

The Alaskan Crosswalk: Exploring Competencies and Credentialing for the State's Direct Care Workforce

A Report of the
Credentialing and Quality
Standards Subcommittee
(CQSS)

Workforce Development
Focus Area of the
Alaska Mental Health Trust
Authority

June 2008



Prepared by

The Western Interstate Commission for Higher Education
Mental Health Program

and

The Annapolis Coalition on the Behavioral Health Workforce

WICHE

 **THE ANNAPOLIS COALITION**
ON THE BEHAVIORAL HEALTH WORKFORCE

TABLE OF CONTENTS

	Page
Table of Contents	iii
Acknowledgments	v
Members of the CQSS	vii
Executive Summary	ix
Introduction	1
National, Regional, and State of Alaska Workforce Initiatives	2
Alaska’s Workforce Development Efforts.....	3
Credentialing and Quality Standards Subcommittee and the Current Project	5
Alaska Workforce Problem and the CQSS Strategy	5
Current CQSS Goals	5
CQSS Process Objectives	5
Desired Long-Term Outcomes	6
External Consultants	6
Background on Competency Development	8
Overview of Competency Development	8
Definition of Competency	9
Background on Certification and Credentialing	11
Definition of Certification	11
Overview of Certification	11
Certification vs. Credentialing.....	12
National Resources	13
Current Competencies for Identified Job Families	13
I. General and Cross Sector	14
II. Behavioral Health	17
Addictions	17
Adult Mental Health	19
Co-Occurring (Mental and Addictive Disorders)	20
Peer Support	21
Child Mental Health	21
III. Child Development	23
IV. Developmental Disabilities	24
V. Traumatic Brain Injury	26
VI. Long Term Care	27
VII. Juvenile Justice and Corrections	27
Crosswalk of National Competencies	29
Alaskan Resources	34
Current Competencies for Identified Job Families	34
I. General and Cross Sector	36

II. Behavioral Health	36
Addictions	36
Adult Mental Health	37
General and Co-Occurring (Mental Health and Substance Abuse)	38
Child Mental Health	40
III. Child Development	40
IV. Developmental Disabilities	41
V. Traumatic Brain Injury	41
VI. Long Term Care	42
VII. Juvenile Justice	43
Crosswalk of Alaska Competencies	44
Summary and Recommendations	49
Summary of Findings	49
Recommendations	51
Endnotes	54
References	55
Appendices	
Appendix A	57
Appendix B	59

ACKNOWLEDGEMENTS

The vision for this project emerged from a strategic planning meeting funded by the Alaska Mental Health Trust where a diverse group of stakeholders generated some priorities for addressing workforce issues impacting Trust beneficiary groups.

Appreciation is expressed to the Alaska Mental Health Trust for recognizing the importance of this initiative and providing the financial support to make the work possible. The collaboration of the Trust with the Alaska Division of Behavioral Health and the University of Alaska System has provided the foundation necessary for the work to move forward from the original brainstorming of strategic ideas to the actual planning and implementation of workforce activities.

Members of the CQSS shaped and provided oversight to this project. They represented the interests of their sector of the health and human service field, while simultaneously addressing the needs of all Alaskans and all disability groups in moving this agenda forward. Further, they played a key role in identifying competency and credentialing resources, both in Alaska and nationally. While the CQSS, as a committee, has endorsed the report, this should not be construed to mean that each member has endorsed each and every statement within the report. The responsibility for errors or omissions rests solely with WICHE and the Annapolis Coalition.

Project leads for the consulting organizations were Michael A. Hoge, Ph.D. (Annapolis Coalition) and Mimi McFaul, Psy.D. (WICHE). Additional WICHE staff included Christa Smith, Psy.D., Jessica Tomasko, L.C.S.W., and Scott Adams, Psy.D..

For further information contact:

Rick Calcote, CQSS Co-Chair
Disaster Response and Training Coordinator
Division of Behavioral Health
3601 C. St., Suite 878
Anchorage, AK 99503
Voice: 907-269-3617
rick.calcote@alaska.gov

Mimi McFaul
Associate Director
WICHE Mental Health Program
3035 Center Green Drive
Boulder, CO 80301
Voice: 303-541-0288
mmcfaul@wiche.edu

Beverly Tallman, CQSS Co-Chair
Director, Trust Training Cooperative
University of Alaska Anchorage
2702 Gambell St., Suite 103
Anchorage, AK 99503
Voice: 907-264-6224
anbit@uaa.alaska.edu

Michael A. Hoge
Senior Science and Policy Advisor
The Annapolis Coalition
Professor of Psychology
Yale Dept. of Psychiatry
300 George St., Suite 901
New Haven, CT 06511
Voice: 203-785-5629
Michael.hoge@yale.edu

MEMBERS OF THE CREDENTIALING AND QUALITY STANDARDS SUBCOMMITTEE

Rick Calcote, CQSS Co-Chair

Disaster Response and Training Coordinator,
Division of Behavioral Health

Beverly Tallman, CQSS Co-Chair

Director, Trust Training Cooperative,
University of Alaska Anchorage

**CQSS Subcommittee Members
(in alphabetical order)**

Jane Atuk

Health Program Manager, Department of Health
and Social Services/Office of Children's Services with
Early Intervention and Infant Learning Programs

Susan Bomalaski

Executive Director, Catholic Social Services

Janet Carter

Executive Director, Regional Alcohol and
Drug Abuse Counselor Training

Kim Champney

Support Services Program Director, REACH, Inc.

Kathy Craft

BH Workforce Development Manager,
University of Alaska (University), State of Alaska
Department of Health and Social Services (DHSS)
and the Alaska Mental Health Trust Authority (Trust)

Delisa Culpepper

Chief Operating Officer, Alaska Mental Health
Trust Authority

Kelly Donnelly

Director of the Children's Residential Services
Certificate Program, University of Alaska,
Anchorage Center for Human Development

Kathleen Graves

Director of Behavioral Health, Alaska Native
Tribal Health Consorti

Kim Haviland

Chair of Board of Commissioners, Alaska Commission for
Behavioral Health Certification and Maniilaq

Barbara Henjum

Superintendent, McLaughlin Youth Center

Bill Herman

Senior Program Officer, Alaska Mental Health Trust
Authority

Jill Hodges

Executive Director, Alaska Brain Injury Network

Karen Johnson

Training Program Manager, Denali Commission

Erin Kinavey

Early Infant/Infant Learning Program Manager, Office of
Children's Services, Department of Health and Social
Services

Randall Madigan

Site Reviewer, Division of Behavioral Health

Cheryl Mann

Department of Human Services, University of Alaska

Sherry McWhorter

Major Divisional Social Services Secretary, The Salvation
Army

Deb Mucha

Career Development Specialist, DOLWD/ESD
Department of Labor and Workforce Development/
Employment Security Division
Employment and Training Technical Unit

Shirley Pittz

Early Childhood Comprehensive Systems Coordinator,
Department of Health and Social Services

Sue Pope

Program Manager, University of Alaska, Anchorage, School
of Social Work

Larry Roberts

Program Coordinator and Advisor, Alaska Rural Behavioral
Health Training Academy

Andrea Schmook
Director of Consumer Directed Services, Anchorage
Community Mental Health Services

Jesalyn Stanton
Executive Director, Salvation Army Serendipity Adult
Day Services

Alberta Unok
Program Associate, Alaska Native Tribal Health
Consortium

Steve Williams
Program Officer, Alaska Mental Health Trust Authority

EXECUTIVE SUMMARY

Vision Statement

By 2015, Beneficiaries of the Alaska Mental Health Trust shall have access to a capable, culturally competent workforce to support their communities and families across the life span.

Since 2003, The Alaska Mental Health Trust Authority (The Trust), in partnership with the Alaska Division of Behavioral Health and the University of Alaska System, has worked towards spearheading initiatives that build on and integrate systematic behavioral health workforce development efforts. In acknowledgement of these workforce challenges, including recruitment, retention, and lack of training opportunities, The Trust is responding by funding the Workforce Development Focus Area as one of its five priority areas.

While this project builds on the extensive history of Alaskan workforce development efforts in behavioral health, it broadened this focus to include the range of health and human service sectors that serve Trust beneficiaries. These service sectors have direct support workers who are similar, in many respects, to those in behavioral health. Effective care of Trust beneficiaries requires strengthening the workforce across the various sectors. Thus, the search for core competencies and credentialing approaches was broadly inclusive of Alaska's direct care workforce.

This report is a product of the Credentialing and Quality Standards Subcommittee (CQSS), which has the primary goal of supporting the development and coordination of competencies and credentialing for the direct care workforce in the state. The CQSS is a subcommittee of the Training Workgroup, one of the three main workgroups of the Workforce Development Focus Area funded by the Trust. Members of the CQSS, drawn from diverse workforce fields, identified a vision and a number of specific goals for the project.

External consultants to the CQSS are the WICHE Mental Health Program and the Annapolis Coalition on the Behavioral Health Workforce. The consultants conducted a review of existing competencies in Alaska and nationally for the broad range of non-medical direct healthcare service positions serving Trust beneficiaries. Consultants also researched and reviewed existing credentialing and certification procedures for the identified occupations in Alaska and nationally. The consultants then developed and analyzed a matrix that "crosswalked" the local and national competency domains with the job families. The result of the crosswalking process was a set of recommendations regarding the development of a core set of competencies for direct care workers serving Trust beneficiaries.

The full report includes the following:

- I. A brief background of national, regional, and state-level workforce development initiatives
- II. Further description of the CQSS project in terms of goals, objectives, and desired outcomes
- III. Competencies overview
- IV. Clarification regarding certification, credentialing, and related concepts
- V. Overview of national resources regarding competencies and credentialing processes, including a comparison or "crosswalk" of those competencies
- VI. Overview of Alaskan competencies, credentialing processes, and a similar comparison or "crosswalk"
- VII. Summary of findings and recommendations regarding a phase approached to the next steps in pursuing the CQSS mission

Credentialing & Quality Standards Subcommittee

CQSS Mission Strengthen the direct care workforce in a broad range of health and human service sectors by developing a core set of competencies and a credentialing system that is built on those competencies.

CQSS Goal Identify a core set of competencies for a targeted number of non-medical, direct care workers or occupations serving Trust beneficiary groups.

It is not uncommon for competency sets to be developed for specific direct care positions. However, they mostly exist in a particular service sector, are not clearly defined, and are without adequate connection to any recognized credential or workplace incentive. The identification of core competencies that are shared among these positions will be helpful both to employers and to individual direct care workers in defining key job responsibilities. It is anticipated that this core set of competencies will inform training and curriculum development for this level of professional leading to the acquisition of relevant knowledge and skills. Training tied to these competencies would then facilitate a more standardized approach to training direct care workers across job sectors.

The composition of workers and the populations served by these workers are varied, making it crucial that training be accessible, affordable and culturally sensitive. Ultimately, the goal would be to institute a formal credentialing or certification process to recognize these individuals for their ability to demonstrate a set of required skills in their respective work environment and to provide expanded career opportunities for this sector of the workforce. The optimal system would offer individuals multiple routes to certification (e.g., workplace-based learning, University coursework, etc.) and reciprocity between different systems.

While it is common to think of graduate degreed professionals when considering the health care workforce, those without graduate preparation often comprise the majority of individuals involved in providing direct care. Over the past several decades, changes in American society and in health and human service delivery have altered the roles of these direct care workers and greatly increased their burden of responsibility. As a result, there is a need for greater training and supports to persons functioning in these direct care capacities (Taylor, Bradley, & Warren, 1996).

Direct service workers constitute a large proportion of the health and human service workforce, yet there is no consensus on common or core competencies for these roles and seldom a clear career path for individuals who accept entry level positions in this workforce (Taylor, Bradley, & Warren, 1996). Although this phenomenon is national in scope, it is a particular challenge in Alaska where there are critical shortages in direct care workers across multiple health and behavioral health disciplines.

Indications are that workforce shortages in this field will become more severe in the next decade, and that providers will be challenged to acquire new skills, particularly for working in a more collaborative or integrated manner with other sectors of the health and human service system. Workforce trends involve a complex combination of inter-related issues such as demographic changes (e.g., aging population), shifts in financing structures (e.g., Medicaid), and innovations in care (e.g., evidence-based practice, technology-based solutions).

National Resources

Competency and certification development for health and human service positions has been occurring across the nation for at least over a decade. This work has been funded by federal and state agencies, foundations, and professional associations. The products of these efforts vary significantly in terms of their depth, quality, dissemination, accessibility, and impact. Previously, no comprehensive review across health and human service sectors or job families has been conducted. Given their potential value to Alaska in its workforce development effort, a systematic effort was made to identify competency sets and credentialing procedures relevant to the job families being examined in this project.

The information about the competency sets and credentialing procedures identified for this project was obtained through the review of published reports, web-based materials, and interviews of key informants. In describing each competency set and credentialing system an effort was made to find and report the following information when available:

- ▶ Identifying information for the resource
- ▶ Identity of the developer
- ▶ Brief history (e.g., origins, revisions)
- ▶ Relevance to the direct care workforce
- ▶ Availability (public domain or proprietary)
- ▶ Organization and content (e.g., competency domains, certification levels)
- ▶ Methods of development
- ▶ Use and impact

The review of national resources is organized by the job families outlined below.

- I. General & Cross Sector
- II. Behavioral Health
 - a. Addictions
 - b. Adult Mental Health
 - c. Co-Occurring (mental & addictive disorders)
 - d. Peer Support
 - e. Child Mental Health
- III. Child Development
- IV. Developmental Disabilities
- V. Traumatic Brain Injury
- VI. Long term care
- VII. Juvenile Justice

Within each section, competency resources were summarized first, followed by a description of credentialing for that job family. In some cases the competencies and credentialing systems are related, having been developed by the same organization. In other instances they are largely unrelated. The resources reviewed in each job family section are further detailed in the full report.

Alaska Resources

In the State of Alaska, there are a number of different types of direct care competencies being used to enhance the knowledge and skills of direct care workers serving Trust beneficiary groups. These competencies have been designed or applied within the State Health and Social Services Department, higher education, provider organizations, the Alaska Native Tribal Health Consortium, and as a part of the Alaska Commission for Behavioral Health Certification. There is currently no singular competency set that is being applied across settings that serve Trust beneficiaries. One of the goals of the Credentialing and Quality Standards Committee (CQSS) is to create a forum for Alaskan entities (e.g., the State, providers, and educators) to communicate with each other and to develop a set of core, direct care competencies necessary to serve all of the Trust beneficiary groups.

In describing each competency set and certification system an effort was made to identify and report the same information that was found for the national competencies and credentialing processes (e.g. information for the resource, identity of the developer, etc.). The review of Alaskan resources is organized by the same job families seen in the national competencies section, with the exception of the Peer Support job family. Detailed tables available in the full report identify the competencies and credentialing processes for each of the job families for both the national and the Alaskan resources.

Summary and Recommendations

Summary of Findings

- ▶ Both nationally and in Alaska, there are diverse health and human service sectors that are staffed at the front lines largely by direct support workers. These workers typically have had little if any post-secondary education or formal preparation for their jobs.
- ▶ Alaska's direct care workforce is not well-defined or routinely examined as a whole. Alaska's titles are largely employer-developed, not well defined, and lack standardization.
- ▶ There are a growing number of well executed efforts within Alaska to develop competencies and credentialing processes. Many of these efforts have faced challenges since competency development and credentialing systems are complex to develop, require considerable resources over a sustained period of time, and can be impeded by the challenge of obtaining consensus on the final products.
- ▶ There exist many resources nationally on competencies and credentialing for health and human services roles. Collectively, they represent a set of riches that Alaska can draw on as it strives to strengthen its workforce.
- ▶ The crosswalk of competencies revealed that there is considerable commonality among the competency sets that have been developed nationally for different sectors of the health and human service field. This commonality yields one fundamental conclusion: There does exist a set of national core competencies that could serve as the foundation for cross-disability competency development in Alaska.
- ▶ Currently there is no single competency set that is being applied across settings that serve Trust beneficiaries.
- ▶ The crosswalk of Alaska competencies revealed that there are a number of different types of direct care competencies being used to enhance the knowledge and skills of direct care workers serving Trust beneficiary groups. Several were created by Alaska stakeholder committees, but most competencies being applied in Alaska are either a modified or original version of national competencies.
- ▶ Most direct care employees who undergo competency related training are not rewarded with higher wages, benefits, or other incentives.
- ▶ With the exception of chemical dependency counselor certification, there are currently no active state certification processes for direct care workers serving trust beneficiaries. However, several efforts are currently underway.
- ▶ The Alaska Native Tribal Health Consortium has been developing a set of core competencies since 2000 which will be applied to ANTHC Behavioral Health Aide positions. The ANTHC and the ACBHC will certify their behavioral health professionals through separate processes due to the differences in the nature of the work each type of employee will perform, and are working together to create a system of reciprocity.
- ▶ While the commonalities in competencies across disability or service groups are striking, there are substantial differences as well. For example, the competencies for adult corrections and juvenile justice are most dissimilar to the others reviewed. This is driven by the large focus on control and management of individuals, as opposed to care giving, which characterizes job duties in correctional facilities and inpatient settings.
- ▶ There are additional differences in competency sets that are related to population characteristics and the nature of services being delivered. These emerge primarily in the master competency domain labeled "interventions" in the crosswalk. There are many common elements of care giving that involve communication, person-centered assessment and planning, referral, professional conduct and development, and advocacy.

