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REPORT OF RECOMMENDATIONS: THE *ANNAPOLIS COALITION* CONFERENCE ON BEHAVIORAL HEALTH WORK FORCE COMPETENCIES

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ABSTRACT: In May 2004, the Annapolis Coalition on Behavioral Health Workforce Education convened a national meeting on the identification and assessment of competencies. The Conference on Behavioral Health Workforce Competencies brought leading consumer and family advocates together with other experts on competencies from diverse disciplines and specialties in the fields of both mental health care and substance use disorders treatment. Aided by experts on competency development in business and medicine, conference participants have generated 10 consensus recommendations to guide the future development of workforce competencies in behavioral health. This article

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outlines those recommendations. A collaborative effort to identify a set of *core* or *common* competencies is envisioned as a key strategy for advancing behavioral health education, training, and other workforce development initiatives.

KEY WORDS: advocacy; behavioral health; co-occurring; competencies.

In September 2001, the Annapolis Coalition on Behavioral Health Workforce Education convened its first national conference. The purpose of the meeting was to build consensus on the current problems and issues in workforce training, and to identify potential strategies for strengthening the effectiveness and relevance of the education offered to all segments of the workforce. The proceedings from that meeting and of subsequent phases of work of the Annapolis Coalition have been published in special issues of the journal *Administration and Policy in Mental Health* (Hoge & Morris, 2002; Hoge & Morris, 2004). Further details about the Annapolis Coalition are also available at: http://www.annapoliscoalition.org.

In the first conference, participants strongly recommended that a subsequent phase of work focus on the topic of *competencies*. This was viewed as a critical area where a collaborative initiative was essential to support future efforts of behavioral health workforce development. Thus, the Annapolis Coalition pursued and obtained funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) to commission a series of position papers and to convene a body of experts in a summit on competencies.

The focus of this phase of work addressed both the identification of competencies and strategies for assessing competence. A primary assumption underlying this initiative was that much of the work on this topic within the behavioral health field is in a relatively early developmental stage and could benefit from an infusion of expertise on competencies in general medicine, business, and industry. Therefore, experts from these other fields were retained to develop review papers on competency modeling (Marrelli, Tondora, & Hoge, 2005) and competency assessment (Bashook, 2005). In addition, experts on competency development and assessment in a broad range of disciplines and specialties in behavioral health contributed written summaries on promising developments related to competencies in their areas of expertise (Hoge et al., 2005).

It was critical in this process to address competencies related to the treatment of mental health problems, mental illnesses, substance use disorders, and these co-occurring illnesses. This project was funded by both the Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT) within SAMHSA, with experts from the

mental health and addiction sectors of the behavioral health field contributing to the position papers and participating in the national meeting. Similarly, this work is relevant to culturally, linguistically, and developmentally diverse populations. Experts on these topics also participated in the formulation of the recommendations below.

Any single effort to address this range of populations and sectors of the field is fraught with difficulties in finding a common, user-friendly language that is relevant and acceptable to this spectrum of persons, problems, and approaches to treatment. An attempt has been made to employ terms and concepts that are widely applicable. We recognize, however, that these efforts are imperfect, as a universally accepted language does not exist.

The Conference on Behavioral Health Workforce Competencies was convened in Annapolis, Maryland on May 10–11, 2004. The review papers mentioned above, which had been distributed in advance, were presented and discussed. Throughout the meeting, ideas were generated regarding future directions for competency development within the behavioral health field. The ideas generated through this process have been integrated into a series of recommendations, which are reported as follows.

RECOMMENDATIONS

Recommendation 1

Behavioral health competencies should be identified and assessed for a broadly defined "workforce" that encompasses: (1) the various providers who deliver care within the formal behavioral health system, (2) members of the general and specialty healthcare system and human service system who routinely encounter individuals with mental health problems or illnesses and substance use disorders, and (3) persons with these disorders and their families.

