of this section.
- (h) The changes made to this section are intended to improve the educational qualifications for licensure in order to better prepare future licentiates for practice, and is not intended in any way to expand or restrict the scope of licensure for marriage and family therapists.

4980.365

- (a) If, during the period of January 1, 2018 and January 1, 2023, an applicant's degree does not contain the content or units required by Section 4980.36, the board may, in its discretion, accept the applicant's education as substantially equivalent if the following criteria are met:**

- (1) The applicant's degree meets the requirements of Sections 4980.37 and 4980.40, regardless of the sunset date of those sections.**
- (2) The applicant remediates his or her deficiencies by completing any additional units, hours and content required by Section 4980.36 from a school that meets the requirements of Section 4980.36(b).**

**THE FOLLOWING DRAFT CHANGES ARE BASED ON
PROPOSED LANGUAGE PENDING IN THE LEGISLATURE (SB 1048, 2007)**

**§4980.80. RECIPROCITY; EQUIVALENT REQUIREMENTS; PAYMENT OF FEES; FURTHER
CONDITIONS**

The board may issue a license to any person who, at the time of application, has held for at least two years a valid license issued by a board of marriage counselor examiners, marriage therapist examiners, or corresponding authority of any state, if the education and supervised experience requirements are substantially the equivalent of this chapter and the person successfully completes the board administered licensing examinations as specified by subdivision (g) of Section 4980.40 (new reference) and pays the fees specified. Issuance of the license is further conditioned upon the person's completion of the following coursework or training:

~~(a) Applicants who completed a two semester or three quarter unit course in law and professional ethics for marriage and family therapists that included areas of study as specified in Section 4980.41 as part of their qualifying degree shall complete an 18 hour course in California law and professional ethics that includes, but is not limited to, the following subjects:~~

~~(1) Advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous patients, psychotherapist patient privilege, recordkeeping, patient access to records, HIPAA, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, and therapist disclosures to patients.~~

~~(b) Applicants who have not completed a two semester or three quarter unit course in law and professional ethics for marriage and family therapists that included areas of study as specified in Section 4980.41 as part of their qualifying degree shall complete a two semester or three quarter unit course in California law and professional ethics that includes, at minimum, the areas of study specified in 4980.41.~~

~~(c) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28 and any regulations promulgated thereunder.~~

~~(d) A minimum of 10 contact hours of training or coursework in human sexuality as specified in Section 25 and any regulations promulgated thereunder.~~

~~(e) A minimum of 15 contact hours of training or coursework in alcoholism and other chemical substance dependency as specified by regulation.~~

~~(f) (1) Instruction in spousal or partner abuse assessment, detection, and intervention. This instruction may be taken either in fulfillment of other requirements for licensure or in a separate course.~~

~~(2) On and after January 1, 2004, a minimum of 15 contact hours of coursework or training in spousal or partner abuse assessment, detection, and intervention strategies.~~

~~(g) On and after January 1, 2003, a minimum of a two semester or three quarter unit survey course in psychological testing. This course may be taken either in fulfillment of other requirements for licensure or in a separate course.~~

~~(h) On and after January 1, 2003, a minimum of a two semester or three quarter unit survey course in psychopharmacology. This course may be taken either in fulfillment of other requirements for licensure or in a separate course.~~

~~(i) With respect to human sexuality, alcoholism and other chemical substance dependency, spousal or partner abuse assessment, detection, and intervention, psychological testing, and psychopharmacology, the board may accept training or coursework acquired out of state.~~

§4980.90. EXAMINATION; PERSONS WITH EDUCATION AND EXPERIENCE WHILE RESIDING OUTSIDE OF CALIFORNIA

(a) Experience gained outside of California shall be accepted toward the licensure requirements if it is substantially equivalent to that required by this chapter and if the applicant has gained a minimum of 250 hours of supervised experience in direct counseling within California while registered as an intern with the board. The Board shall consider hours of experience gained in another state during the 6-year period immediately preceding the issuance of the applicant's original MFT license in that state.