But there are inescapable differences in the range of interventions provided, which can range from personal care and nutritional support of a physically disabled individual to crisis intervention with an individual diagnosed with a severe mental illness. The range of knowledge and skills required to intervene with these diverse populations cannot be fully represented in a core set of competencies.

- ▶ Some competency sets were designed to specify the “minimum” level of competence necessary to function in a role, while others were developed using exceptional workers as the data source in order to identify “optimal” performance. The former approach is quite common in credentialing and licensing systems, which function to ensure public safety and must avoid the perils of legal liability that would occur from restricting the practice of those who are minimally qualified. However, there remains a need to strive for excellence in workforce preparation and service delivery.
- ▶ There has been a striking lack of involvement of persons in recovery and family members in the development of competencies in health and human services. Many of the competency sets were developed in an era when consumer and family involvement and influence in quality improvement efforts were unusual. However, their participation and feedback on issues related to workforce competency are long overdue.
- ▶ Credentialing systems in health and human services vary widely. They are non-existent in some sectors and widely employed in others. There has been substantial resistance to credentialing, primarily from employers. However, this appears to be slowly diminishing as the magnitude of workforce problems grow and employers seek new strategies to strengthen the workforce and create payer support for wages and benefits that might slow turnover among the workforce. Despite the absence of rigorously developed evidence for the impact of credentialing, there is anecdotal evidence that credentialing may “raise the bar” for a workforce in the manner desired by the CQSS.

Recommendations for Alaska

Phase 1: Credentialing & Core Competency Assessment

As Phase 1 of the CQSS initiative, the job classifications or “job families” and titles in Alaska that are relevant to this initiative have been identified. At this juncture it is clear from the crosswalk of both national and Alaskan competencies that exist for these jobs that there is considerable commonality in terms of the core competencies. It is also clear that disability or population specific initiatives within Alaska could benefit from a more coordinated or integrated approach as most suffer from a lack of adequate resources and staffing to develop and apply robust competency models independently.

Outlined below is a series of additional proposed stages to move this work forward. Phase 2 must precede all others, which could then follow in accord with local priorities and funding availability.

Phase 2: Develop the Alaska Core Competency Model

Suggested time frame: 9/1/08 – 6/30/09

This is a complex and critical task that will involve drawing on existing national and Alaska-based competencies to create and validate a set of core competencies for the identified job classifications. The competencies will be sufficiently detailed to guide curriculum development, training, and the assessment of competence among trainees and employees. This is suggested as the critical next step for the CQSS. More detailed recommendations about this phase are outlined below, following the review of other phases.

Phase 3: Develop assessment model & tools to evaluate trainee/employee competence

Suggested time frame: 7/1/09-3/31/10

The capacity to evaluate the knowledge, skills, and attitudes of trainees and employees on the Alaska Core Competencies will be essential if their value is to be realized. Without practical, reliable, and valid methods of

assessment, the impact of training or the capacity of employees to perform their duties cannot be determined. Assessment tools are also an essential precursor to a competency-based credentialing approach. It is recommended that the CQSS initiate and manage this process as soon as the Alaska Core Competencies are complete.

Phase 4: Develop standardized curriculum and training modules

Suggested time frame: 7/1/09 – 6/30/11

With the core competencies identified, it is both possible and critical to develop a standardized curriculum and to strengthen existing curricula used to train this workforce. Training modules built around the core competencies should be developed and made readily available to trainers and educators in Alaska who also would receive continuing education and support regarding the use of “evidence-based teaching methods” to implement the curricula. It is recommended that the Alaska Mental Health Trust Authority work to ensure that responsibility for this agenda be assumed by a consortium of groups and organizations that might include: the University of Alaska system, professional associations, and other training organizations. This agenda might be coordinated through the Training section of the Workforce Development Focus area, but is likely not the purview of the CQSS.

Phase 5: Develop credentialing system

Suggested time frame: 4/01/10 – 3/31/11

With the competencies identified and assessment methods and tools created, a state-wide credentialing system focused on these competencies could be developed. This would be a voluntary system with levels that range from an entry level “registration” credential to higher level “certification”. For the credentialing system to have impact, efforts must be initiated to promote support of credentialing by employers and payers. Employers must be encouraged to provide the types of work-place based learning opportunities and supervision that qualify an employee for credentialing and give preference to credentialed applicants for positions. Most critically, an increased credential level must directly or indirectly lead to increased compensation and job opportunities. An absence of such incentives will lead to the credentialing process being viewed as a meaningless burden. Oversight of the development of a credentialing system falls within the charge of the CQSS.

Phase 6: Develop specialty competencies

Suggested time frame: 7/1/09 – 6/30/11

There are competencies unique to each job classification or job “family” (e.g. addiction treatment). Once the core competencies are developed, the specialty competencies for entry level practice in different sectors of the health and human service field should be identified in order to strengthen employee performance and the quality of care provided. The existence of the core competencies should narrow and limit the number of specialty competencies that must be identified and trained, making these tasks easier for each sector. It is likely that much of the specialty training will occur through workplace-based learning. Since this scope of work relates closely to training initiatives, it is recommendation that coordination of these efforts fall within the Training section of the Workforce Development Focus Area, but outside of the CQSS.

Developing the Alaska Core Competencies

The review of the competencies and the literature on competency development generated a series of recommended strategies for Phase 2 in which the Alaska Competency Model is developed. These are outlined below:

1. Restrict the focus of the Alaska Core Competency Model to positions involving community-based care. This could be defined to include residential and shelter care positions. However, it would exclude positions related to inpatient and correctional facility services, as the focus on “command and control” in these settings generates a competency set that is dissimilar to community-based positions.

2. Utilize existing national competency sets as the primary resource in building the Alaska Core Competency Model. Extensive competency has been completed for numerous disciplines using DACUM processes, expert panels, literature reviews, key informant interviews and surveys. It would be impractical and cost prohibitive for Alaska to conduct original research on all of the job families to build its core competency model from original source data. The publicly available detail in these national models could serve as the source data for Alaska's model, with the resulting product tailored to Alaska's unique service and workforce needs.
3. Many of the Alaskan competency models were derived from national competency sets. However, the Alaskan models should be reviewed to identify any unique characteristics that need to be imported into a cross-disability Alaska Core Competency Model.
4. In terms of specific methodology for the competency development, the following steps are proposed:
 - a. Establish a final set of Master Competency Domains by establishing inter-rater reliability of the master domains identified in a preliminary fashion in this review.
 - b. Using multiple raters/judges, place the individual competencies from the national models into the Master Competency Domains.
 - c. Using multiple raters/judges drawn from varied job family sectors, rate each competency on frequency, importance, and criticality.
 - d. Using the findings from these ratings, reduce the competencies within each set to a manageable/practical number.
 - e. Using experts and exceptional employee from each job family in Alaska, develop behavioral descriptors for each competency at three levels: Exceptional (expert), Acceptable (minimum), and Unacceptable level. This provides the tools necessary for educational and credentialing programs, which can only test to a minimum level of competence, while highlighting an optimal level of competence to which each individual can aspire.

In developing the behavioral descriptors, focus principally on skills. While knowledge and attitudes are extremely important, the behavioral manifestations of these should be identified in the descriptors as behavior or performance constitute the desired workforce outcome.

INTRODUCTION

Access to health and behavioral health services in Alaska is seriously challenged by shortages across the professional and paraprofessional workforce. For example, Alaska will face a 47.3% increase in the need for behavioral health professionals by 2010.¹ Problems in recruitment, retention, and training are pervasive. Recruitment efforts tend to be costly while vacancy and turnover rates remain high. Limited incentives and resources available to support and retain the workforce once they are hired. Training does not always prepare providers with the knowledge and skills needed to work effectively with different populations. Alaska shares these problems with other rural and frontier states, but has a greater challenge given the diversity of populations and their wide dispersion across the vast landmass of the state.

Workforce Development is one of five major focus areas of Trust activities, deemed by the Trustees to be an important issue to address in Alaska. In partnership with the Alaska Division of Behavioral Health and the University of Alaska System, the Trust is spearheading initiatives that build on and further integrate systematic behavioral health workforce development efforts that have been occurring since 2003.

Strategic planning meetings sponsored by the Alaska Mental Health Trust Authority (The Trust) held in the first half of 2006 resulted in the identification of three primary areas of activity within the Workforce Development Focus Area: retention, recruitment, and training. Each has several projects focused on achieving specific goals. This report focuses on the activities of Training Committee. More specifically, this report is a product of the Credentialing and Quality Standards Subcommittee (CQSS), which has the primary goal of supporting the development and coordination of competencies and credentialing for the direct care workforce in the state.

The mission of the CQSS is to strengthen the direct care workforce in a broad range of health and human service sectors by developing a core set of competencies and a credentialing system that is built on those competencies. To foster the mission, this phase of work involved a review of competencies used nationally and in Alaska for the non-medical direct healthcare positions serving Trust Beneficiary Groups.² Clarifying the core competencies that are shared among these positions is intended to facilitate the acquisition of relevant knowledge and skills among the workforce through more focused, competency-based training, yielding a stronger workforce for employers and enhanced quality of care for Trust beneficiaries. The development of credentialing processes is intended to increase the professionalism and professional recognition for employees and expand their career opportunities.

This report provides: 1) a brief background of national, regional, and state-level workforce development initiatives; 2) further description of the CQSS project in terms of goals, objectives, and desired outcomes; 3) an overview of competencies; 4) clarification regarding certification, credentialing, and related concepts, 5) an overview of national resources regarding competencies and credentialing processes, including a comparison or “crosswalk” of those competencies; 6) an overview of Alaskan competencies, credentialing processes, and a similar comparison or “crosswalk”; and 7) a summary of findings and recommendations regarding a phase approached to the next steps in pursuing the CQSS mission.

NATIONAL, REGIONAL, AND ALASKA WORKFORCE INITIATIVES

The national crisis regarding the behavioral health workforce was the focus of national stakeholders group convened in Annapolis, Maryland in September of 2001. Leaders from across the nation, including WICHE, met to define the nature of the problems and strategies to address them. This meeting led to the formation of the Annapolis Coalition on the Behavioral Health Workforce, which has led a multi-year effort to promote planning and action to address this crisis.

The *President's New Freedom Commission on Mental Health*, which released its report in 2003, described the significant workforce problems facing mental health systems throughout the country. Indications are that workforce shortages in this field will become more severe in the next decade, and that providers will be challenged to acquire new skills, particularly for working in a more collaborative or integrated manner with other sectors of the health and human service system. Workforce trends involve a complex combination of inter-related issues such as demographic changes (e.g., aging population), shifts in financing structures (e.g., Medicaid), and innovations in care (e.g., evidence-based practice, technology-based solutions).

Different agencies and organizations within Alaska have worked for many years to recruit and retain a skilled behavioral health workforce. However, several regional and national initiatives have helped the State clarify and move forward with its workforce improvement agenda.

The Health Resources and Services Administration (HRSA) provided funding for a Mental Health roundtable on rural mental health workforce issues facilitated by the Western Interstate Commission for Higher Education (WICHE). The meeting was held in Reno, Nevada in September, 2003 and included leaders in mental health and higher education, as well as legislators from WICHE member states who shared perspectives on workforce shortages in the West. This meeting focused on the implications of these shortages and a discussion of possible solutions. The product of this meeting was a broader understanding of the multilevel contexts in which rural and frontier workforce shortages exist nationally, regionally, and in particular states, as well as potential solutions.³ Recommendations focused on:

1. Identification of regional strategies and mechanisms to address critical mental health professional shortages in rural and frontier areas of the WICHE West;
2. Action planning for cross-sector, inter-institutional, and interstate collaborative action to expand access to professional training to improve the supply of critical mental health professionals in frontier areas; and
3. Exploring opportunities for regional integration and coordination of funding strategies to support mental health professional training to promote frontier practice.

Formal work on these issues in Alaska was initiated by the University of Alaska in December, 2003. Faculty in behavioral health disciplines from both the Fairbanks and Anchorage campuses met to discuss important issues and goals related to developing the workforce. The WICHE Mental Health Program conducted key informant surveys of faculty and facilitated the December meeting, then helped organize and facilitate the *Alyeska Summit* in May, 2004, which resulted in the identification of specific workforce development goals and support of over one million dollars for these efforts.⁴

A particular strength of the Alaska approach was using a data-driven decision making process. University faculty involved in the partnership, with the help of WICHE, synthesized data regarding behavioral health professional shortage areas, workforce projections, student totals in all behavioral health programs and projected graduates, as well as macro-level trends such as the number of people projected to enter versus leave the workforce by 2025. The data helped clarify workforce trends, areas of need, and served to focus decision-making.

At the national level, the Substance Abuse and Mental Health Services Administration (SAMHSA) contracted with the *Annapolis Coalition* to lead a multi-phase process culminating in a consensus-based national Action Plan for Behavioral Health Workforce Development.⁵ The plan was sponsored by all SAMHSA Centers (CMHS, CSAT, CSAP) and encompassed workforce issues for substance use disorders, mental illnesses, and co-occurring disorders from the

perspective of prevention, treatment, resilience, and recovery. While the planning process and resulting report released in 2007 sought to identify common issues, it also respected the unique needs of each specialty area, including rural behavioral health.

Simultaneous to the Annapolis Coalition’s planning, the WICHE Mental Health Program received funding from SAMHSA to sponsor a conference to bring together public mental health system and higher education stakeholders to enhance efforts to address rural mental health professional shortages. The meeting, called “Building Partnerships in Rural Mental Health Workforce Development,” was held in Mesa, Arizona in March 2005. WICHE partnered with the Annapolis Coalition at this meeting to help craft the workforce development strategies applied to rural and frontier areas. A formal process was undertaken at the meeting to identify recommended strategies related to rural and frontier areas.⁶

Alaska’s Workforce Development Efforts

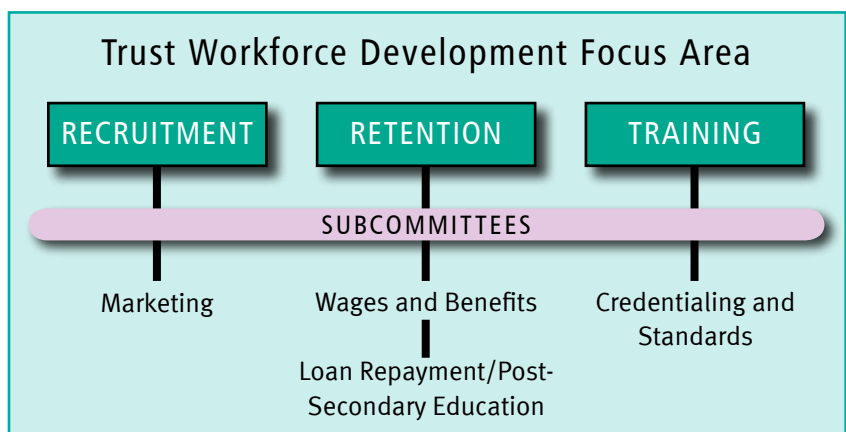
Representatives of the State of Alaska participated in all of the rural-focused meetings described above while continuing their independent workforce development efforts. Indeed, Alaska has in many ways been on the cutting edge of workforce development nationally. Another example of this initiative occurred in January, 2006 when the Alaska Mental Health Trust Authority (The Trust), in partnership with the Alaska Division of Behavioral Health and the University of Alaska System, brought stakeholders together to further examine and discuss the workforce trends and demands in Alaska, including recruitment, retention, education, training, and career opportunities.

The Alaska Mental Health Trust Authority, referred to simply as “The Trust,” was established in 1956 to provide leadership in advocating for, planning, implementing, and sustaining a comprehensive and integrated system of mental health services in Alaska. The Trust serves people with mental illnesses, developmental disabilities, chronic alcoholism, Alzheimer’s disease and related disorders, and traumatic head injury resulting in permanent brain injury. These groups are referred to as the Trust beneficiaries.⁷ This unique partnership in this project involving a non-profit Trust, higher education system, and a State division has demonstrated the commitment within Alaska to collaboratively addressing the workforce development issues impacting Trust beneficiaries.

While this project builds on the extensive history of Alaskan workforce development efforts in behavioral health, it broadened this focus to include the range of health and human service sectors that serve Trust beneficiaries. These service sectors, which are identified in a subsequent portion of the report, have direct support workers who are similar, in many respects, to those in behavioral health. Effective care of Trust beneficiaries requires strengthening the workforce across all these sectors. Thus, the search for core competencies and credentialing approaches was broadly inclusive of Alaska’s direct care workforce.