Competency-based training and assessment is being increasingly offered in graduate level professional programs and medical residencies, and has historically been offered to a segment of the substance use disorders workforce. It is essential to extend this approach to the continuing education of the existing workforce and to the non-degreed or bachelor-degreed staff members who, in many settings, receive little substantive training about mental illnesses, substance use disorders, and their treatment. There are multiple pathways to competence, which may include elements of personal experience, training, and professional development. However, none of these pathways guarantees competence. Thus, there is the need to identify and assess competencies for each segment of the workforce.

The majority of individuals who are diagnosed with mental illnesses and substance use disorders seek help *outside* of specialty behavioral health systems. Thus, the workforce must be broadly conceptualized to encompass others who routinely encounter individuals with these disorders in the general and specialty healthcare system and in other human service systems. This includes, for example, primary care and emergency department personnel, clergy, teachers, law enforcement, and criminal justice or juvenile justice workers (US Department of Health and Human Services, 1999). Behavioral health competencies must be identified, training systems developed, and provider competencies assessed for these caregivers with the same sense of urgency that is applied to the specialty behavioral health workforce.

Similarly, the critical roles of persons with mental health problems or illnesses and substance use disorders, and the families of these individuals in providing self-care, peer support, and assistance to their loved ones must be recognized. These individuals constitute a core segment of a broadly defined ''workforce.'' They require education and training to effectively achieve and support recovery. Developing competency sets for persons with these illnesses and their families will foster the effective provision of support.

Recommendation 2

Initiatives to identify and assess competencies in behavioral health must strive to achieve reliability and validity through the use of established methods of competency development.

There are both highly-developed methods and a substantive body of knowledge pertaining to competency development and assessment in fields such as education, organizational psychology, and business management. Casual approaches to these complex tasks will jeopardize the value of efforts to employ competency-based strategies of workforce development in behavioral health. ''Armchair competency development'' must give way to rigorous and systematic efforts to make progress on this critical agenda.

With respect to competency development in behavioral health, some of the core strategies that should be adopted are: employing a systematic method of data collection to identify and define competencies; using multiple data sources, such as focus groups, semi-structured interviews, behavioral event interviews, surveys, work logs, and observation of persons judged to be competent or exemplary; organizing competencies for a specific role into a manageable number of *clusters* that contain the required knowledge, skills, and attitudes; and differentiating *core* competencies (common to all individuals in an organization, discipline, or

specialty), *job family* competencies (common to all individuals performing a similar job or function), and *tiered-level* competencies (differentiating those at different levels, such as direct care, supervisory, and program management; Marrelli et al., 2005).

Key principles and methods regarding competency assessment have been articulated by Bashook (2005). These include: using accepted psychometric tests and procedures to establish the reliability, validity, feasibility, and credibility of the proposed assessment; assessing multiple domains, such as knowledge, decision-making, skills, and practice performance; and using multiple data sources, such as written and oral exams, global rating forms, supervisors' summary reports, client surveys, client record audits, portfolios, 360-degree evaluations, rating scales, role-playing computer simulations, and standardized patient examinations. Learner-directed and strengths-based approaches to the assessment process merit particular attention.

Recommendation 3

All members of the behavioral health workforce should develop competencies in the identification, assessment, treatment, and prevention of mental health problems or illnesses and substance use disorders, including the care of individuals with co-occurring mental and addictive disorders.

The frequent co-occurrence of mental illnesses and substance use disorders is now well established (Harwood, Kowalski, & Ameen, 2004). This makes it imperative that the specialty behavioral health workforce be trained in identification, assessment, and treatment strategies for both types of disorders. Segments of the workforce will, of course, continue to specialize, and linkage and referral of individuals between specialty mental health and substance use disorder treatment programs will continue. However, a solid knowledge and skill base covering the spectrum of these disorders is essential at each portal of entry into the specialty behavioral health system, and particularly at those portals where individuals with co-occurring mental illnesses and substance use disorders present with greatest frequency, such as crisis or emergency services. Provider organizations need to demonstrate their competence in treating persons with mental health problems or illnesses, substance use disorders, or these co-occurring illnesses, whether this competence resides at the individual provider level or within organized treatment teams.