~~(b) Education gained while residing outside of California shall be accepted toward the licensure requirements if it is substantially equivalent to the education requirements of this chapter, and if the applicant has completed all of the following: For purposes of this section and section 4980.80, the board may, in its discretion, accept education as substantially equivalent when the applicant has been granted a degree in a single integrated program primarily designed to train marriage and family therapists and the applicant's education meets the requirements of Sections 4980.36. If the applicant's degree does not contain all of the content or the number of units required by Section 4980.36, the board may, in its discretion, accept the applicant's education as substantially equivalent if all of the following criteria are met:~~

(A) The applicant's degree is from a school that meets the requirements of subdivision (b) of Section 4980.36 and contains all of the following:

(1) A minimum of 48 overall units

(2) A minimum of six (6) practicum units

(3) A minimum of 150 practicum hours of face-to-face counseling

(4) A minimum of 12 semester or 18 quarter units in the areas of marriage, family, and child counseling and marital and family systems approaches to treatment as specified in paragraph (2) of subdivision (d) of Section 4980.36.

(B) The applicant remediates his or her deficiencies by completing the course content and units required by Section 4980.36 and this section.

(C) The degree title need not be identical to that required by subdivision (b) of Section 4980.36.

~~(a) (D) Applicants who completed a two semester or three quarter unit course in law and professional ethics for marriage and family therapists that included areas of study as specified in Section 4980.41 as part of their qualifying degree shall complete an 18-hour course in California law and professional ethics that includes, but is not limited to, the following subjects:~~

~~(4) (i) Advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous patients, psychotherapist-patient privilege, recordkeeping, patient access to records, HIPAA, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions~~

and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, and therapist disclosures to patients.

(E) The following coursework may be taken either in fulfillment of other requirements for licensure or in a separate course. The board may accept training or coursework acquired out of state.

(i) Child abuse assessment and reporting

(ii) Human sexuality as specified in paragraph (7) of subdivision (d) of Section 4980.36

(iii) Substance abuse, addiction, and co-occurring disorders as specified in paragraph (8) of subdivision (d) of Section 4980.36

(iv) Spousal or partner abuse assessment, detection, and intervention strategies, and same gender abuse dynamics.

(v) Psychological testing

(vi) Psychopharmacology

(vii) Content required by subdivision (e) of Section 4980.36.

~~(1) A two semester or three quarter unit course in California law and professional ethics for marriage, family, and child counselors that shall include areas of study as specified in Section 4980.41.~~

~~(2) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28 and any regulations promulgated thereunder.~~

~~(3) A minimum of 10 contact hours of training or coursework in sexuality as specified in Section 25 and any regulations promulgated thereunder.~~

~~(4) A minimum of 15 contact hours of training or coursework in alcoholism and other chemical substance dependency as specified by regulation.~~

~~(5) (A) Instruction in spousal or partner abuse assessment, detection, and intervention. This instruction may be taken either in fulfillment of other educational requirements for licensure or in a separate course.~~

~~(B) On and after January 1, 2004, a minimum of 15 contact hours of coursework or training in spousal or partner abuse assessment, detection, and intervention strategies.~~

~~(6) On and after January 1, 2003, a minimum of a two semester or three quarter unit survey course in psychological testing. This course may be taken either in fulfillment of other requirements for licensure or in a separate course.~~

~~(7) On and after January 1, 2003, a minimum of a two semester or three quarter unit survey course in psychopharmacology. This course may be taken either in fulfillment of other requirements for licensure or in a separate course.~~

~~(8) With respect to human sexuality, alcoholism and other chemical substance dependency, spousal or partner abuse assessment, detection, and intervention, psychological testing, and psychopharmacology, the board may accept training or coursework acquired out of state.~~

~~(c) For purposes of this section, the board may, in its discretion, accept education as substantially equivalent when both of the following apply:~~