The Trust, along with leaders at the University of Alaska, the Division of Behavioral Health, and other community stakeholders clarified its priorities for the Workforce Development Focus Area through strategic planning meetings with stakeholders in January, 2006 and May, 2006. The goal of this Focus Area is to create a competent workforce serving Trust beneficiaries through strategies intended to improve recruitment, retention, and training. Focused workgroup planning occurred for one year prior to the allocation of funds in July 2007 to support the work.

Three formal committees – Recruitment, Retention, and Training – were created to address specific workforce issues. Each of these workgroups will be briefly described below.



Recruitment Focus Area

The primary goal of the Recruitment Focus Area is to increase the number of qualified people recruited into positions that serve Trust Beneficiaries. There are several projects underway to achieve this, including a “Grow Your Own” initiative and the Alaska Alliance for Direct Service Careers (AADSC).

Retention Focus Area

The primary goal of the Retention Focus Area is to improve incentives and the support of qualified employees that serve Trust Beneficiaries. The workgroups and projects identified to achieve such goals include the Student Loan Repayment Program Subcommittee, the Wages and Benefits Review Subcommittee, the Technical Assistance and Training Pilot.

Training Focus Area

The primary goal of the Training Focus Area is to improve access to and increase the amount of education and training offered to both the current and future workforce. Five groups or projects are underway in this area, including a Training Cooperative, Support for Existing Effective Education and Training Programs, Support for Geriatric Education and Training Project, Interdisciplinary Education in Children’s Mental Health, and the Credentialing and Quality Standards Subcommittee (CQSS).

CREDENTIALING AND QUALITY STANDARDS

As part of the Training Focus Area, the goal of the Credentialing and Quality Standards Subcommittee (CQSS) is to support the development and coordination of competencies, credentialing, and standardization processes for direct care workers in the state. Members of the CQSS, drawn from diverse workforce fields, identified a vision statement and a number of specific goals for the project. Background information and the vision and goals are presented below.

Alaska Workforce Problem and the CQSS Strategy

Access to health and behavioral health services in Alaska is seriously impeded by shortages across the professional and paraprofessional workforce. Alaska shares this problem with other rural and frontier states, but workforce challenges are magnified by the diversity of individuals in the state and their wide dispersion across the vast landmass of Alaska. The direct care workforce across service sectors serving Trust beneficiaries is also significantly diverse. It appears that competencies (i.e., a set of skills required to perform a job) for these paraprofessional positions are not well-defined. There exists no formal structure for these individuals to get trained or oriented for their respective positions. Additionally, one would expect a considerable amount of consistency in the competencies required for direct care positions across the various job families representing different workforce sectors (e.g., mental health, developmental disability).

Current CQSS Goals

The goal of the CQSS is to identify a core set of competencies for a targeted number of non-medical, direct care workers or occupations serving Trust beneficiary groups. It is not uncommon for competency sets to be developed for specific direct care positions; however, they mostly exist in a particular service sector, are not clearly defined, and are without adequate connection to any recognized credential or workplace incentive. The identification of core competencies that are shared among these positions will be helpful both to employers and to individual direct care workers in defining key job responsibilities. It is anticipated that this core set of competencies will inform training and curriculum development for this level of professional leading to the acquisition of relevant knowledge and skills. Training tied to these competencies would then facilitate a more standardized approach to training direct care workers across employers. The composition of workers and the populations served by these workers are varied, making it crucial that training be accessible, affordable and culturally sensitive. Ultimately, the goal would be to institute a formal credentialing or certification process to recognize these individuals for their ability to demonstrate a set of required skills in their respective work environment and to provide expanded career opportunities for this sector of the workforce. The optimal system would offer individuals multiple routes to certification (e.g., workplace-based learning, University coursework, etc.) and reciprocity between different systems.

CQSS Process Objectives

The vision identified by larger Workforce Focus Area and endorsed by the CQSS is stated below.

By 2015, Beneficiaries of the Alaska Mental Health Trust shall have access to a capable, culturally competent workforce to support their communities and families across the life span.

Toward this vision, the CQSS, a group of over twenty individuals representing workforce sectors serving Trust beneficiaries (see page 3 for a list of subcommittee members), met in December, 2007 to clarify the scope of work and to gain consensus on project goals. Due to the complexity of this process, the CQSS identified activities for the first phase (i.e., Phase One - December, 2007 through June, 2008) of a multi-year, multi-phase project. As one of its first activities, the CQSS identified job families (e.g., mental health, long-term care) in Alaska on which this project would focus. The external consultants noted in the next section conducted a review of existing competencies in Alaska and nationally for the broad range of non-medical direct healthcare service positions serving Trust beneficiaries.

Consultants also researched and reviewed existing credentialing and certification procedures for the identified occupations in Alaska and nationally. The consultants then developed and analyzed a matrix that “crosswalked” the local and national competency domains with the job families. The result of the crosswalking process was a set of recommendations regarding the development of a core set of competencies for direct care workers serving Trust beneficiaries. These recommendations can be found at the end of this report.

Stakeholders also identified desired long-term outcomes for this project. As the table below displays, there are four areas of outcomes: employee-level, employer-level, state-level, and the Trust Workforce Development Focus Area. This should not be considered an exhaustive list of all desired long-term outcomes, but it does highlight some essential outcomes that would indicate a successful initiative.

Desired Long Term Outcomes

Employee Level	1	Improved and ongoing training will be available for the direct care workforce serving Trust beneficiaries.
	2	Increased sense of professionalism among direct care workforce.
	3	Improved career flexibility and ladders including multiple paths to credentialing or certification (i.e., employees will understand what training and what options are available).
	4	Enhanced financial aid and non-financial incentives for continued learning.
Employer Level	1	Employers will have a better prepared workforce.
	2	Improved retention of the workforce serving Trust beneficiaries.
	3	Reduced duplication and complexity in navigating the training and education system.
State of Alaska	1	Promotion and increased understanding of the concept of “universal worker.”
	2	Reduction of duplication and increase communication across systems serving Trust beneficiaries.
	3	Creation of an iterative process between funding streams and the credentialing practices.
	4	Establishment of a unified “Board” or “Commission” that monitors when standards need to be changed with necessary legislative backing (e.g., via statute).
Trust Workforce Development Focus Area	1	Inform the work of the Training Cooperative (e.g., clarify the training needs for specific occupations).
	2	Benefit to other Trust workforce development workgroups (e.g., Wages and Benefits Subcommittee can use information from this project to inform the legislature on how competency standards can improve workforce capacity and can be tied to employer employee incentives).

Note: These are anticipated outcomes by the conclusion of this project. However, realistic re-assessments of the progress made within our projected time period (e.g., by 2010) need to be conducted at regular intervals throughout the project to determine concrete progress and to delineate how outcomes are measured.

External Consultants

External consultants to the Subcommittee are the WICHE Mental Health Program and the Annapolis Coalition on the Behavioral Health Workforce.

WICHE Mental Health Program: The WICHE Mental Health Program has been working with states to address rural workforce development issues since its inception in 1955. WICHE’s mission is twofold: 1) to assist Western states in the improvement of systems of care for persons with mental illness and their families; and 2) to advance the preparation of

a qualified mental health workforce in the West. In pursuing these objectives, the program has developed considerable expertise in rural policy research, program evaluation, needs assessment, strategic planning, and other technical assistance designed to assist public mental health systems. WICHE has been involved in Alaska-based workforce development issues prior to the Aleyska Behavioral Health Summit in 2003.

Annapolis Coalition on the Behavioral Health Workforce: The Annapolis Coalition is committed to improving the recruitment, retention, and training of the workforce for prevention and treatment of mental and substance use conditions. It is the most widely recognized policy and consultation organization on these issues within the United States. The mission of the Annapolis Coalition is to build a national consensus on the nature of the workforce crisis and to identify, disseminate, and implement strategies to strengthen the workforce.

During this phase of the project, the consultants served the primary function of performing a national search of existing competencies and associated systems of credentialing related to all (non-medical) direct healthcare service positions. This report is the result of that work. However, the consultants also provided 1) expert guidance and assistance with the development of the strategic plan for the standardization and coordination of credentialing and certificate level programs within the State of Alaska; and 2) continuing expert consultation to the Committee during the implementation phase.

WICHE and the Annapolis Coalition have conducted research on Alaska and national competencies and certification processes. They developed a methodology to “crosswalk” the Alaska competencies with national resources and will identify and present recommendations to the CQSS by the end of the fiscal year 2008.

The life expectancy for the Committee will be September 2007 thru June 2009. The Committee will meet approximately seven times per year, which shall include at least three face-to-face meetings each year with the full membership and the research consultant(s) from WICHE and the Annapolis Coalition.

BACKGROUND ON COMPETENCY DEVELOPMENT

Overview of Competency Development

The “competency” of individuals who provide health and human services has received increasing attention over the past decade (Joint Commission on Accreditation of Healthcare Organization [JCAHO], 2000). As a concept, “competency” seems critical and compelling. However, the tasks of building and assessing competence are quite complex (Hoge, Tondora, & Marelli, 2005).

Numerous forces have converged to create the recent focus on competencies. Public and private payors have become increasingly concerned about the capacity of the workforce to provide effective care. Additional concern was created by data indicating that there is wide variation in practice patterns among the workforce and frequent failures to deliver care that is evidence-based or compliant with practice guidelines.

Concerns about workforce competency 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 reports emphasized the large number of errors in care that harm patients, the characteristics of systems of care that hamper efforts of the workforce to deliver care effectively, and the lack of access, relevance, and effectiveness that too often characterizes the education and training systems that are responsible for preparing the workforce. Finally, the increase in consumerism in healthcare has highlighted the lack of preparation for the workforce to deliver care that is person-centered, family driven, and centered on shared–decision making.

Historical Origins

The concept of competencies has distant origins. Thousands of years ago the Chinese recognized differences in individual abilities and employed civil service exams in selection for government jobs. Apprenticeships constituted a common approach to skill development in medieval times. Educators have historically defined the knowledge and skills inherent in their curricula. Objective testing to assess intellectual capabilities emerged in late 1800s.

The 20th Century witnessed an explosion of research focused on analyzing supervisor behavior, performance factors, and predictors of positive performance. Assessments of aptitude, tests of knowledge, grades, and credentials were increasingly recognized as poor predictors of job performance. In 1978, the *Uniform Guidelines on Employee Selection Procedures* were issued by the federal government and required that worker selection be based on job-related qualifications, derived from an analysis of work behaviors and desired work outcomes. Harvard psychologist David McClelland and his colleagues pioneered methods in which workers deemed successful in their jobs were compared with those deemed less successful.

Four Approaches to Competencies

Four different approaches have emerged for competency identification and development. The Industrial-Organizational Psychology framework emphasizes the job rather than the performer. Job duties and tasks are identified and job incumbents and their supervisors are asked to clarify the knowledge, skills, abilities, and personal characteristics needed to perform each task. All levels of performers are included in this process and are not differentiated in terms of their capabilities. This approach tends to yield long and detailed lists of knowledge, skills, abilities and personal characteristics.

The Differential Psychology model focuses on differences between superior and other performers. Rather than examining required knowledge and skills, the emphasis is on physical and cognitive abilities, values, interests, and personality traits. Competencies are considered to be largely innate and difficult to develop. This approach is often used to select individuals for leadership positions.

In the Educational Psychology approach, the competencies required for successful job performance are identified and the emphasis is on developing individuals so they will be successful. Differences between individuals do not receive much attention. There is an emphasis on teaching knowledge and skills, while also developing more complex abilities and personal characteristics that are desirable for job.

The Human Performance Technology (HPT) approach focuses on organization strategies that maximize the performance of employees. Exemplary performers are identified and studied. Factors that contribute to the success of these exemplary performers are then applied to helping other employees build competencies and excel. This approach is often used as the foundation for organizational development and design initiatives, process improvement, training and development programs, performance management, and implementation of incentive systems.

Definition of Competency

There is often a lack of consensus about the definition of competency and its various elements. The same term may carry different meaning in different competency approaches or models. The particular terms are not important in and of themselves. What is essential is consistency within a group or organization in the use of the terms.

Based on a review and integration of published works on the topic, Hoge, Tondora, and Marrelli (2005) offered a definition of the competency construct and four elements of competency.

“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 **KSAPs** (*knowledge, skills, abilities, and personal characteristics*) as the elements of competency. **Knowledge** is awareness, information, or understanding about facts, rules, principles, guidelines, concepts, theories, or processes needed to successfully perform a task. A **skill** is a capacity to perform physical or mental tasks **with a specified outcome**. An **ability** is a demonstrated cognitive or physical capability to successfully perform a task with a **wide range of possible outcomes**. **Personal characteristics** involve work habits or behavioral patterns that contribute to effective work performance. These are at times referred to as attitudes, values, or traits. To be most useful, an individual competency is usually described by a cluster of knowledge, skills, abilities, and personal characteristics that are required for effective performance.

Competency Models and Their Utility

Individual competencies are grouped and organized into a competency model that contains the required competencies for a job. The term “core competencies” generally refers to everyone in an organization or field. “Job family competencies” apply to everyone providing a particular type of service, working with a specific population, or in a specific setting. “Level competencies” are tailored to each job level within a job family.

The active use of competencies in workforce development creates a culture in which individual skills and individual growth are valued. Clear competency models inform employees about the requirements of their positions and inform educators about the optimal content of orientation and training curricula. Competencies can guide workforce planning, employee selection, personnel evaluation, performance management, employee development, succession planning, compensation systems, and reward and recognition programs.

Competency Modeling Strategies

There are multiple approaches to competency development. Marrelli, Hoge, and Tondora (2005) have summarized the key steps in the process and these are summarized briefly below. As a caveat, it is important to highlight the legal implications of applying competency models. If used to make employment decisions of any nature, the competency development process must adhere to rigorous standards. Employment decisions include hiring, promotion, re-assignment, evaluation, compensation, termination, selection for training that could lead to promotion, and certification.

The ability to defend such decisions depends on the reliability and validity of the competency model. The federal Uniform Guidelines on Employee Selection Procedures (1978) provide detailed guidance on the requirements for validation of instruments used in personnel decisions. Further, it is important to distinguish between the competencies that are “essential” and “non-essential” for job performance as the Americans with Disabilities Act (ADA) is designed to ensure that qualified persons with disabilities have the same access to employment as persons without disabilities and are not excluded due to an inability to perform non-essential disabilities (Marrelli, 1994; Federal Register, 1991).

Overview of the Competency Modeling Process

There are seven steps in the competency development process. The first involves creating a clear definition of the objectives. Given the multiple potential uses of competencies, as described above, the purpose and application of the competencies must be clarified.

The second step involves obtaining support of a sponsor for the project, including any required resources. This is followed by implementation of a communication strategy to the sponsor and key project stakeholders with periodic updates on progress.

The fourth step involves planning the methodology for competency development, including the data collection strategies and the workforce sample. In the fifth step the data is collected, analyzed, and organized into a competency model.

The final two steps in the process involve application of the competency, followed by its evaluation and a plan for subsequent revision if required.

The most critical decision points focus on the methodology. Data for competencies can be derived from job incumbents, supervisors, and clients. Exceptional performers are often considered the best informants, but information can be gained by comparing the information they provide with the perspective of average performers. Workers from different levels are required if the competency model is to detail competency by level.

Competency models are strengthened by the use of multiple data collection strategies. Approaches vary in their reliability, validity, and efficiency, practicality, and the extent to which participants will find them acceptable. The most common sources of data include: literature reviews, focus groups, expert panels, surveys, observations of employees, work logs, structured interviews, and behavioral event interviews. In the latter method, individuals are interviewed about what they did, thought, said, and felt in challenging or difficult situations. The competencies that appeared to be instrumental in their success are extracted from their stories.

Conclusion

The development and use of competencies is a complex endeavor. The project must be carefully planned and adequately supported, with systematic efforts to communicate routinely with those involved or potentially affected. Multiple methods of data collection should be used to define a job and build a competency model, with a focus on the reliability and validity of the information collected. The model should be applied, evaluated, and revised periodically.

BACKGROUND ON CERTIFICATION AND CREDENTIALING

For this project, certification is considered the pathway (i.e., steps, processes) toward achieving a credential for direct care workers. The differences between certificates, certification, and credentialing are discussed in this section.

Definition of Certification

Certification represents a declaration of a particular individual's professional competence.⁸ It acknowledges the acquisition of knowledge, experience, and specialized skill-sets for practitioners in a particular field.

The National Organization for Competency Assurance (NOCA) lists a number of the benefits of certification, which include:

- ▶ Higher wages for employees in the form of bonuses, education assistance or higher salary.
- ▶ A more productive and highly trained workforce for employers.
- ▶ Prestige for the individual and a competitive advantage over non-certified individuals in the same field.
- ▶ Enhanced employment opportunities.
- ▶ Assisting employers in making more informed hiring decisions.
- ▶ Assisting consumers in making informed decisions about qualified providers.
- ▶ Protection of the general public from incompetent and unfit practitioners.
- ▶ Establishment of a professional standard for individuals in a particular field.