Considerable innovative work has been conducted to identify core competencies for the treatment of substance use disorders (Center for Substance Abuse Treatment, 2000; Haack & Adger, 2002; US Department of Health and Human Services, 1998). This will be invaluable in informing competency development for the traditional mental health work-

force. Project Mainstream, which is a creative interdisciplinary effort to develop academic faculty with the skills to teach substance use disorders assessment and treatment, is a model approach to building a cadre of teachers who can promote this training agenda. The products of competency development initiatives underway in the various disciplines that focus primarily on mental health are also available to inform the training of those whose principal interest involves treating individuals with substance use disorders (Hoge et al., 2005).

Recommendation 4

The content of competency-based training and education must be broadened beyond the traditional clinical paradigm to include prevention, early intervention, rehabilitation, and recovery- and resilience-oriented approaches to care.

Much of the pre-professional education and training in the specialty behavioral health disciplines is grounded in a strong clinical tradition that heavily emphasizes acute treatment. While this is an essential element of a comprehensive behavioral health education, it must be accompanied by training and supervised experience in prevention and early intervention, rehabilitation, and recovery- and resilience-oriented approaches. These are now major paradigms for conceptualizing illness and adaptation to illness, treatment, and improvements in health, especially for adults. Those who will care for children and their families must be trained in the core values, principles, and approaches that comprise the system-of-care framework that guides this work nationally.

As trainees are taught the technical competencies in these diverse approaches, educators must not lose sight of the importance of teaching the essential interpersonal competencies that involve an ability to listen effectively, establish a meaningful therapeutic relationship, and to offer compassion and hope. In broadening the focus of behavioral health education and in emphasizing the critical interpersonal dimensions of care, those in recovery and their families should be engaged as educators of the workforce, teaching about illness, treatment, and recovery based on their lived experience.

Recommendation 5

The traditional focus on the competency of individuals in the workforce must be complemented by concerted attention to defining and assessing the competencies of the treatment teams, organizations, and systems in which these individuals function.

Most workforce development initiatives focus on the individual student or provider, just as the field tends to focus on the individual recipient of service when conceptualizing illness or treatment. However, services are

increasingly delivered through multidisciplinary or multi-specialty teams, requiring further development of the concept of team competency.

Similarly, the organizations and systems where the workforce is deployed play a critical role in either promoting or undermining the efforts of individuals to function competently (Gilbert, 1996; Langdon, 2000; Rummler & Brache, 1995). The organizational context exerts positive or negative influence through a variety of avenues: the information, tools and motivational enhancements it provides (Marrelli, 2001); the attitudes of leaders; and the organizational climate (Corrigan, Steiner, McCracken, Blaser, & Barr, 2001; Lehman, Greener, & Simpson, 2002; Rosenheck, 2001). Thus, future efforts to build a competent workforce must simultaneously intervene at the individual, team, organization, and system levels.

Recommendation 6

Persons with mental health problems or illnesses and substance use disorders and the families of these individuals should play a central role in building a competent workforce by having formal input into both the identification of essential competencies and into competency assessments of individual providers, treatment teams, service organizations, and systems of care.

The recovery community has traditionally played a major role in shaping the substance use disorders field and providing services. In mental health, consumers increasingly play a more central role in the care process. They are asking for and are being provided more information about their illnesses and treatment options. They also play a much more active decision-making role in treatment selection and treatment decisions, as well as a more widely recognized role in caring for themselves and their peers.

Persons with mental illnesses and substance use disorders and their families have a unique perspective on the knowledge and skills that define the competent performance of health care delivery. Draft sets of competencies developed by disciplines or specialties should be formally circulated for review and comment to those in recovery, their families, and the advocacy organizations that represent them. These individuals should also be sources of input in 360-degree evaluations, which use multiple perspectives and sources of feedback in assessing the competence of an individual, team, or organization. Competency sets or assessments conducted without input from patients and their families will increasingly be considered of questionable validity and credibility.