~~(1) The applicant has been granted a degree in a single integrated program primarily designed to train marriage and family therapists.~~

~~(2) The applicant's education meets the requirements of Sections 4980.37 and 4980.40.~~

~~(A) The degree title need not be identical to that required by subdivision (a) of Section 4980.40.~~

~~(B) If the applicant's degree does not contain the content required by Section 4980.37 or the overall number of units required by subdivision (a) of Section 4980.40, the board may, in its discretion, accept the applicant's education as substantially equivalent if the following criteria are met:~~

~~(i) The applicant's degree contains the required number of practicum units and coursework required in the areas of marriage, family, and child counseling, and marital and family systems approaches to treatment as specified in Section 4980.40.~~

~~(ii) The applicant remediates his or her specific deficiency by completing the course content required by Section 4980.37 or units required by subdivision (a) of Section 4980.40.~~

~~(iii) The applicant's degree otherwise complies with this section.~~

CURRENT MFT EDUCATIONAL REQUIREMENTS

§4980.37. DEGREE PROGRAM; COURSE OF STUDY AND PROFESSIONAL TRAINING

(a) In order to provide an integrated course of study and appropriate professional training, while allowing for innovation and individuality in the education of marriage and family therapists, a degree program which meets the educational qualifications for licensure shall include all of the following:

(1) Provide an integrated course of study that trains students generally in the diagnosis, assessment, prognosis, and treatment of mental disorders.

(2) Prepare students to be familiar with the broad range of matters that may arise within marriage and family relationships.

(3) Train students specifically in the application of marriage and family relationship counseling principles and methods.

(4) Encourage students to develop those personal qualities that are intimately related to the counseling situation such as integrity, sensitivity, flexibility, insight, compassion, and personal presence.

(5) Teach students a variety of effective psychotherapeutic techniques and modalities that may be utilized to improve, restore, or maintain healthy individual, couple, and family relationships.

(6) Permit an emphasis or specialization that may address any one or more of the unique and complex array of human problems, symptoms, and needs of Californians served by marriage and family therapists.

(7) Prepare students to be familiar with cross-cultural mores and values, including a familiarity with the wide range of racial and ethnic backgrounds common among California's population, including, but not limited to, Blacks, Hispanics, Asians, and Native Americans.

(b) Educational institutions are encouraged to design the practicum required by subdivision (b) of Section 4980.40 to include marriage and family therapy experience in low-income and multicultural mental health settings.

§4980.39. ADDITIONAL COURSEWORK

(a) Any applicant for licensure as a marriage and family therapist who began graduate study on or after January 1, 2004, shall complete, as a condition of licensure, a minimum of 10 contact hours of coursework in aging and long-term care, which could include, but is not limited to, the biological, social, and psychological aspects of aging.

(b) Coursework taken in fulfillment of other educational requirements for licensure pursuant to this chapter, or in a separate course of study, may, at the discretion of the board, fulfill the requirements of this section.

(c) In order to satisfy the coursework requirement of this section, the applicant shall submit to the board a certification from the chief academic officer of the educational institution from which the applicant graduated stating that the coursework required by this section is included within the institution's required curriculum for graduation, or within the coursework, that was completed by the applicant.

(d) The board shall not issue a license to the applicant until the applicant has met the requirements of this section.

§4980.40. QUALIFICATIONS

To qualify for a license, an applicant shall have all the following qualifications:

(a) Applicants shall possess a doctor's or master's degree in marriage, family, and child counseling, marital and family therapy, psychology, clinical psychology, counseling psychology, or counseling with an emphasis in either marriage, family, and child counseling or marriage and family therapy, obtained from a school, college, or university accredited by the Western Association of Schools and Colleges, or approved by the Bureau for Private Postsecondary and Vocational Education. The board has the authority to make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation or approval. In order to qualify for licensure pursuant to this subdivision, a doctor's or master's degree program shall be a single, integrated program primarily designed to train marriage and family therapists and shall contain no less than 48 semester or 72 quarter units of instruction. The instruction shall include no less than 12 semester units or 18 quarter units of coursework in the areas of marriage, family, and child counseling, and marital and family systems approaches to treatment.