Overview of Certification

Most definitions indicate that that a competency involves the acquisition and application of knowledge, skills, or attitudes that enable one to effectively perform the activities of a given occupation or function to the standards expected in employment. Typically, competency is achieved through training in the classroom and, just as often, on-the-job. Additionally, recognition of competency achievement takes different forms. One can earn a certificate, certification, an undergraduate or graduate degree, or licensure. Each of these formal recognitions brings particular benefits, such as the ability to practice specific treatments or be reimbursed for services at a higher rate.

Understanding the differences between different types of formal recognition for competency development can highlight relative advantages or disadvantages to implementing one type or another. To this end, the table below indicates basic differences between a certificate and certification in a given area of knowledge and practice.

Certificate	Certification
Results from an educational process.	Results from an assessment process that recognizes an individual's knowledge, skills and competency in a particular specialty.
For newcomers and experienced professionals.	Typically requires professional experience.
Awarded by educational programs or institutions often for-profit.	Awarded by a third-party, standard-setting organization, typically not for profit.
Indicates completion of a course or series of courses with a specific focus (different from a degree granting program).	Indicates mastery/competency as measured against a defensible set of standards, usually by application or exam.
Course content determined by the specific provider or institution, not standardized.	Standards set through a defensible, industry-wide process (job analysis/role delineation) that results in an outline of required knowledge and skills.
Usually listed on a resume detailing education.	Typically results in credentials to be listed after one's name (LNCC, ONC, CCRN).
Demonstrates knowledge of course content at the end of a set period in time.	Has on-going requirements in order to maintain; holder must demonstrate he/she continues to meet requirements.

<http://www.aalnc.org/edupro/certificate.cfm>

As the table indicates, a certificate program is usually an educational offering that confers a document at the program's conclusion, whereas a certification generally refers to an earned credential that demonstrates the holder's specialized knowledge, skills, and experience. While gaining specialized knowledge at the certificate level may produce a more qualified practitioner, it may not include an applied component to demonstrate knowledge gain. It also may not have a further reward attached to it, which limits the motivation to pursue that education. In other words, many people may see it simply as a "hoop" that must be jumped through. Certification, on the other hand, typically has rewards attached to it as it includes the applied component and requires that one demonstrate competency.

Although there is not a single set of certification standards used across all professions in America, the National Organization for Competency Assurance (NOCA)⁹ does use a standard process of accreditation of the certification processes used by a wide range of organizations. At present, they accredit the certification programs of 87 major organizations¹⁰ using the National Commission for Certifying Agencies (NCCA) Requirements. The NCCA's mission is to help "to ensure the health, welfare, and safety of the public through the accreditation of a variety of certification programs/organizations that assess professional competency."¹¹

The NCCA *Standards for the Accreditation of Certification Programs* have 21 standards organized into five categories to which a given credentialing program must adhere. The categories and their related standards are presented in a table in Appendix A.¹² One can review these standards to get a clearer sense of what general certification processes might include.

Certification vs. Credentialing

Definitions of the terms certification and credentialing vary depending on the profession or workforce sector in which they are operationalized. However, there is also considerable overlap in these definitions, so confusion is understandable.

Included here is a list of some commonalities and distinctions between certification and credentialing. There is not consensus on the boundaries of these definitions as they are often defined in context-dependent situations. Therefore, the information provided below are some general common distinctions between certification and credentialing and should not be viewed as an exhaustive list.

1. Both are formal acknowledgements or attestations, usually in writing, by a third or outside party that someone has the requisite knowledge, skills, etc. to do something.
2. Both can involve the taking of an exam, but in some cases an exam taken for a certification would be one step in the process of gaining a credential.
3. As indicated in #2, certification can be a step in the process of achieving the credential. If it is not, it is still a formal recognition of specialty knowledge and skill (and may augment a credential already possessed).
4. Obtaining a credential also means that the professional commits to a professional code of ethics.
5. Professional credentials are designed to be portable, meaning that a credentialed professional will be recognized for their skills and knowledge wherever they choose to work.¹³

It appears that efforts to promote credentialing of direct support workers have been slow to gain ground. Anecdotal evidence, however, suggests that professions that have introduced credentialing, such as addiction counseling, child care, Certified Nursing Assistants, have seen significant increases in wages. Employers managing service agencies seem to increasingly understand that a livable wage will be essential to solving their workforce problems and that workforce certification is more likely to result in governmental increases in payments, in contrast to the annual and often unsuccessful struggle for cost of living adjustments (COLAs) in payments to provider agencies.

NATIONAL RESOURCES

Current Competencies for Identified Job Families

Competency and certification development for health and human service positions has been occurring across the nation for at least over a decade. This work has been funded by federal and state agencies, foundations, and professional associations. The products of these efforts vary significantly in terms of their depth, quality, dissemination, accessibility, and impact. Previously, no comprehensive review across health and human service sectors or job families has been conducted.

Given their potential value to Alaska in its workforce development effort, a systematic effort was made to identify competency sets and credentialing procedures relevant to the job families being examined in this project. Where possible, resources that are recognized and implemented nationally were selected to represent the state of the art for competency development and credentialing relevant to the job families under study. Less developed and less visible resources were typically of lesser quality and utility and, therefore, not summarized.

The resources summarized below were identified by members of this CQSS, staff of the Annapolis Coalition and WICHE Mental Health Program, and other experts who were surveyed as part of this review. The information about the competency sets and credentialing procedures was obtained through the review of published reports, web-based materials, and interviews of key informants. Competency and credentialing materials tend not to be well described in print. Therefore, this project required an effort to pull disparate sources of information together to assemble the picture puzzle of competency development and credentialing systems that exist in health and human services for a direct care workforce. The puzzle may never be complete but a blueprint has emerged that will convey to the reader the key elements of these systems in this country.

In describing each competency set and credentialing system an effort was made to find and report the following information if available:

- ▶ Identifying information for the resource
- ▶ Identity of the developer
- ▶ Brief history (e.g., origins, revisions)
- ▶ Relevance to the direct care workforce
- ▶ Availability (public domain or proprietary)
- ▶ Organization and content (e.g., competency domains, certification levels)
- ▶ Methods of development
- ▶ Use and impact

The review of these national resources is organized by the job families outlined below. This provided the most logical flow, since some of the resources described first in this review, served as foundations for resources described in later sections.

- I. General and Cross Sector
- II. Behavioral Health
 - a. Addictions
 - b. Adult Mental Health
 - c. Co-Occurring (Mental and Addictive Disorders)
 - d. Peer Support
 - e. Child Mental Health
- III. Child Development
- IV. Developmental Disabilities

- V. Traumatic Brain Injury
- VI. Long Term Care
- VII. Juvenile Justice

Within each section, competency resources were summarized first, followed by a description of credentialing for that job family. In some cases the competencies and credentialing systems are related, having been developed by the same organization. In other instances they are largely unrelated. Below is a list of the resources reviewed in each job family section:

	Competencies	Credentialing
General and Cross Sector	Community Support Skills Standards	U.S. Department of Labor Registered Apprenticeships
Addictions	TAP-21 Addiction Counseling Competencies	International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse
		NAADAC Credentialing
Adult Mental Health	USPRA Role Delineation Study	USPRA Certified Psychiatric Practitioner
Co-occurring (Mental and Addictive Disorders)	SAMSHA/CSAT TIP 42 Intermediate Competencies	International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse
Peer Support	Illinois Recovery Support Specialist, Role Delineation Study	Illinois Certified Recovery Support Specialist
Child Mental Health	Michigan Association for Infant Mental Health Competency Guidelines	MI-AIMH Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health
Developmental Disabilities	National Alliance for Direct Support Professionals Competencies	National Alliance for Direct Support Professionals Credentialing
Traumatic Brain Injury	None	American Academy for the Certification of Brain Injury Specialists (AACBIS)
Long Term Care	Paraprofessional Healthcare Institute Competencies and Skill Standards	Federal Guidelines for Home Health Aide (HHA) Certification
Juvenile Justice/ Corrections	National Institute of Corrections Competency Profile	American Correctional Association Professional Certification Program

I. General and Cross Sector

Competencies

Community support skills standards

The national search for competencies revealed one set that was specifically designed to be applicable to direct care providers **throughout human services**. It is of considerable relevance to the mission of the Credentialing and Quality Standards Subcommittee, which similarly is looking at core or generic core competencies rather than those specific to an area of work. Released in 1996, the document generated by this project was titled *The Community Support Skills Standards: Tools for Managing Change and Achieving Outcomes – Skill Standards for Direct Service Workers in the Human Services* (Taylor, Bradley, & Warren, 1996). The title “Community Support Human Service Practitioner” was adopted to reference a front-line employee irrespective of job title, work setting, or population being served, excluding only those roles that were principally administrative, institutional, or custodial in nature.

The development of these competencies was led by the Human Services Research Institute (HSRI), which is an organization that provides technical assistance to state and federal government in an effort to improve the lives of

persons with mental, physical, and developmental disabilities. The project was funded by the U.S. Department of Education through its Office of Vocational and Adult Education for the purposes of fostering:

“... the adoption of national, voluntary, skills standards for direct service workers, to increase both horizontal and vertical career opportunities for human service personnel, and to create a foundation for a nationally recognized, voluntary certification of direct services practitioners. The project is based on the assumption that the development of skill standards in the human service field is a critical step toward strengthening educational and training programs, improving responsiveness to service participants, increasing the marketability of workers, and enhancing the effectiveness and quality of services” (pg 1).

The excerpt from the report conveys a striking similarity to the mission and objectives of Alaska’s CQSS.

This initiative was part of a national skills standards movement promoted by the U.S. Departments of Labor and Education and the National Skills Standards Board (NSSB), which was established by Congress in 1994 but is now defunct. *Health and Human Services* was one of 15 U.S. industry sectors identified by the NSSB that were to be the focus of standardized skills standards, assessments, and certifications. The NSSB model emphasized convening broad coalitions to development standards, and HSRI convened a diverse technical committee to guide the work. The standards development process appears to have included technical experts and workers with a background in developmental disabilities, mental health, psychosocial rehabilitation, addictions, long-term care, and child welfare.

A modified DACUM process was used to conduct a job analysis using “master” or expert human service workers, as identified by a combination of job tenure and peer and supervisor recognition. This process occurred in five workshops conducted across the United States and involving workers from diverse sectors of the field. The result was a list of duties, tasks, relevant knowledge, and optimal personal attributes for human service workers that were then validated by obtaining survey feedback from 1000 human service workers across the nation. A *Standards Development Team*, which included direct service workers, educators and trainers, consumers, and family members then used the information from the job analysis to draft the skills standards. The standards were then validated using feedback obtained through five additional workshops (Taylor, Bradley, & Warren, 1996). In summary, the methods included job analysis (DACUM), expert consensus, and validation using survey methods.

There are a dozen competency *areas* in this set, which include: participant empowerment; communication; assessment; community and service networking; facilitation of services; community living skills and supports; education, training, and self-development; advocacy; vocational, educational, and career support; crisis intervention; organizational participation; and documentation. Each area is comprised of *skill standard statements* (144 in total) that describe general job functions, and each of these is further described by *activity statements* that outline specific tasks related to the skill. There are suggested performance indicators for each activity that serve as potential guides for assessing worker skill. It is worth noting that these skills standards described a “master” or expert level, as opposed to a “minimal” level of skill as is typical in most certification or licensing procedures.

A nationally recognized certification process tied directly to the Community Support Skills Standards was not created. Developers of the standards report informally that employers provided some resistance, fearing increased wage pressures or unionization. The demise of the National Skills Standards Board may have been a further impediment.

However, these standards did have significant influence. They served as the foundation for varied curricula, including the web-based College for Direct Support (www.collegeofdirectsupport.com). They were also the basis for the standards and certification program of the National Alliance for Direct Support Professionals, as described below. The standards are the basis for a provider driven credentialing program in Ohio, which the State does not recognize, and the foundation for a U.S. Department of Labor Apprenticeship Program, which yields a credential for the occupational title “direct support specialist”. This apprenticeship initiative is also described below.

Certification

U.S. Department of Labor registered apprenticeships

In 1937, the Congress passed the National Apprenticeship Act, frequently referred to as the Fitzgerald Act. Administered by the Department of Labor Employment and Training Administration (ETA) through its Office of Apprenticeship (www.doleta.gov/OA), this agency establishes minimum standards and regulations for *registered* apprenticeship programs. These traditionally have focused on trades, but have evolved to include some jobs within the “social services”. Relevant apprenticeships include: child development specialists, direct support specialists, youth development practitioner, and counselors (prisons/inmate).

Federal and state governments provide technical assistance and support for apprenticeship programs. A business, organization, union, or association actually manages the apprenticeship under the federal and state program standards, which are designed to ensure non-discrimination, organized instruction and experience, proper supervision, periodic performance evaluation, and a schedule of progressive increases in wages that is tied to increases in skill. The minimum apprenticeship age is 16. However, most apprentices are 18 years of age or older.

A formal Apprenticeship Agreement governs the experience of each apprentice. The core of the apprenticeship involves a minimum of 2,000 hours of structured on-the-job training as detailed in the standards. This is paired with a minimum of 144 hours of *related instruction*, obtained in the classroom or through distance education and approved self-study courses. After completing one to four years (2,000 hours to 8,000 hours) as an apprentice, the individual receives an Apprenticeship Completion Certificate and is recognized as a qualified journey worker nationwide. Thus, national recognition and portability of the credential are key goals of this program. Some apprenticeship programs have simultaneous accreditation through post-secondary institutions and apply credit for apprenticeship completion towards an Associate Degree.

The mission of the National Association of State and Territorial Apprenticeship Directors (NASTAD) is to coordinate the apprenticeship activities across the approximately 27 states that have an apprenticeship agency within state government. Alaska is not listed among these. However, there is an Apprenticeship Director based in Anchorage, provided by the U.S. Department of Labor. In an effort to study the economic impact of registered apprenticeships, NASTAD conducted a survey of 21 states in 1995. The findings, which are now dated, indicated that apprentices were earning an average of \$12.25 an hour or \$24,509 annually. Return on investment estimates indicated that for every \$1.00 invested in this program by government, \$134.00 in wages were paid to apprentices and \$20.60 in state and federal income taxes were collected.

While this model would appear to be of relevance and utility in Alaska’s question to strengthen its workforce, it remains unclear how vibrant this model is in health and human services. The apprenticeships in social services do not appear to be well publicized and the standards are inaccessible. Anecdotal reports suggested that Kansas was actively supporting the direct support specialist apprenticeship. However, it appears that only two employer agencies within Kansas are participating.

II. Behavioral Health

Behavioral health is a diverse sector that addresses multiple populations. There are unique segments of this workforce, each with their own competency and credentialing systems. This section exams those resources for: addictions; adult mental health, co-occurring; and child mental health.

A. Addictions

Competencies

TAP 21 - Addiction Counseling Competencies

Within the field of substance use disorders treatment there is set of competencies that is recognized both nationally and internationally. Its focus is on those competencies that are “...essential to the effective practice of counseling for psychoactive substance use disorders.” (Center for Substance Abuse Treatment, 2006, p.1). This is the most well-developed and broadly disseminated competency set in behavioral health.

These competencies are documented in Technical Assistance Publication (TAP-21), titled *Addiction Counseling Competencies: The Knowledge, Skills, and Attitudes of Professional Practice* (CSAT, 2006). Their development was funded by the federal government through the Center for Substance Abuse Treatment, which is housed within the Substance Abuse and Mental Health Services Administration. TAP-21, which is the name frequently used to refer to this publication, was initially released in 1998 and then updated and reissued in 2006. The document and the competencies are in the public domain.

This document has been used to define the content of multiple addiction counselor training programs and has been translated into numerous languages. There is ample evidence to support the statement contained in the Introduction to the 2006 edition that this competency set “...has become a benchmark by which curricula are developed and educational programs and professional standards are measured...” for this sector of the field (CSAT, 2006, p. 1). In this sense it serves as a demonstration for Alaska of how core competencies might catalyze uniformity and higher quality in curriculum development and training.

TAP-21 is built around 123 competencies that are organized into four “foundations” (understanding addiction, treatment knowledge, application to practice, and professional readiness) and eight “practice dimensions”. The latter include: clinical evaluation; treatment planning; referral; service coordination; counseling; client, family, and community education; documentation; and professional and ethical responsibilities.

This competency set was developed by the Curriculum Committee of the National Addiction Technology Transfer Center (ATTC) Network, which is federally funded to support the improvement of addiction treatment. The method of development involved an expert panel (the Curriculum Committee) informed by a review of the literature. Efforts to assess and document the validity of the competencies have included a national survey, comparison with a role delineation study (International Certification and Reciprocity Consortium (ICRC)/Alcohol and Other Drug Abuse, 1991), and review by stakeholder committee convened by the federal government with representatives from five national educational, certification, and professional associations. The specific knowledge, skills, and attitudes for each competency were subsequently identified through recommendations generated by these national organizations and additional “field reviewers.”