Increasing the involvement in this process of persons with these illnesses and their families will impact the nature of the standards being applied. The notion of striving to ensure ''minimum'' levels of provider competency is largely unacceptable to the recipients of service. Naturally, they desire, expect, and increasingly demand the best available services,

and thus consider ''excellence'' to be the most appropriate standard to apply in efforts to build a competent workforce.

Recommendation 7

All segments of the workforce must develop competencies in delivering culturally, linguistically, and developmentally appropriate services.

Reviews by the Institute of Medicine (2003a) and the US Surgeon General (US Department of Health and Human Services, 2001) have concluded that communities of color within this country suffer a disproportionate burden from behavioral health disorders. This appears to be due in part to barriers in access to care and to the receipt of poorer quality care. A variety of factors may also impede these individuals from seeking help, including lack of knowledge about behavioral health illnesses and available services, shame and stigma, and cultural values. This situation is complicated by the fact that fewer than 10% of current behavioral health professionals are individuals of color, yet the four major ethnic groups comprise approximately 30% of the US population (Duffy et al., 2004).

Members of the workforce must be assisted in achieving competence in conducting cultural formulations, developing rapport with culturally diverse individuals, and engaging these individuals in the treatment planning process (National Asian American Pacific Islander Mental Health Association, 2002). Conducting a competent cultural assessment entails asking about the client's cultural identity, considering possible cultural explanations of illness, identifying cultural forces and effects in the client's psychosocial environment, and examining cultural elements in the consumer-clinician relationship (Ida, personal communication, 2004).

In a similar fashion, members of the workforce must be competent to provide developmentally appropriate services. Children, adolescents, and elders have unique needs that require a workforce with more than generic skills. Treating children and adolescents, for example, requires skills to provide treatment within the context of families, across multiple child-serving systems, and in communities where these young persons live. Thus, individual provider or team skills in cross-agency and family collaboration are essential (Huang, Macbeth, Dodge, & Jacobstein, 2004). As another example, effectively treating older adults requires an ability to identify the frequently undiagnosed substance use disorders from among the complex physical, cognitive, social, and mental health problems that occur in the geriatric population. Also required is the ability to tailor services to the changing metabolism, medical complications, and medication interactions that complicate the treatment process (Barry, Blow, & Oslin, 2002).

Recommendation 8

Given the prevalence of stigma, disparities in access to care, and inequities in coverage for care for those with mental illnesses and substance use disorders, a core competency that should be developed by all members of the behavioral health workforce is the ability to advocate effectively for individuals and for groups of individuals who are diagnosed with these disorders.

In *Mental Health: A Report of the Surgeon General* (1999), David Satcher cited financial barriers, stigma, and a pervasive and unwarranted hopelessness about mental illnesses and their treatment as elements contributing to the disparities experienced by those with these disorders. The strategies he outlined to combat these obstacles include confronting barriers to care, confronting negative attitudes and misunderstandings, and educating those who are uninformed or misinformed. Given the magnitude of the barriers facing individuals with mental illnesses and substance use disorders, there is a compelling case that each member of the workforce must develop competencies to advocate on behalf of both individuals and groups diagnosed with these disorders.

It can easily be argued that the disparities in access are even more severe with respect to substance use disorders. For example, it is estimated that just one person in 10 with a drug use disorder and one in 20 with an alcohol use disorder receives treatment (Wright, 2004). It is equally important that the workforce possess advocacy skills to support these individuals and challenge these disparities.

Addressing disparities must begin *within* the specialty behavioral health workforce. Too often, stigma, bias, blame, or disrespect for persons with these illnesses and their families exist in members of the workforce who deliver care. Addressing the attitudinal elements of competency to practice within this field is of paramount importance.

Recommendation 9

A "competency collaborative" should be established to link the multiple groups and organizations that are developing behavioral health competencies. This collaborative should identify the optimal common or core competencies to be demonstrated by most providers.