The coursework shall include all of the following areas:

(1) The salient theories of a variety of psychotherapeutic orientations directly related to marriage and family therapy, and marital and family systems approaches to treatment.

(2) Theories of marriage and family therapy and how they can be utilized in order to intervene therapeutically with couples, families, adults, children, and groups.

(3) Developmental issues and life events from infancy to old age and their effect upon individuals, couples, and family relationships. This may include coursework that focuses on specific family life events and the psychological, psychotherapeutic, and health implications that arise within couples and families, including, but not limited to, childbirth, child rearing, childhood, adolescence, adulthood, marriage, divorce, blended families, stepparenting, and geropsychology.

(4) A variety of approaches to the treatment of children. The board shall, by regulation, set forth the subjects of instruction required in this subdivision.

(b) (1) In addition to the 12 semester or 18 quarter units of coursework specified above, the doctor's or master's degree program shall contain not less than six semester or nine quarter units of supervised practicum in applied psychotherapeutic techniques, assessment, diagnosis, prognosis, and treatment of premarital, couple, family, and child relationships, including dysfunctions, healthy functioning, health promotion, and illness prevention, in a supervised clinical placement that provides supervised fieldwork experience within the scope of practice of a marriage and family therapist.

(2) For applicants who enrolled in a degree program on or after January 1, 1995, the practicum shall include a minimum of 150 hours of face-to-face experience counseling individuals, couples, families, or groups.

(3) The practicum hours shall be considered as part of the 48 semester or 72 quarter unit requirement.

(c) As an alternative to meeting the qualifications specified in subdivision (a), the board shall accept as equivalent degrees, those master's or doctor's degrees granted by educational institutions whose degree program is approved by the Commission on Accreditation for Marriage and Family Therapy Education.

(d) All applicants shall, in addition, complete the coursework or training specified in Section 4980.41.

(e) All applicants shall be at least 18 years of age.

(f) All applicants shall have at least two years experience that meet the requirements of Section 4980.43.

(g) The applicant shall pass a board administered written or oral examination or both types of examinations, except that an applicant who passed a written examination and who has not taken and passed an oral examination shall instead be required to take and pass a clinical vignette written examination.

(h) The applicant shall not have committed acts or crimes constituting grounds for denial of licensure under Section 480. The board shall not issue a registration or license to any person who has been convicted of a crime in this or another state or in a territory of the United States that involves sexual abuse of children or who is required to register pursuant to Section 290 of the Penal Code or the equivalent in another state or territory.

(i) (1) An applicant applying for intern registration who, prior to December 31, 1987, met the qualifications for registration, but who failed to apply or qualify for intern registration may be granted an intern registration if the applicant meets all of the following criteria:

(A) The applicant possesses a doctor's or master's degree in marriage, family, and child counseling, marital and family therapy, psychology, clinical psychology, counseling psychology, counseling with an emphasis in marriage, family, and child counseling, or social work with an emphasis in clinical social work obtained from a school, college, or university currently conferring that degree that, at the time the degree was conferred, was accredited by the Western Association of Schools and Colleges, and where the degree conferred was, at the time it was conferred, specifically intended to satisfy the educational requirements for licensure by the Board of Behavioral Sciences.

(B) The applicant's degree and the course content of the instruction underlying that degree have been evaluated by the chief academic officer of a school, college, or university accredited by the Western Association of Schools and Colleges to determine the extent to which the applicant's degree program satisfies the current educational requirements for licensure, and the chief academic officer certifies to the board the amount and type of instruction needed to meet the current requirements.

(C) The applicant completes a plan of instruction that has been approved by the board at a school, college, or university accredited by the Western Association of Schools and Colleges that the chief academic officer of the educational institution has, pursuant to subparagraph (B), certified will meet the current educational requirements when considered in conjunction with the original degree.