Certification

In the United States there are two major, national/international credentialing systems for addiction counselors. One is managed by the *International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse* and the second is managed by *NAADAC, the Association for Addiction Professionals*. Each of these systems is described below. The competing and potentially duplicative nature of these systems has been a source of significant concern. In 2005, both

organizations announced joint discussions to explore merging their credentialing system. However, progress on these discussions appears to have been slow and without resolution. Updates on the discussions are available at: <http://naadac.org/documents/index.php?CategoryID=22>.

International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse

The International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (IC&RC) is a non-profit organization whose members are certifying agencies involved in credentialing or licensing alcohol and other drug abuse counselors, clinical supervisors, prevention specialists, co-occurring professionals and criminal justice professionals. The IC&RC mission focuses on public protection by establishing international standards of practice in the addiction field and implementation of a standardized testing and credentialing system. However, it is the member boards, and not the IC&RC that actually certify individuals. The system of standards and credentialing is also designed to provide recognition for professionals and reciprocity of their credential around the world.

In existence since 1981, the IC&RC has 73 member agencies and 37,000 certified professionals around the world. The credentialing process is recognized by the United States Department of Transportation (DOT), the American Society of Addiction Medicine (ASAM), and the United States Department of Defense. IC&RC's member boards are located in 44 states, the District of Columbia, two US territories, a dozen international locales, and those affiliated with the Indian Health Services and World Federation of Therapeutic Communities.

The IC&RC has been quite successful in implementing reciprocity among its member boards. However, the movement to professionalize the addiction field has led to an increased emphasis on graduate education and licensure. Licensure requirements are increasingly impeding the mobility of the workforce, despite the continuation of reciprocity surrounding IC&RC credentials.

Of the many certifications offered, the most relevant credential for this review is Alcohol and Other Drug Abuse Counselor (AODA). The minimum standards for this credential as set by the IC&RC include 6000 hours of relevant supervised work experience. However, a bachelor's or master's degree in behavioral science can substitute for a significant number of these hours. Also required are: 270 hours of educational instruction; 300 hours of supervision; acceptable performance on a written exam and case presentation exam; a signed code of ethics. Recertification must occur every two years and essentially requires 40 hours of continuing education.

Supervised experience must be demonstrated across twelve core domains. These include: screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, client education, referral, reports and record keeping, and consultation.

The IC&RC exams are derived from role delineation studies that are conducted by the IC&RC. These identify for a specific job / certification category the tasks involved and rate the importance, critical nature, and frequency of each. The role delineation study for all the AODA is under revision and the IC&RC refused to release copies of the previous study.

NAADAC, the Association for Addiction Professionals Credentialing System

Known as "NAADAC, the Association for Addiction Professionals", this membership organization for addiction counselors and related professionals has approximately 11,000 members and 46 state affiliates. Founded in 1972, it was originally known as the National Association of Alcohol and Drug Abuse Counselors. Its new name is designed to acknowledge the increasing inclusion of professionals involved in the areas of tobacco use and gambling treatment and prevention.

In addition to its advocacy functions, the organization provides training, as well as certifications, including the National Certified Addiction Counselor (Levels I and II) and multiple other specialized credentials. NAADAC certification is a "national" certification and candidates must have a state-level certification to apply. The organization reports certifying 15,000 counselors over the past eight years. The NAADAC Certification Commission manages training and the credentialing process.

The stated purpose of the credentialing process is to increase recognition of the professionalism of the field, set a uniform national standard for practice in this field, recognize individual counselors who have achieved that standard, assist employers and payers in identifying qualified practitioners, and promote continued professional development of those working in this health care sector.

Requirements for the National Certified Addiction Counselor, Level I (NCAC I) include:

a current state license as a substance abuse counselor, 270 hours of training, 6000 hours of supervised work experience, a signed ethics codes, and acceptable performance on a Level I examination. Level II requirements are similar but more stringent, including a bachelor's degree, 450 hours of training, and 10,000 hours of experience.

The written exam is comprised of 250 multiple-choice questions. The areas covered through this exam include: psychopharmacology of psychoactive substances (30%), counseling practice (40%), theoretical base of counseling (15%), and professional issues (15%). The organizations Handbook for Candidates (<http://www.ptcny.com/PDF/NCC2008.pdf>) provides a four page detailed outlined of content covered on the exam. While competencies could be inferred from this list, there is no specific list of competencies or competency domains. Test questions are developed by addiction experts and reviewed by the NAADAC Certification Commission for "construction, accuracy, and appropriateness". The Professional Testing Corporation consults to the Commission on test development and administers the exam. The resources available for this review do not describe any research or validation efforts focused on the exam or the certification process.

B. Adult Mental Health

Competencies

USPRA Role Delineation Study

As difficult as it may be to fathom, there are no nationally recognized core competencies for mental health practice. For entry level direct care staff, the work on competencies in the field of psychiatric rehabilitation is probably most relevant to working in the mental health field.

The U.S. Psychiatric Rehabilitation Association (USPRA, www.uspra.org) is an organization whose mission is to promote the community readjustment of people with psychiatric disabilities. The concept of psychiatric or psychosocial rehabilitation involves promoting the recovery of individuals diagnosed with mental health conditions that seriously impair their ability to lead meaningful lives. The interventions in this model place a strong emphasis of accessing and coordinating community resources and in building skills necessary to lead a satisfying life vocationally, educationally, and socially.

Formerly known as IAPSRS, the organization conducted a Role Delineation Study, or job analysis, which became the foundation for its subsequent certification process. As a first step in this process, a six member expert panel identified the domains, tasks, knowledge, and skills deemed essential for the psychiatric rehabilitation practitioner. The content validity of these was then established through review by a representative sample of rehabilitation practitioners. A total of seven domains with 75 associated tasks were identified. The domains are: interpersonal competencies; professional role competencies; community resources; assessment, planning, and outcomes; system competencies; interventions; and diversity. The content of these domains is available without charge through the organization's website.

Certification

USPRA Certified Psychiatric Rehabilitation Practitioner

Until 2001, IAPSRS/USPRA maintained a voluntary Registry for Psychiatric Rehabilitation Practitioners. Based on a review of an application and submitted case studies, the Registry was phased out with the introduction of a test-based credential. The Psychiatric Rehabilitation Certification Program is directed by the Certification Commission, which was chartered by the IAPSRS/USPRA but is administratively and fiscally independent.

The intended function of the certification process is to ensure competence and professionalism in this field and to promote the recognition of certified practitioners. Eligibility is open to a complete spectrum of individuals, from those with certifications or advanced degrees in psychiatric rehabilitation to those with only a high school diploma or GED. However, those without certifications or degrees must have two years of rehabilitation experience *and* a minimum of 45 hours of training or 3 college credits in psychiatric rehabilitation in order to qualify for certification. The application process involves several elements: submitting information on prior education, training, and experience; signing the profession's Code of Ethics, and agreeing to a criminal background check. Recertification is required every three years and involves documentation of psychiatric rehabilitation practice and active continuing education.

The core of the initial certification process, however, is the exam. Test items for the certification exam are written by experienced practitioners and are designed to assess (1) knowledge, (2) application of knowledge, and (3) ability to analyze complex situations. Items are reviewed and improved by a second group of experts, and then rated for importance, criticality, and relevance. Those rated highly on these dimensions are included in the bank of potential questions. For each question on each exam a group of experts rate "...the probability that a 'minimally acceptable' candidate will answer this item correctly." A procedure known as the Angoff Modified Technique is then used to analyze this data and produce a final pass/fail cutting score for each exam, which has 150 questions and is administered over three hours. In the first five years of its implementation, the average pass rate for the exam was 67%.

USPRA indicates that 65% of CPRPs have been at their current employer for more than five years and that 89% have reported "personal value" in being certified. Perhaps most important, this CPRP credential is "recognized" in twelve states through various regulations. These states include: Arizona, Florida, Georgia, Hawaii, Illinois, Iowa, Louisiana, Maine, Minnesota, New York, Pennsylvania, and Virginia. The nature of the recognition varies widely and details can be found at <http://www.uspra.org/files/public/States-Recognition-CPRP.pdf>

C. Co-Occurring (Mental Health and Addictions)

Competencies

SAMHSA/CSAT TIP 42 Intermediate Co-Occurring Competencies

Evidence of the frequency with which individuals simultaneously experience mental and addictive disorders has led to a focus on developing "co-occurring" approaches to service delivery and workforce development. While there are evidence-based "tool kits" for integrated dual disorders treatment (www.samhsa.gov) and other models and training resources, the competency models for practitioners in this field have not been developed in detail.

The most widely cited resource on co-occurring competencies is the SAMHSA/CSAT TIP 42 Treatment Improvement Protocol. Titled *Substance Abuse Treatment for Persons with Co-Occurring Disorders* (CSAT, 2005), it discusses *examples* of competencies at the basic and advanced level and lists six specific competency areas at the intermediate level. These include: integrated diagnosis of substance abuse and mental disorders; integrated assessment of treatment needs; integrated treatment planning; engagement and education; early integrated treatment methods; and longer term integrated treatment methods. Each competency area has an associated, but very brief list of competencies that comprise the broader competency area. The expert panel that drafted TIP 42 created this competency model in collaboration with the New York State Office of Mental Health and the New York State Office of Alcohol and Substance Abuse Services.

Certification

International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse – Certified Co-Occurring Disorders Professional

The IC&RC is described above as an organization that credentials addiction counselors. It began offering credentialing for the Certified Co-Occurring Disorders Professional (CCDP) in 2007. The minimum standards are more stringent than

those for the Alcohol and Other Drug Abuse (AODA) Counselor and include 4,000 hours of co-occurring work experience plus 2,000 hours of additional work experience in counseling over the past ten years. Also required are: a minimum of a Bachelor's degree in co-occurring disorder (COD) or behavioral science; 200 total hours of training (140 hours in COD; 30 hours in addictions; and 30 hours in mental; 200 hours of supervision, acceptable performance on a co-occurring specific exam; and a signed code of ethics. As with the AODA, recertification is biannual and requires 40 hours of continuing education specific to this specialty. The role delineation study on which the credential process was based is currently under revision and unavailable to the public.

D. Peer Support

Competencies

Illinois Recovery Support Specialist, Role Delineation Study

There is increasing emphasis on peer support as a workforce strategy within behavioral health. While there are informal peer support roles, development efforts have focused on formal competency identification and credentialing, often accompanied by eligibility for reimbursement of services provided. The pioneering and most visible work nationally was conducted in Georgia (www.cacps). Given interest within Alaska in considering the potential use of peer support competencies developed in the state of Illinois, these were selected as the focus of this review.

The Illinois Certification Board (ICB; www.iodapca.org) manages professional certification programs within the State of Illinois in the fields of mental health and addictions. To support the development of a credential for peer support professionals in behavioral health, the Board commissioned the Comprehensive Examination Services to complete the Recovery Support Specialist, Role Delineation Study in March of 2007. The competencies draw on the unique functions of a peer support role and the unique perspectives that are obtained through the personal experience of recovery from mental illness or co-occurring mental health and addiction problems.

The study revealed four core competency or performance domains: advocacy; professional responsibility; mentoring; and recovery support. The first two are similar in composition to competencies for any profession or service role. The latter two focus much more explicitly on the unique role, functions, and tasks that are inherent in one person in recovery helping another.

Credentialing

Illinois Certified Recovery Support Specialist

The certification system implemented by the Illinois Certification Board is voluntary, but is intended to serve as a guide to employers seeking to hire peer support specialists. The requirements for certification include: a high school diploma or GED; training in the four core competency domains (100 hours minimum); supervised practical experience (100 hours minimum); 2000 hours of work experience; and successful completion of an objective test (the CRSS exam). Applicants must agree in writing to disclose their personal experience as a person in recovery. Recertification requires 40 hours of continuing education over each two year period.

E. Child Mental Health

Competencies

Michigan Association for Infant Mental Health Competency Guidelines

The Michigan Association for Infant Mental Health (MI-AIMH) is an interdisciplinary, professional organization with the mission of promoting the development of infants, toddlers, and families through training and advocacy. This organization has published a competency set in a document titled the *MI-AIMH Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health: Competency Guidelines* (MI-AIMH, 2002). The document

is available for purchase at nominal cost at www.mi-aimh.msu.edu. However, there are restrictions and costs associated with the use of the competencies as explained in the section on certification, which follows below.

The competencies have been articulated for four job levels: infant family associate, infant family specialist, infant mental health specialist, and infant mental health mentor. The first two are most relevant to this review, as the educational prerequisite includes a Bachelor's or Associate's degree or a high school diploma. Competencies were originally developed for the mental health specialist level (3), but increasing awareness of the importance in the direct care workforce led to development of levels 1 and 2. Finally, recognition of the important of supervisors and mentors led to competency development for the most senior level (4).

In this model there are eight competency domains for Levels 1 and 2, each further defined by a list of specific competencies. The eight domains are: theoretical foundations; law, regulation, and agency policy; systems expertise; direct service skills; working with others; communicating; reflection; and thinking. The competencies were developed over an eight year period by various expert panels using a consensus method. Focus groups were conducted with and work journals were produced by individuals actively working in this field and this information was used to build the behavioral descriptors for the competencies. The competencies serve as the foundation for the endorsement process, which was developed in part with funding from the W.K. Kellogg Foundation.

Certification

MI-AIMH Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health

The Michigan Association for Infant Mental Health launched its efforts to offer an "Endorsement" in 2002 in order to "...recognize the professional development of infant and family service providers ... and to verify that an applicant has attained a specified level of functioning and understanding based on a set of competencies that have been identified and agreed upon..." (pg i. , MI-AIMH, 2002). According to the MI-AIMH Director, Deborah Weatherston, the organization had developed the competencies and believed that these should "lead to something" for members of the workforce who obtained proficiency in the competencies.

For the two non-graduate degreed levels relevant to this review (infant family associate or specialist) the endorsement process involves submission of a range of materials. These include a portfolio documenting all educational experiences, paid work experiences, and supervision related to infant mental health. Also required are three professional reference ratings and a signed Code of Ethics from the applicant. At these two levels there is no written exam. A three member panel from MI-AIMH reviews the applications and makes a determination regarding award of the Endorsement and the review process explicitly examines how the materials submitted demonstrate training and skill in the competencies. Once endorsement is received, providers must maintain membership in MI-AIMH and complete 15 hours of relevant continuing education credit each year to remain current.

The rights to the competencies, the endorsement process, and all supporting documentation needed to implement the endorsement system can be purchased for use in a state. It has now been implemented in seven states and several additional states reportedly have expressed interest, including Alaska. The initial cost is \$20,000, which can be spread across three years. There are additional costs for required training and technical assistance about the endorsement process plus annual costs for updated materials. The later cost is approximately \$2,000 per year. The states who have implemented the endorsement have formed a "League" that meets annually.

The impact of the competencies and the endorsement process reportedly has been significant. Michigan Medicaid regulations have been rewritten to require that staff providing Medicaid funded "0 to 3" home-based services either have or are pursuing endorsement at level 2 (minimum) or level 3 (preferred). Anecdotal evidence suggests greater recognition and professionalism of infant mental health as a specialty in the following ways: an increased number of community mental health centers providing services identified as "infant mental health"; employers, such as the mental health centers, funding increased levels of training and supervision, which are required for staff to qualify for endorsement; and employers advertising for staff and indicating that endorsement is a preferred qualification. In summary, this initiative stands as a clear example of the potential positive impact of competency development and efforts to certify or endorse individuals on a workforce and the system of services in which they are employed.

III. Child Development

Competencies

DEC Recommended Practices in Early Intervention/Early Childhood Special Education

The Division for Early Childhood (DEC) of the Council for Exceptional Children (CEC) is a non-profit organization committed to improving the lives of children with special needs from birth through age eight. The concept of “special needs” is defined to include children with disabilities, developmental delays, at risk for developmental problems, or those who are talented or gifted. There is *some* overlap between this focus area and the field of developmental disabilities.

DEC promotes policies and practices that enhance child development and support families. DEC used an expert consensus model in 1993 to identify a series of “recommended practices” to promote child development and family functioning. This work was revised and significantly updated using a literature review and focus groups with practitioners, staff trainers, researchers, administrators, and family members. The resulting product is called *DEC Recommended Practices in Early Intervention/Early Childhood Special Education* (Sandall, McLean, Smith, 2000).

While the document is not explicitly about competencies, the recommended “practices” do convey considerable information about the job duties and skills required for serve this population. There are seven domains for the recommended practices. Five of these are organized under the heading of “direct services”: assessment; child-focused interventions; family-based practice; interdisciplinary models; and technology applications. The remaining two are organized as “indirect supports”: policies, procedures, and systems change; and personnel preparation. Each domain is organized into a list of practices. The number of practices is quite large (240 across all domains) making the document and the implied competencies difficult to comprehend and utilize. Little information was available about the impact of this work in the field.