There are numerous efforts underway to develop and assess behavioral health workforce competencies. These are being conducted by professional associations, advocacy groups, universities, the Addiction Technology Transfer Centers, state departments of health, and other organizations. It is clear that most are working on this agenda separately, at times unaware of the strategies and progress being made by others in the field, and shouldering the burden of marshalling the resources and technical assistance to support these solo efforts.

While each group or organization will need to maintain its independence in this process, substantial benefits and efficiencies would accrue from an ongoing collaboration. Individuals leading these various competency initiatives could be linked electronically and via periodic meetings to accomplish the following functions:

- Share information regarding ongoing efforts to develop and employ competency models and to assess competence.
- Assemble key resources on competency development and assessment and make these readily accessible to individual and organizational members of the collaborative.
- Identify common, core, or cross-cutting competencies and competency domains.
- Consider cooperative endeavors to develop and implement core competency models and assessment strategies, or to jointly acquire technical assistance.
- Review the relevance of competencies identified by one sector of the field (e.g., substance use disorders) for other groups and organizations that are developing competency models.
- Crosswalk existing and emerging competency models to promote further development of competencies for treating individuals with co-occurring mental illnesses and substance use disorders.
- Identify and disseminate case examples of "successful" efforts to identify and assess competencies.
- Communicate collectively and formally with professional associations, state departments of health, accrediting organizations, and other relevant bodies to inform them of available competency models and promote the adoption of these competencies in training, certification, and licensing processes.

A specific comment is warranted regarding the concept of developing a set of common, core, or cross-cutting competencies. The Institute of Medicine, in its report on *Health Professions Education: A Bridge to Quality* (2003b), has argued that quality of care in America will not be achieved unless the healthcare specialties collaborate in identifying and defining core competencies that are shared in five key areas: patient-centered care, work in interdisciplinary teams, evidence-based practice, quality improvement, and informatics. An informal review of current competency initiatives in behavioral health reveals considerable similarity in the competencies identified. Progress on defining, teaching, and assessing these competencies is likely to proceed at a much greater pace if there is an effort to pursue this work collectively, while maintaining the independence of each contributing group or organization and recognizing the

unique competencies that define each discipline or specialty in behavioral health. Core competencies may be particularly useful in building curricula for two segments of the workforce: (1) direct care, non-degreed or bachelor-degreed staff members, and (2) those caregivers who encounter individuals with mental illnesses and substance use disorders *outside* of the specialty behavioral health system (e.g., primary care providers, emergency room personnel, teachers).

Recommendation 10

Federal, state, foundation, and professional association funding priorities should support a health services research agenda that evaluates the link between competent performance and health care outcomes.

It is imperative that the objective of improved healthcare outcomes be kept at the forefront of efforts to build a competent workforce. In behavioral health, the research base on the relationship between provider competence and improved health status is sparse. Efforts to define and measure competent performance should be accompanied by increased funding for research to examine the relationship of such performance to the health and well-being of those individuals with mental illnesses and substance use disorders who receive care.

CONCLUSION

Competency-based approaches to workforce education and development are a significant departure from tradition in health care, which historically emphasized the completion of formal training, combined with experience, as the essential qualifications for practice. As a departure from tradition, competency-based approaches can evoke considerable apprehension. This is not altogether unjustified, as the competencies in behavioral healthcare are in a relatively early phase of development, have largely undemonstrated links to health care outcomes, and will likely impact decisions about graduation from training programs, as well as certification and licensure.

Yet it seems imperative to press forward with this agenda, constantly striving to better define the knowledge, skills, and abilities that are essential or optimal in the delivery of care, and devising training and staff development initiatives to build these competencies in the workforce. Collaboration will be a cornerstone of these efforts if they are to succeed. There needs to be collaboration across the fields of mental health and substance use disorders treatment, across disciplines and specialties, and across the diversity of human service systems. Most important, the foun-

dation of these efforts must be a strong collaboration with persons with mental illnesses and substance use disorders and their families.

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