(2) A person applying under this subdivision shall be considered a trainee, as that term is defined in Section 4980.03, once he or she is enrolled to complete the additional coursework necessary to meet the current educational requirements for licensure.

(j) An applicant for licensure trained in an educational institution outside the United States shall demonstrate to the satisfaction of the board that he or she possesses a qualifying degree that is

equivalent to a degree earned from a school, college, or university accredited by the Western Association of Schools and Colleges, or approved by the Bureau of Private Postsecondary and Vocational Education. These applicants shall provide the board with a comprehensive evaluation of the degree performed by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES), and shall provide any other documentation the board deems necessary.

§4980.41. ELIGIBILITY TO SIT FOR LICENSING EXAMINATIONS; COURSEWORK OR TRAINING

All applicants for licensure shall complete the following coursework or training in order to be eligible to sit for the licensing examinations as specified in subdivision (g) of Section 4980.40:

(a) A two semester or three quarter unit course in California law and professional ethics for marriage and family therapists, which shall include, but not be limited to, the following areas of study:

(1) Contemporary professional ethics and statutory, regulatory, and decisional laws that delineate the profession's scope of practice.

(2) The therapeutic, clinical, and practical considerations involved in the legal and ethical practice of marriage and family therapy, including family law.

(3) The current legal patterns and trends in the mental health profession.

(4) The psychotherapist/patient privilege, confidentiality, the patient dangerous to self or others, and the treatment of minors with and without parental consent.

(5) A recognition and exploration of the relationship between a practitioner's sense of self and human values and his or her professional behavior and ethics.

This course may be considered as part of the 48 semester or 72 quarter unit requirements contained in Section 4980.40.

(b) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28 and any regulations promulgated thereunder.

(c) A minimum of 10 contact hours of training or coursework in human sexuality as specified in Section 25, and any regulations promulgated thereunder. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it shall be considered as part of the 48 semester or 72 quarter unit requirement contained in Section 4980.40.

(d) For persons who began graduate study on or after January 1, 1986, a master's or doctor's degree qualifying for licensure shall include specific instruction in alcoholism and other chemical substance dependency as specified by regulation. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it shall be considered as part of the 48 semester or 72 quarter unit requirement contained in Section 4980.40.

(e) For persons who began graduate study during the period commencing on January 1, 1995, and ending on December 31, 2003, a master's or doctor's degree qualifying for licensure shall include coursework in spousal or partner abuse assessment, detection, and intervention. For persons who began graduate study on or after January 1, 2004, a master's or doctor's degree qualifying for licensure shall include a minimum of 15 contact hours of coursework in spousal or partner abuse assessment, detection, and intervention strategies, including knowledge of community resources, cultural factors, and same gender abuse dynamics. Coursework required

under this subdivision may be satisfactory if taken either in fulfillment of other educational requirements for licensure or in a separate course. The requirement for coursework shall be satisfied by, and the board shall accept in satisfaction of the requirement, a certification from the chief academic officer of the educational institution from which the applicant graduated that the required coursework is included within the institution's required curriculum for graduation.

(f) For persons who began graduate study on or after January 1, 2001, an applicant shall complete a minimum of a two semester or three quarter unit survey course in psychological testing. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it may be considered as part of the 48 semester or 72 quarter unit requirement of Section 4980.40.

(g) For persons who began graduate study on or after January 1, 2001, an applicant shall complete a minimum of a two semester or three quarter unit survey course in psychopharmacology. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it may be considered as part of the 48 semester or 72 quarter unit requirement of Section 4980.40.

(h) The requirements added by subdivisions (f) and (g) are intended to improve the educational qualifications for licensure in order to better prepare future licentiates for practice, and are not intended in any way to expand or restrict the scope of licensure for marriage and family therapists.