A second set of relevant competencies have been developed by the Council for Professional Recognition. These are closely tied to the Child Development Associate (CDA) National Credentialing Program, and so are described in the section below.

Credentialing

Child Development Associate (CDA) National Credentialing Program.

The Council for Professional Recognition is a nonprofit organization that promotes performance improvement and professional recognition in the field of early childhood care and education. The target population is birth through age five. The Council manages the Child Development Associate (CDA) National Credentialing Program, which includes standard settings and assessment of applicants. In existence in various forms since 1975, the CDA Program is designed to assess and credential early childhood care and education professionals based on performance.

The CDA is a widely recognized credential. The District of Columbia and all but one state incorporate this credential into their child care center licensing regulations. Almost 15,000 individuals are credentialed each year and the total number who have received the CDA exceeds 200,000. Like most credentialing processes, it is intended to promote professionalism, continuing education, career opportunities, and recognition of the profession.

The CDA Credential is awarded for three child care settings: (1) center-based; (2) family child care, which is conducted in the home; and home visitor. Bilingual “endorsements” can be obtained for each setting.

Caregiver performance is based on the national *CDA Competency Standards*, which are comprised of six goals and thirteen related Functional Areas that identify caregiver tasks. Goals and Functional Areas are the same across settings, but the definitions of Functional Areas and sample behaviors vary by setting and age group. These are detailed in a series of *CDA Competency Standards Book* tailored to each setting. The following table of Goals and Functional areas is reprinted from www.cdacouncil.org.

CDA Competency Goals	Functional Areas
Goal 1. To establish and maintain a safe, health learning environment.	1. Safe 2. Healthy 3. Learning environment
Goal 2. To advance physical and intellectual competence	4. Physical 5. Cognitive 6. Communication 7. Creative
Goal 3. To support social and emotional development and to provide positive guidance.	8. Self 9. Social 10. Guidance
Goal 4. To establish positive and productive relationshipw with families.	11. Families
Goal 5. To ensure a well-run, purposeful program responsive to participant needs.	12. Program management
Goal 6. To maintain a commitment to professionalism.	13. Professionalism

Candidates for the CDA must be 18 years of age or older, possess a high school diploma or GED, and have 480 hours of relevant experience and 120 hours of formal child care education distributed over eight topic areas. Applicants prepare and submit a professional resource file, parent opinion questionnaires, and an observation instrument completed by an advisor. A representative of the Council actually visits with the applicant and administers an oral interview and the Early Childhood Studies Review, which is a two hour multiple choice exam. The Council offers one year Professional Preparation Program for those seeking organized and supported preparation in obtaining the credential.

Recredentialing must occur after three years, and then for each subsequent five year term. Requirement include first aid certification, continuing education, recent work experience in the field, a letter of recommendation from a CDA, and current membership in a local or national early childhood professional organization.

IV. Developmental Disabilities

Competencies

National Alliance for Direct Support Professionals Competencies

The National Alliance for Direct Support Professionals (NADSP; www.nadsp.org) has developed a credentialing system for individuals providing direct care at the frontlines of the human service system. It refers to these individuals as *direct support professionals*. NADSP was founded by 28 organizations concerned about high staff turnover, inadequate training, limited educational and career opportunities, and low wages among the direct care workforce. Membership in NASDP includes representatives from the developmental disabilities, mental health, and the child welfare sectors, although there is a heavy emphasis on developmental disabilities in terms of the organization’s focus.

The NASDP Credentialing Guidebook identifies 15 competency areas comprised of 167 specific skills are relevant to the credentialing process (NADSP, 2005). The fifteen areas are: participant empowerment; communication; assessment; community and service networking; facilitation of services; community living and skills supports; education, training, and self-development; advocacy; vocational, educational, and career support; crisis prevention and intervention; organizational (employer) participation; documentation; facilitation of relationships and friendships; person-centered support; and supporting health and wellness. The Guidebook and the competencies and skills can be accessed online without charge at <http://www.nadsp.org/pdf/NADSPCredentialingGuidebook.pdf>.

The NADSP competencies incorporated those from the Community Support Skills Standards developed by HSRI (Taylor, Bradley, & Warren, 1996), with three added competencies derived from a validation study in Minnesota with those

standards and a national validation survey. The final NADSP competencies were approved by the NADSP Executive Committee.

Certification

National Alliance for Direct Support Professionals Credentialing

The National Alliance of Direct Support Professionals offers a voluntary credentialing system at three levels: Direct Support Professional – Registered (DSP-R); Certified (DSP-C); and Specialist (DSP-S). From the employee perspective, these credentials are designed to offer recognition and validation of their knowledge, skills, and commitment to ethical practices. From the “employer” perspective, which in the developmental disabilities field can be an organization or the person with the disability (and their family members), the credentials can serve as evidence of preparation for the DSP role.

NADSP provides online verification of credential status to employers on a fee basis, provided that the applicant gives permission. Employers are encouraged by NADSP to support employee efforts to become credentialed in order to demonstrate a commit to the employee and to foster retention. From a policy level, the credentialing process is intended to raise the quality of care through ensuring a common knowledge base and skill set in the workforce.

The requirements for becoming a *Direct Support Professional – Registered* involve five elements. The individual must: pass a criminal background check that examines the past 12 months; submit a letter from their employer confirming that all training required by the employer and state have been completed; provide proof of continuous employment in community human services for 6 months; provide a letter of “intended professional commitment; and a signed commitment to adhere to the NADSP Code of Ethics. There is a one time application fee of \$50.00 and no subsequent fees or requirement for renewal.

Requirements for the *Direct Support Professional – Certified* involve a demonstration of competence. The basic elements of the application requirements involve: prior DSP-Registered status; proof of two continuous years of relevant work experience; a professional resume; updated letter of professional commitment, signed commitment to the Code of Ethics, and a letter of support from an individual that has received services from the DSP (or their family member or legal representative. Also required is completion of one of two “approved” education and training programs that involve 200 hours of instruction and 3000 hours of work experience. Finally, the applicant submits a portfolio of work samples that must demonstrate competence in 8 of 15 NADSP competency areas. Re-certification must occur every two years and the principal requirement is proof of 20 hours of continuing education.

A *Direct Support Professional – Specialist* is defined as an individual who has obtained specialized training and demonstrated specialized competence in one of four areas: inclusion; health support; positive behavioral support; and mentoring and supervision. The application requirements involve: DSP-Certified status; 40 hours of continuing education in the specialized competence (e.g. positive behavioral support); a portfolio that demonstrates the specialized competence; one year of work experience related to the specialized competence, and a letter of support from an employer. Renewal is required every two years and requires re-certification at the “Certified” level plus 5 hours of continuing education related to the specialized competence.

The state and employer training requirements imbedded in the requirements for *Registered* status vary, but usually involve a mix of classroom and workplace-based learning that covers topics such as infection control, first aid, and safety. At the *Certified* level the training program must have been reviewed by NADSP and the curriculum deemed congruent with the association’s competencies. The *Credentialing Guidebook* lists two approved curricula. The first is the U.S. Department of Labor or state Department of Labor certified apprenticeship programs for the occupational title of “direct support specialist”. The second is the College of Direct Support, which provides asynchronous on-line learning, which is combined with employer based training. A reported six additional curricula are in the process of being accredited.

Portfolios are intended to demonstrate competencies. They combine diverse work samples that can include: journal entries, photo essays, audio or video tapes, oral presentations, or artwork, to name just a few. NASDP actively encourages the use of mentors or mentoring programs to assist candidates in preparing their applications and portfolios. Once submitted, portfolios are formally scored by experts who have been trained to conduct such reviews.

The NADSP credentialing program is relatively new, but it appears that a modest number of workers are in the pipeline for certification. The State of Illinois will soon require registration (the first level) for all employees and supporting a \$1.00 per hour wage increase for each subsequent level of certification achieved. Other states are considering formal support of this credential, although Alaska does not appear to be among them.

IV. Traumatic Brain Injury

Competencies:

An explicit competency set for this field does not appear to exist. A list of content areas has been identified by the American Academy for the Certification of Brain Injury Specialists. This information is contained in the section below.

Credentialing:

American Academy for the Certification of Brain Injury Specialists (AACBIS)

The AACBIS is a standing committee of the Brain Injury Association of America. AACBIS (<http://www.aacbis.net/index.html>) strives to improve care to individuals with brain injury by offering published resources, training, and a voluntary national certification program for entry level staff and experienced professionals from any relevant discipline. The purpose of the certification program is to promote best practices in brain injury care, a career path for those working in the field, and recognition that a professional has received specific training in brain injury services. AACBIS explicitly states that its credential is *not* verification that an individual is suitable for employment.

A substantial, though still small, number of individuals in the nation has this certification. Its overall impact is not known. However, brain injury programs surveyed in 1990 indicated that 75% of licensed staff and 84% of unlicensed staff required specialized training for this field, and the majority of respondents indicated that they would give a hiring preference and higher pay to individuals with such specialized training.

Two certifications exist for distinct levels of experience and supervisory skills: Certified Brain Injury Specialist (CBIS) and CBIS Trainer* (CBIST). Certification is based on a comprehensive training manual, *The Essential Brain Injury Guide*, which covers the following topics:

- ▶ Incidence and epidemiology of brain injury
- ▶ Continuum of services
- ▶ Brain anatomy and brain-behavior relationships
- ▶ Functional impact of brain injury
- ▶ Effective treatment approaches
- ▶ Children and adolescents with brain injury
- ▶ Health and medical management
- ▶ Family issues
- ▶ Legal and ethical issues

From the materials available, it appears that these are training content areas as opposed to a distinct list of competencies. Therefore, they are not listed in the national competency crosswalk.

The requirements for CBIS certification, which is the level relevant for this review, include work experience, training, and acceptable performance on a national written examination that presents scenarios to which the candidate's knowledge must be applied. A Performance Based Assessment (oral evaluation) has been discontinued. Recertification is required

annually, but continuing education requirements are spread over two year periods. Information on the methods used to derive the content area or exam was not available.

V. Long Term Care

Competencies

The Paraprofessional Healthcare Institute (PHI; <http://phinational.org/>) is focused on improving the lives of individuals receiving long term care at home, in residential care, or day services. The assumption underlying this organization's efforts is "quality care through quality jobs". There is a strong focus on strengthening the direct care workforce in order to ensure better care. PHI developed and promotes improved workforce practices through technical assistance and policy change, and also manages the online National Clearinghouse on the Direct Care Workforce as an informational resource.

Direct care workers in this health and human service sector work under numerous title and job classes, including: certified nursing assistant (CNA), nursing assistant, home health aide, home care aide, personal assistant, personal care attendant, and direct support professional. PHI estimates that as a group, these workers deliver 70 to 80 percent of the paid, direct, long-term care and personal assistance for the elderly, chronically ill, and disabled.

PHI (2006) has a set of competencies and skill standards for this workforce. There are 10 competency domains, each defined by a list of standards, which in other models might be referred to as competencies or tasks. The 10 domains are: role of the direct care worker; consumer rights, ethics, and confidentiality; communication, problem solving, and relationship skills; personal care skills; health related topics; in-home and nutritional support; infection control; safety and emergencies; apply knowledge to the needs of specific consumers; and self care.

Certification

With respect to certification, home health aides (HHAs) constitute the most relevant job class in the long-term care job family. Home health aides provide basic nursing services, food preparation, and household services for persons receiving physician-prescribed care in their homes or in licensed residential care facilities. States "certify" home health aides in compliance with guidelines established by the federal government. Typical requirements for certification include: a background check and completion of a state approved training program that includes basic instruction and supervised experience. Federal regulation requires employers, such as home health agencies, to assess the competency of home health aides prior to allowing them to provide services. Re-certification typically involves completion of continuing education and may require a satisfactory performance evaluation from an employer.

VI. Juvenile Justice and Corrections

Competencies

National Institute of Corrections Competency Profile

The United States Department of Justice, through its National Institute of Corrections (NIC) developed a Competency Profile for correctional officers (www.nicic.org/Library/o10552). Released in 1992, this relatively brief document is publicly available. This competency set was developed by the National Academy of Corrections, which is the training division of NIC for both adult corrections and juvenile justice. A DACUM process was used to develop the profile by two DACUM facilitators and a seven member panel of correctional officers drawn from across the country. The profile lists the optimal characteristics of a correctional officer in terms of knowledge, skills, traits, and attitudes. The required tools and equipment are also specified.

The core of the profile is a two page table that identifies seven "duties" for a correctional officer, with from three to ten tasks specified for each duty. The seven duties are essentially the competency domains in this model. They include:

manage and community with inmates; direct inmate movement; maintain key tool and equipment control; maintain health, safety and sanitation; communicate with staff; participate in training; and distribution authorized items to inmates. These competencies are relevant because they served as a foundation for the certification program described below.

The NIC profile is focused on duties related to managing incarcerated individuals. In an effort to identify competencies related to juvenile detention *and* community based juvenile justice services a broadcast email was sent to professionals involved in initiatives to improve juvenile justice across the nation. The responses suggest that many states have curricula focused on this workforce. Those curricula tend to encompass work in both detention and community based services, covering topics that include safety and control as well as more health and mental health related topics. Competencies are implied in these curricula, but tend not to be explicitly identified.

Certification

American Correctional Association Professional Certification Program

The American Correctional Association (ACA) is considered the largest association of corrections personnel in the world. It was founded in 1870 and known initially as the National Prison Association. Since 1978 it has been accrediting adult and juvenile correctional facilities and currently accredits a reported 80% of such facilities in the U.S.

The ACA manages a Professional Certification Program. It certifies individuals in one of six major categories: executive, manager, supervisor, officer, nurse, and nurse manager. For each category there is separate certification for work with adults and juveniles.

The “officer” category is relevant to this review, as it involves certification for “line” staff working directly with offenders, includes entry level personnel, and requires only a high school diploma or GED and a minimum of one year of experience.

Candidates complete an application and, if qualified, receives a study guide and list of recommended readings. All applicants must take a 200 item test and pass with score of 75% or greater. ACA engaged a consultant to develop the test, which has been in use just since the year 2000.

The certification exam is based on the DACUM produced by the National Institute for Corrections, as described above. However, the ACA certification Study Guide identifies a set of “capabilities areas” as the foundation for the test, as these differ to some extent from the NIC duties. The ACA capabilities for the correctional officer level include: ethics; expertise/legal issues; general knowledge; health/safety/sanitation; offenders-management/control; skill/equipment control; and maintain health, safety, and sanitation / communicate. Only the latter three are identified with specific tasks or behavioral descriptors and these are quite brief.

Even where the NIC and ACA competencies seem similar in name to the competencies for other job families, they are, in fact, quite different. There is an extremely strong emphasis on safety and control throughout the competencies. In the NIC duties, for example, “manage and communicate with inmates” includes tasks such as “enforce rules and regulations; provide written and verbal counseling (i.e., disciplinary action...)”.

Recertification is required every three years and involves completion of 40 hours of continuing education contact hours during the previous three year interval, evidence of continued work in the field, and documentation of satisfactory performance evaluations from the employer. ACA provides on-line verification of certification status for employers.

The National Partnership for Juvenile Justice Services, through its Center for Research and Professional Development, provides staff training on detention services and reports that it can develop certification for such staff. However, the website provides no description of certification programs and there was no staff response to an inquiry about this service.

Crosswalk of National Competencies

With the key national competency sets identified, the next step in this review process was to compare the competencies. The core question for this phase of the CQSS process is whether there is sufficient commonality among competency sets to warrant consideration of establishing a single core competency set for the Alaskan job families under study.

Conducting the comparison required a focus on competency “domains” or “areas”. These are the summary categories used in most competency sets to organize the larger number of individual and more detailed competencies that had been identified. For example, there were up to 167 individual competencies identified in a single competency set, whereas the maximum number of competency domains was 15.

Comparing competency domains required a review of the individual competencies that comprised each domain, since the names assigned to domains by developers seemed at times somewhat arbitrary or obscure. It is critical to highlight that the organization of competency domains is also somewhat arbitrary, as developers had the option to cluster individual competencies in various ways in their efforts to create domains centered on a competency theme. Thus, for this review, competency domains were examined to determine their predominant content, recognizing that there would seldom if ever be an exact match in name and content among competency domains from different competency sets. The review process was further complicated by the fact that, while some competency sets were relevant to the direct care entry level workforce, they may have been designed for multiple levels of the workforce within a job family.

In systematically comparing domains from different competency sets, the similarities and commonality of content were quite striking. The reviewer from the Annapolis Coalition created names for a set of “master” competency domains and assigned the domains from individual competency sets to these master categories. The master domains were modified slightly as an increasing number of competency sets were reviewed and “cross walked” with the other sets. Representatives of the WICHE Mental Health Program reviewed and approved the master domain categories and then used these for the crosswalk of competency domains from Alaskan resources. That analysis appears in a latter section of this report.

The crosswalk of national competencies can be found in Tables 1 and 2.

CREDENTIALING AND QUALITY STANDARDS CROSSWALK – NATIONAL COMPETENCY DOMAINS

Job family ►	General/Cross Sector	Developmental disabilities	Addictions
Competency set ►	Community Support Skills Standards	National Alliance of Direct Support Professionals	Addiction Counseling Competencies
Competency “domains” ▼			
1. Interpersonal	Communication	Communication	
2. Assessment	Assessment	Assessment	Clinical evaluation Understanding addiction
3. Planning	Facilitation of services Participant empowerment	Facilitation of services Provide person centered supports	Treatment planning
4. Intervention	Facilitation of services Community living skills and supports Vocational, educational, and career support Crisis intervention	Facilitation of services Community living skills and supports Vocational, educational, and career support Crisis prevention and intervention Build and maintain friendships/relationships Provide person centered supports	Counseling Education (client, family, community) Treatment knowledge Application to practice
5. Community resource and referral	Community and service networking	Community and service networking	Referral Service coordination
6. Documentation	Documentation	Documentation	Documentation
7. Professional and ethical conduct	Facilitation of services Organizational participation	Facilitation of services Organizational participation	Professional and ethical responsibilities Professional readiness
8. Professional development	Education, training, and self development	Education, training, and self development	Professional readiness
9. Advocacy	Advocacy Participant empowerment	Advocacy Participant empowerment	
10. Health and wellness		Supporting health and wellness	
11. Cultural competency	Organizational participation	Organizational participation	
12. Quality improvement	Organizational participation	Organizational participation	
Unassigned comp. domains			
TITLES USED	Community support human service practitioner Direct service worker (informal)	Direct support professional	Counselors
Number of domains/competencies	12/144	15/167	12/123

Job family ►	Long term care	Mental health	Child mental health
Competency set ►	PHI Competencies and Skill Standards	USPRA Role Delineation Study	Michigan Association for Infant Mental Health
Competency “domains” ▼			
1. Interpersonal	Communication, problem solving, and relationship skills Role of the direct care worker	Interpersonal competencies	Communication Working with others
2. Assessment	Apply knowledge to the needs of specific consumers	Assessment, planning, outcomes	
3. Planning		Assessment, planning, outcomes	
4. Intervention	Personal care skills In-home and nutritional support Safety and emergencies Apply knowledge to the needs of specific consumers	Interventions	Direct service skills Theoretical foundations
5. Community resource and referral		Community resources	Systems expertise
6. Documentation			
7. Professional and ethical conduct	Consumer rights, ethics, and confidentiality Role of the direct care worker	Professional role competencies	Working with others Law, regulation, and agency policy
8. Professional development	Self-care (of the worker)	Professional role competencies	Reflection
9. Advocacy		System competencies	
10. Health and wellness	Health related tasks Infection control		
11. Cultural competency		Diversity	
12. Quality improvement		Assessment, planning, outcomes	
Unassigned comp. domains			Thinking
TITLES USED	Direct care worker	Psychiatric rehabilitation practitioner	Infant family associate Infant family specialist
Number of domains/competencies	10/88	7/75	8/61 (specialist level)

Job family ►	Co-occurring (mental and addictive disorders)	Peer support	Childhood development
Competency set ►	SAMHSA/CSAT TIP 42	Illinois Recovery Support Specialist	DEC Recommended Practices
Competency “domains” ▼			
1. Interpersonal	Engagement and education		
2. Assessment	Integrated diagnosis		Assessment
3. Planning	Integrated assessment		
4. Intervention	Engagement and education Early integrated tx models Longer term treatment models	Mentoring Recovery support	Child-focused interventions Family-based practices Technology applications (assistive)
5. Community resource and referral	Early integrated tx models		Family-based practices
6. Documentation	Longer term tx models		
7. Professional and ethical conduct	longer term tx models	Professional responsibility	Interdisciplinary models
8. Professional development			Personal preparation
9. Advocacy		Advocacy	Policies, procedures, and systems change
10. Health and wellness			
11. Cultural competency			Policies, procedures, and systems change
12. Quality improvement			
Unassigned comp. domains			
TITLES USED	Counselors Clinician		Educators, practitioners, families, administrators
Number of domains/competencies	6 (intermediate level)		7/240

Job family ►	Child development	Corrections and juvenile justice	
Competency set ►	CDA Competency Standards	NIC Competency Profile of Correctional Officer	
Competency “domains” ▼			
1. Interpersonal	Goal II. (physical, cognitive, communication, creative)	Manage and communicate with inmates Communicate with staff	
2. Assessment			
3. Planning			
4. Intervention	Goal II. (physical, cognitive, communication, creative) Goal III. (self, social, guidance) Goal IV. (families)		
5. Community resource and referral	Goal IV. (families)		
6. Documentation			
7. Professional and ethical conduct	Goal VI. (professionalism)		
8. Professional development	Goal VI. (professionalism)	Participate in training	
9. Advocacy			
10. Health and wellness	Goal I. (safe, healthy, learning environment)	Maintain health, safety, and sanitation	
11. Cultural competency			
12. Quality improvement	Goal V. (program management)	Direct inmate movement Maintain key, tool, and equipment control	
Unassigned comp. domains		Distribute authorized items to inmates	
TITLES USED	Child development associate	Correctional officer	
Number of domains/competencies	6/13	7/48	

ALASKAN RESOURCES

Current Competencies for Identified Job Families

In the State of Alaska there are a number of different types of direct care competencies being used to enhance the knowledge and skills of direct care workers serving Trust beneficiary groups. These competencies have been designed or applied within the State Health and Social Services Department, higher education, provider organizations, the Alaska Native Tribal Health Consortium, and as a part of the Alaska Commission for Behavioral Health Certification. There is currently no singular competency set that is being applied across settings that serve Trust beneficiaries. One of the goals of the Credentialing and Quality Standards Committee (CQSS) is to create a forum for Alaskan entities (e.g., the State, providers, and educators) to communicate with each other and to develop a set of core, direct care competencies necessary to serve all of the Trust beneficiary groups.

The following is a review of competencies and certification processes currently in existence in Alaska and a discussion of how they are being employed. In describing each competency set and certification system an effort was made to understand the following:

- ▶ Identifying information for the resource
- ▶ Identity of the developer
- ▶ Methods of development
- ▶ Brief history (e.g., origins, revisions)
- ▶ Organization and content (e.g., competency domains, certification levels)
- ▶ Use and impact
- ▶ Relevance to the direct care workforce
- ▶ Availability (public domain or proprietary)

Although efforts were made to gather comprehensive information regarding competencies and certification for each job family, the degree to which background information was available was varied. Therefore, some of the job families below are accompanied by a greater level of detail and background information than others. The review of these Alaska resources is organized by the job families outlined below. The Job families outline is followed by a table that lists competencies and credentialing processes for each of the job families.

Job Families

- I. General and Cross Sector
- II. Behavioral Health
 - a. Addictions
 - b. Adult Mental Health
 - c. Co-Occurring (mental and addictive disorders)
 - d. Child Mental Health
- III. Child Development
- IV. Developmental Disabilities
- V. Traumatic Brain Injury
- VI. Long Term Care
- VII. Juvenile Justice

	Competencies	Credentialing
General and Cross Sector	U.S. Department of Labor Office of Apprenticeship – Direct Support Specialist Competencies	
Addictions	Alaska Commission for Behavioral Health Certification Counselor Competency Description	Alaska Commission for Behavioral Health Certification Chemical Dependency Counselor Certification
Adult Mental Health		Alaska Commission for Behavioral Health Certification Behavioral Health Counselor Certification Matrix
Co-occurring (Mental and Addictive Disorders)	Alaska Department of Health and Social Services Co-occurring Disorders Competencies	
	Alaska Native Tribal Health Consortium Behavioral Health Aide Competencies Alaska Native Tribal Health Consortium Behavioral Health Aide/Practitioner Certification Requirements and Specialized Core Training	
Child Mental Health	University of Alaska, Anchorage Children’s Residential Service Certificate Program Student Outcomes and Competencies	
Child Development	Direct Service Staff Early Infant (EI) Infant Learning Program (ILP) Professional Development Core Competencies	
Developmental Disabilities	U.S. Department of Labor Office of Apprenticeship – Direct Support Specialist Competencies	
Traumatic Brain Injury	National Alliance for Direct Support Professionals Competencies	American Association for the Certification of Brain Injury Specialists
Long Term Care	Adult Abuse and Neglect Prevention Goals and Objectives Training Matrix for Excellence in Care Certification	
Juvenile Justice/ Corrections	Juvenile Justice Officer I Promotional Criteria	

Several of the competencies sets are currently under development and intended for dissemination within the next fiscal year. Some of the competency sets discussed are national in origin or are based partly on national competencies. These national resources are referenced and discussed in depth in the national resources section of this report.

With the exception of chemical dependency counselor certification, there are currently no state active certification processes for direct care workers serving trust beneficiaries. However, several efforts are currently underway to create certification processes for other types of direct care providers. The absence of a competency or certification category for any job family below indicates that the committee is unaware of any competencies or certification processes being used at this time.

I. General and Cross Sector

Competencies

The U.S. Department of Labor Office of Apprenticeship-Direct Support Specialist Competencies Matrix

The U.S. Department of Labor Office of Apprenticeship-Direct Support Specialist Competencies Matrix will be used by mentors or supervisors to train direct care workers at 8 pilot sites participating in the Direct Support Specialist Occupational Endorsement (DSSOE) program through Prince William Sound Community College. The pilot sites serve people with mental illnesses, individuals with developmental disabilities, and older adults in long-term care settings.

An employee of the Alaska Alliance for Direct Service Careers is being trained by NASDP to assist these pilot sites in implementing competencies into training at the pilot sites. The Direct Support Professional Occupational Endorsement will require 17 credits, 240 hours of instruction, 2,000 hours on the job (this is where the apprenticeship work will occur), and will take about 1.5 years to complete. The college will begin taking students for this endorsement in the fall of 2008. The endorsement program is intended to become a state certification in the future.

II. Behavioral Health

A. Addictions

Competencies

Alaska Commission for Behavioral Health Certification Counselor Competency Description

The Alaska Commission for Behavioral Health Certification (ACBHC) certifies specialists in the field of chemical dependency. The ACBHC uses a *Counselor Competency Description* in the Chemical Dependency Counselor certification process. The competency description is based on the Northwestern Frontier Addiction Technology Transfer Center Performance Assessment Rubric for the Addiction Counseling Competencies.¹⁴ The ACBHC's description outlines both knowledge and skills foundations. Examples of knowledge and skills are, understanding addiction and required counselor professional practice capacities, such as clinical evaluation. The five ACBHC certification levels are Counselor Tech, Chemical Dependency Counselor I, Chemical Dependency Counselor II, Chemical Dependency Counselor Supervisor, and Administrator. The ACBHC also certifies Native Alaskans as Traditional Counselors. The competency description outlines what behavioral skills and knowledge foundations and practice capacities should be required for four of the six types of certification. It does not include the fifth level of certification, which is the administrator level, or the Traditional Counselor certification. The competency description is available on the Alaska Commission for Behavioral Health Certification website.¹⁵

Certification

Alaska Commission for Behavioral Health Certification Chemical Dependency Counselor Certification.

Chemical dependency professionals are certified in Alaska by the *Alaska Commission for Behavioral Health Certification*. Alaska's Regional Alcohol and Drug Abuse Counselor Training¹⁶ (RADACT) provides training required for certification, but not certification itself. RADACT is one of several sources of training for certification. As mentioned above, the ACBHC offers five sequential levels of certification which apply to positions ranging from entry level, direct support to professional positions that require a graduate education. The ACBHC also certifies Traditional Counselors. Traditional Counselors are native Alaskans who meet the requirements described below.

The training matrix was informed by the Northwestern Frontier Addiction Technology Transfer Center Performance Assessment Rubric and the recommendations of a number of Alaskan stakeholders. In order to assist with reciprocity between the tribal system and ACBHC, the most recent revision of the matrix was also based on recommendations from the Behavioral Health Aide competencies provided by the Alaska Native Tribal Health Consortium.

The Commission receives ongoing feedback regarding certification requirements from directors, counselors, and other professionals in the addictions field, as well as representatives from the University system and various training groups. Based on this information, national best practices, and state initiatives, the matrix and requirements are periodically revised.

The five ACBHC certification levels are Counselor Tech, Chemical Dependency Counselor I, Chemical Dependency Counselor II, Chemical Dependency Counselor Supervisor, and Administrator. The first two levels, Counselor Tech (CT) and Chemical Dependency Counselor I (CDC I), require no test for certification. Instead, certification is based on the fulfillment of various requirements that include coursework, hours of work experience, practicums, and trainings. CDC II and CDC Supervisor certification requires applicants to pass a National Association of Alcohol and Drug Abuse Counselors (NAADAC) test (levels I and II of the test, respectively). In addition, applicants for certification at these levels must also fulfill additional coursework, hours of experience, practicums, and training requirements. The Administrator certification requires more advanced coursework, experience, training, and supervision, but no test.

The Traditional Counselor certification is offered to native Alaskans who have a history of service within their communities involving the resolution of community substance abuse issue. Their service history must be documented by three letters of recommendation. There are no coursework, experience, practicum, or training requirements for this certification and no test is required.

Applicants are certified only in the state of Alaska and certification must be renewed every two years. The Alaska Department of Behavioral Health encourages certification of chemical dependency professionals, but does not require it. However, ACBHC is currently advocating for a change that would require all who work within the field to become certified. According to Alaska sources in the field of chemical dependency, certification may correlate with higher wages, but not necessarily.

The table shows the number of certifications obtained for each title for the fiscal year of 2007.¹⁷

Fiscal year 2007 (July 1, 2006 – June 30, 2007) ACBHC, Total Annual		
	Recertification	New Certification
CT	16	15
CDCI	72	28
CDCII	53	26
CDCS	18	4
ADM	4	0
TC	0	3
Total	163	76
Grand Total		239

B. Mental Health

Certification

Alaska Commission for Behavioral Health Certification Behavioral Health Counselor Certification Matrix

The *Alaska Commission for Behavioral Health Certification Behavioral Health Counselor Certification Matrix* describes the certification requirements for Behavioral Health Counselors (BHC’s). The matrix is will be the foundation of the Commission’s BHC certification process. However, it was not yet in use at the time that this report was written. The Commission plans to certify counselors at four levels, Behavioral Health Tech, Behavioral Health Counselor I, Behavioral Health Counselor II, and Advanced Behavioral Health Counselor.

The BHC matrix summarizes work experience, practicum, training, and coursework requirements for the certification of BHC’s. The experience, practicum, and training areas all specify the number of hours required for certification at each

BHC level. The practicum requirements also specify the types of experience required for certification (e.g., supervised intakes). The coursework requirements vary across levels of certification, preparing employees for more advanced clinical practice and greater responsibility (e.g., case management) with higher levels of certification. Letters of recommendation from supervisors are also required at each certification level.

The Alaska Native Tribal Health Consortium (ANTHC) is working with the Commission to create reciprocity between ANTHC's Behavioral Health Aide (BHA) certification and the Commission's BHC certification so that behavioral health workers could move between systems without having to fulfill additional certification requirements. The Alaska Native Tribal Health Consortium's BHA competencies and certification process is described below in this report's section on co-occurring disorders.

C. General and Co-occurring (Mental Health and Substance Abuse)

Competencies

Alaska Department of Health and Social Services Co-Occurring Disorders Competencies

The *Alaska Department of Health and Social Services Co-Occurring Disorders Competencies for Licensed, Certified, or Degreed Mental Health and Substance Abuse Counselors* were finalized by a committee of employees of the Alaska Division of Behavioral Health, Department of Health and Social Services. After the Trust Workforce Development Focus Area was initiated, development of these competencies was suspended in order to allow them to be incorporated into and considered by the Trust's initiatives. These competencies exist only as a placeholder at this point and are not yet used in Alaska.

Numerous sources were consulted by developers of the Co-occurring Disorders Competencies. These sources are:

- ▶ U.S. Substance Abuse and Mental Health Service Administrative Center for Substance Abuse Treatment Improvement Protocol 42: "Substance Abuse Treatment for Persons with Co-occurring Disorders."¹⁸
- ▶ State of Texas, Texas Administrative Code, Chapter 411, subchapter N-Standards for Services to people with Co-Occurring Psychiatric and Substance Abuse Disorders.¹⁹
- ▶ Co-Occurring Capability: An Implementation Guide for Behavioral Health Provider Agencies.²⁰
- ▶ Northwestern Frontier Addiction Technology Center Competencies²¹
- ▶ Alaska Native Tribal Health Consortium Behavioral Health Aide Competencies (ANTHC).²²

The Co-occurring Disorders Competencies were created for three levels of counselors: entry level, intermediate, and advanced. A separate document for each level of counselor was created, each containing a set of bullet points which briefly describe various knowledge and skills required for competency at each level. Examples of skills and knowledge required at the entry level are ability to use various screening tools, capacity to communicate well with clients, and utilization of supervisor feedback. The intermediate level competencies require mastery of the entry-level requirements as well as skills and knowledge related to doing intakes, screening, referral, treatment, and charting. The advanced level competencies acknowledge the entry level and intermediate competencies as a foundation for success at the advanced level. The advanced skills and knowledge requirements focus on such things as knowing ones own clinical limitations, cultural competency, and the ability to manage complex, multi-disciplinary cases.