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NON-QUALIFYING DEGREES

Likely to be Missing from an Out-of-State Degree:¹

Content related to public mental health including:

1. Principles of mental health recovery
2. Methods of service delivery in recovery model practice environments
3. Opportunity to meet with various consumers and family members of consumers of mental health services
4. Case management
5. Treatment, systems of care, services, supports, and advocacy for the severely mentally ill
6. Collaborative treatment

Content related to cultural competency and socioeconomic status including:

1. Understanding of various cultures and the social and psychological implications of socioeconomic position
2. A variety of cultural understandings of human development.
3. The understanding of human behavior within the social context of:
 - a. socioeconomic status
 - b. the cultures found within California
4. Matters that may arise within marriage and family relationships and life events within a variety of California cultures, including abuse, parenting, marriage, divorce, blended families, aging and grief.
5. Cultural competency and sensitivity, including a familiarity with the racial, cultural, linguistic, and ethnic backgrounds of persons living in California.
6. Effects of socioeconomic status on treatment and available resources.

Other Items:

1. Minimum of 60 semester or 90 quarter units of instruction
2. Evidence based practice
3. Behavioral addictions and co-occurring substance abuse and mental health disorders
4. Minimum of 9 semester or 13 quarter units and 225 hours of face-to-face counseling experience in practicum
5. Practicum training content:
 - a. working with families
 - b. documentation of services, treatment plans, and progress notes
 - c. how to find and use resources
6. Disaster and trauma response

Likely to be Missing from a Degree Earned in California that no Longer Qualifies After Sunset Date:¹

Content related to public mental health including:

1. Principles of mental health recovery
2. Methods of service delivery in recovery model practice environments
3. Opportunity to meet with various consumers and family members of consumers of mental health services
4. Case management
5. Treatment, systems of care, services, supports, and advocacy for the severely mentally ill
6. Collaborative treatment

¹ Based on proposal dated September 2007

Content related to cultural competency and socioeconomic status including:

1. The social and psychological implications of socio-economic position
2. A variety of cultural understandings of human development.
3. The understanding of human behavior within the social context of:
 - a. socioeconomic status
 - b. the cultures found within California
4. Matters that may arise within marriage and family relationships and life events *within a variety of California cultures*, including abuse, parenting, marriage, divorce, blended families, aging and grief.
5. Cultural competency and sensitivity, including a familiarity with the cultural and linguistic backgrounds of persons living in California.
6. Effects of socioeconomic status on treatment and available resources.

Other:

1. Minimum of 60 semester or 90 quarter units of instruction
2. Evidence based practice
3. Behavioral addictions and co-occurring substance abuse and mental health disorders
4. Minimum of 9 semester or 13 quarter units and 225 hours of face-to-face counseling experience in practicum
5. Practicum training content:
 - a. working with families
 - b. documentation of services, treatment plans, and progress notes
 - c. how to find and use resources
6. Disaster and trauma response

Courses currently permitted to be taken outside of the degree program (for degrees earned either in-state or out-of-state):

- Child abuse assessment and reporting
- Human sexuality
- Alcoholism and other chemical substance dependency
- Spousal or partner abuse assessment, detection, and intervention strategies
- Psychological testing
- Psychopharmacology
- California Law and Ethics (out-of-staters only)

For degrees earned out-of-state, the board may accept education as substantially equivalent² when the degree meets all requirements, except that:

1. The degree title does not have to be identical
2. If the applicant's degree does not contain all required content or the overall number of units the board may accept the degree if both of the following criteria are met:
 - The applicant's degree contains the required number of practicum units and coursework required in the areas of marriage, family, and child counseling, and marital and family systems approaches to treatment
 - The applicant remediates his or her specific deficiency by completing the required course content or units

This idea has been kept in the proposed language for both people who earned their degree in another state, and has been incorporated into the proposed language for people who earned their degree prior to the change in the educational requirements, but did not apply for registration or licensure by the sunset date.

² This language is pending in the legislature and is expected to pass this year (SB 1048)