Alaska Native Tribal Health Consortium Behavioral Health Aide Competencies

Alaska Native Tribal Health Consortium Behavioral Health Aide/Practitioner Certification Requirements and Specialized Core Training

The *Alaska Native Tribal Health Consortium Behavioral Health Aide Competencies* were developed over the past three years. However, the planning process for competency development began about eight years ago, in 2000. The

competencies were developed by a multi-stakeholder committee including representatives from the Alaska Native Tribal Health Consortium (ANTHC), the University of Alaska, State Behavioral Health, and village-based direct care providers within the Alaska Tribal Health System. Since 2003, the competencies have been continuously revised by stakeholders. The ANTHC competency set described below and employed in this report's crosswalk analysis was in draft form at the time of the writing of this report. ANTHC submitted a final draft in June of 2008 and received internal approval for their Behavioral Health Aide Competencies.

In 2004, the Behavioral Health Aide (BHA) Workgroup was created to work on the BHA certification initiative. The workgroup is facilitated by ANTHC and is comprised of the Alaska Native Tribal Behavioral Health Programs, University of Alaska Fairbanks, State of Alaska Division of Behavioral Health, Alaska Mental Health Trust Authority, Alaska Commission for Behavioral Health Certification, Regional Alcohol and Drug Abuse Counselor Training, Rural Behavioral Health Association, and the Federal Community Health Aide Program Certification Board. Certification of BHA's will be based on the *Alaska Native Tribal Health Consortium Behavioral Health Aide/Practitioner Certification Requirements and Specialized Core Training*.

The 2008 draft of the ANTHC Behavioral Health Aide (BHA) competencies is organized according to five levels: Behavioral Health Aide Trainee, Behavioral Health Aide I, Behavioral Health Aide II, Behavioral Health Aide III, and Behavioral Health Practitioner. Each level is defined by various courses or seminars, contact hours, practicum, and supervision requirements. The BHA Trainee will be a non-certified position, however, the BHA I-III, and Behavioral Health Practitioner will be certified positions.

In addition to certifying BHA's and Behavioral Health Practitioners, there will also be a "grand-parenting" process that will offer employees working within the Alaska Tribal Health System in the field of Behavioral Health to become certified as BHAs. The level at which employees can grand-parent in as BHAs will depend upon their training and previous work experience. Some examples of positions that can be grand parented are Community Health Representatives, Family Wellness Counselors, Family Service Workers, Chemical Dependency Counselors, Counselor Technicians, and Village-Based Counselors.

The BHA Trainee is the newest to the field of behavioral health and they will be going through orientation to behavioral health and training. The BHA I has knowledge to recognize issues and provide general information to clients and the community that incorporates that recognition with support from their supervisor. The BHA II has knowledge to recognize symptoms, conditions, or characteristics, and can respond therapeutically with support from their supervisor. The BHA III can apply knowledge in an interaction with a client within the assessment and treatment of that client. The BH Practitioner will have achieved the highest level of professional qualifications and/or credentials for BHA's and can apply knowledge to mentor and support others in the use of skills to participate in supervision and evaluation of BHAs I, II, and III.

The key efforts of the BHA Program are to:

1. Provide behavioral health (substance use and mental health) services as close to where Alaska Native people live (rural and remote villages), with the goal of providing services in all villages.
2. Promote Alaska Native community-based behavioral health and wellness.
3. Provide culturally and contextually appropriate behavioral health services for the customers/owners of the Alaska Tribal Health System.
4. Focus on providing competencies that support consumer education, prevention, early intervention, case management, and supportive aftercare and follow-up.
5. Link BHAs with necessary and appropriate clinical supervision and support.

As mentioned above, in June of 2008, the Behavioral Health Aide competencies were approved by the Community Health Aide Program Certification Board. The competencies will be property of the Indian Health Services and ANTHC. ANTHC plans to continue to work with the Alaska Commission for Behavioral Health Certification in order to facilitate reciprocity between Tribal and ACBHC certification for behavioral health workers so that an ANTHC certified

Behavioral Health Aide can move into a position as an ACBHC certified Behavioral Health Counselors without additional certification requirements or vice versa.

Certification

There is currently no active certification process for direct care workers serving individuals with co-occurring disorders. However, there is a certification process for individuals specializing in chemical dependency treatment. This process is described in the following section on addictions.

D. Child Mental Health

Competencies

University of Alaska, Anchorage Children's Residential Service Certificate Program Student Outcomes and Competencies

The only set of competencies currently being used in the field of child mental health are being applied within the *University of Alaska, Anchorage Children's Residential Service Certificate Program*. This is a five course, 16 credit program for direct service providers working with children in out of home care settings. The certificate requires a total of 180 practicum hours. The program and the *Student Outcomes and Competencies* it uses were created in response to the need expressed by providers of child mental health services for better trained direct care workers.

The program and competencies were based on the University of Oklahoma Child Residential Youth Care Program, as well as advice regarding skills and necessary knowledge provided by employers and other Alaskan stakeholders. The program was piloted during the 2006/2007 academic year. In the spring of 2007, the curriculum and competencies were revised. During the 2007/2008 academic year the certificate program received final approval from the University of Alaska. The 36 Student Outcomes and Competencies are outlined alongside related methods of assessment. The competencies include such focus areas as child development, cultural competency, behavior management, documentation, assessment, and legal issues. The primary methods of student evaluation include class participation, class discussion, homework and projects, and various forms of observation (e.g., videotape and live observation).

Employees who receive the Children's Residential Services Certificate will work with children in a variety of child behavioral health sites ranging from emergency short-term placement to intensive longer-term psychiatric treatment. Some employers promote employees who receive the certificate and these employees receive pay increases. However, there is no guaranteed pay raise with the acquisition of this certificate. The competencies and curriculum are University of Alaska intellectual property and are not public domain at this time.

III. Child Development

Competencies

Direct Service Staff Early Infant (EI)/Infant Learning Program (ILP) Professional Development Core Competencies

In Alaska, a number of agencies serving children have been offered the *Direct Service Staff Early Infant (EI)/Infant Learning Program (ILP) Professional Development Core Competencies*. These competencies were created by the Office of Children's Services, which is now in the Alaska Department of Health and Social Services. They were adapted from competencies created by a national organization called the Council on Exceptional Children²³ (COEC). The Alaska EI/ILP competencies are based specifically on a document from the COEC's Division of Early Childhood called *Recommended Practices in Early Intervention/Early Childhood Special Education* and are meant for use with children birth-8 years old. The *Early Infant/Infant Learning Program Professional Development Core Competencies* are composed of service coordination, service delivery, family centered approach to working with children, child development, professionalism, and general requirements regarding laws, regulations, policies and procedures.

The Direct Service Staff Early Infant/Infant Learning Program Professional Development Core Competencies were distributed to supervisors at 18 Alaskan agencies serving children. These agencies receive EI/ILP grants from the state of Alaska to provide services to infants and toddlers and their families. The competencies were intended to assist agencies with training and evaluation of employees and to guide service delivery and staff development by, for example, informing training plans. Key informants in Alaska have suggested that the competencies were not formatted in a way that allowed them to be easily applied within these agencies and thus, they have not been applied by supervisors.

New competencies intended to be an improvement on the original, longer version were created in the fall of 2007. This version of the competencies is currently being revised by EI/ILP stakeholders including, parents, State staff, University of Anchorage faculty, and employers. The new competencies are called the *Alaska Early Infant Professional Core Competencies for Direct Care Staff*. These competencies are divided into eight different roles. Each role contains about 20 different behavioral descriptions that outline the successful fulfillment of each role. These competencies have not yet been distributed to agency supervisors. The target date for distribution is February of 2009.

IV. Developmental Disability

Competencies

U.S. Department of Labor office of Apprenticeship-Direct Support Professional Competencies

Until recently, there were no competencies being used to train direct care workforce who serve people with developmental disabilities in Alaska. However, the *U.S. Department of Labor office of Apprenticeship-Direct Support Professional Competencies* will be used by mentors or supervisors to train direct care workers at 8 pilot sites participating in the Direct Support Specialist Occupational Endorsement (DSSOE) program through Prince William Sound Community College. Some of these pilot sites serve people with developmental disabilities. The occupational endorsement program is described in the above section on cross sector competencies. The U.S. Department of Labor competencies can be found under the title, “U.S. Department of Labor Registered Apprenticeships” in this paper’s section on national resources.

V. Traumatic Brain Injury

There are currently no traumatic brain injury (TBI) specific direct care job titles in Alaska. However, many direct care workers provide services for individuals with a TBI and the number of individuals with a TBI is expected to grow with the return of veterans from the war in Iraq.

Competencies

National Alliance for Direct Support Professionals Competencies

The *National Alliance for Direct Support Professionals Competencies* (NADSP, 2005) will be used to train employees in the near future. These competencies are not specific to TBI. The competencies and the NADSP certification process are outlined in detail in the national developmental disabilities resources section of this report.

Certification

American Academy for the Certification of Brain Injury Specialists

The *American Academy for the Certification of Brain Injury Specialists (AACBIS)*²⁴ materials are being used by some employers to train direct care workers serving people with a TBI. Most direct care employees in Alaska do not obtain certification, however, a handful have been certified by AACBIS. The AACBIS resources are discussed in this report’s section on national TBI resources.

Rather than using the NADSP and AACBIS materials, some employers in Alaska create their own unique training programs for new employees. Training specific to working with individuals with TBI's is required by employers, but does not earn employees higher pay or other benefits.

VI. Long Term Care

There are several competency resources currently being applied to direct care workers in long term care settings in Alaska. They range in content from general direct support professional skills and knowledge to the more specific focus areas of abuse and neglect prevention and dementia care.

Competencies

Adult Abuse and Neglect Prevention Goals and Objectives

The Adult Abuse and Neglect Prevention Goals and Objectives were created at the University of Alaska Anchorage's Social Work Evaluation Program. They were developed by the Abuse Prevention Training Project and funded under a three-year pilot grant from the Centers for Medicaid and Medicare Services through the Alaska Department of Health and Social Services. The Goals and Objectives were developed by a curriculum committee comprised of representatives of a several service provider groups. They were revised several times by a panel of experts including curriculum developers, state employees, trainers, facility workers, and supervisors. The state is now attempting to make the training a mandatory requirement for all caregivers in an effort to ensure ongoing dissemination of the curriculum.

There are eight goals in the Goals and Objectives document. For example, one goal is to be able to recognize the stressors that can put caregivers at risk for harming a vulnerable adult. Each goal is comprised of one or more specific objectives, such as describing strategies to intervene with escalating behavior.

Current funding is devoted to integrating the curriculum across the caregiver workforce in the following ways: training the trainer (equipping agency and community-based supervisors and staff with the skills to deliver the training locally), creating an on-line course, delivering the curriculum face-to-face at conferences and regional meetings, and integrating the material into existing university programs. The curriculum is currently being used across Alaska by hospitals, assisted living homes, adult protective services, and other agencies serving vulnerable adults. The Center for Medicare and Medicaid Services, who funded the project, has specified that the Goals and Objectives should not be published until after the completion of the project at the end of May, 2008. Therefore, the full curriculum is considered public domain, but was not available at the time that this report was written.

Training Matrix for Excellence in Care Certification

The *Training Matrix for Excellence in Care Certification* from the Alzheimer's Association of America was created as a template for educating staff who serve older adults with dementia. Fulfillment of each of the matrix's training requirements is necessary in order for providers to qualify as a center of excellence in dementia care. The matrix is composed of ten learning objective. Under each learning objective are more specific knowledge and skills content, such as verbal and non-verbal communication. The matrix also specifies the style (e.g., in-service or staff meeting) and type (e.g., caregiver workshop) of training.

The matrix is used by older adult providers to train workers who serve individuals with Alzheimer's and other forms of dementia. The training outlined in the matrix is a requirement for all employees hired into the Serendipity Adult Day Services programs in Alaska and is provided on the job through quarterly in-service training days, staff meetings. Certification is not related to wage increases or other benefits.

VII. Juvenile Justice

Competencies

Juvenile Justice Officer I Promotional Criteria

There are no formal competencies used to train juvenile justice direct care workers in Alaska. However, there is a set of competency-based promotional criteria used to evaluate employees and determine whether they are prepared to be promoted to the next job level. The *Juvenile Justice Officer I Promotional Criteria* are applied to officers at the entry level and above. The Criteria have been used for nearly 30 years by the state of Alaska and were based upon the American Correctional Association and National Juvenile Detention Association Guidelines, in addition to recommendations received from the Alaska Division of Juvenile Justice managers.

The Juvenile Justice Officer I (JJOI) position is an entry level job with no previous experience required. All JJO I's receive standard training including safety and security, suicide prevention, first aide, and physical management before commencing employment and during the first six months on the job. The Juvenile Justice Officer I Promotional Criteria are used to evaluate the performance of JJO I's in order to determine whether they can be promoted to JJO II's. Employees are rated along five dimensions. These are treatment intervention, interpersonal relation, control, paperwork, and philosophical adaptation. Each dimension is broken down into categories and further into criteria for each category. For example, the treatment/intervention dimension is broken down into background information, intervention tools, ability to use intervention tools, and treatment related performance. Employees are rated on a four point scale with ratings on the upper half of the scale qualifying the employee for promotion.

Employees are expected to meet the promotional criteria for moving into a Juvenile Justice Officer II position within 18 months of their start date, otherwise, they may be fired. The JJO I is a flex position which means that employees can move up to JJO II at any time. JJO II's are promoted to JJO III's based on the same JJO I promotional criteria, but are expected to have greater skill in each of the dimensions outlined in the document. JJO II's advance to JJO III positions only when a space is open.

CROSSWALK OF ALASKA COMPETENCIES

The crosswalk of Alaska Competencies can be found in the table below. For more detailed information on the crosswalking process, please refer to the section titled “Crosswalk of National Competencies.” The competencies are also organized in a table in Appendix B which provides a brief summary of which competency domains are common across competency sets.

Job family ▶	Alaska General (Mental Health and Addiction)	Alaska Cross-Sector Disabilities (Long Term Care, Developmental Disabilities, Mental Health)	Alaska Addictions
Competency set ▶	Alaska Department of Health and Social Services (DHSS)	Direct Support Specialist Occupational Endorsement (DSSOE) Competencies	Alaska Commission for Behavioral Health (Chemical Dependency Certification Matrix)²⁵
Competency “domains” ▼			
1. Interpersonal	Interpersonal competencies Client centered communication	Communication	
2. Assessment	Clinical evaluation and diagnosis Co-occurring disorders	Assessment	Clinical evaluation Understanding addiction (Dual diagnoses)
3. Planning	Treatment/rehabilitation planning	Facilitation of services	Treatment planning
4. Intervention	Substance use/mental health treatment and prevention Individual and family counseling Treatment coordination Crisis management Education: client, family, community Medication management	Community living skills and supports Vocational, educational, and career support Crisis prevention and intervention	Counseling Education: client, family, community Treatment/recovery knowledge Application to practice (Multiple treatment interventions) (Safety)
5. Community resource and referral	Intake/screening/referral Community education and organizing Community resources	Community and service networking	Referral Service coordination (Community resources and case management)
6. Documentation	Charting/records	Documentation	Documentation
7. Professional and ethical conduct	Professional and ethical responsibilities Behavioral healthcare policies and procedures	Organizational participation	Professional and ethical responsibilities (Principles and practices of supervision)
8. Professional development	Training Self-assessment	Education, training, and self development	Professional readiness
9. Advocacy	Comprehensive planning Community collaboration and coordination	Advocacy Participant empowerment	
10. Health and wellness			(Recovery, health, wellness, and balance)

11. Cultural competency	Client expectations Culturally competent Treatment team strategies Impact of cultural factors Cultural awareness		Knowledge of Alaska Native traditional health and healing (Working with diverse populations)
12. Quality improvement	Professional evaluations		(Documentation and quality assurance)
Unassigned comp. domains			
TITLES USED	Mental Health Counselor Substance Abuse Counselor Behavioral Health Aid I, II, & III Behavioral Health Practitioner Village Based Counselor Family Service Worker	Direct Support Specialist Direct Support Professional Direct Service Professional Individual Service Providers Individual Support Specialist Day Habilitation Providers Recreation Workers Activity Workers Residential Aides Life Skills Specialists Supported Employment Specialist Job Coaches Primary Live-in Care Provider Case Coordinator/Manager Respite Provider/Worker Personal Care Attendant/Assistant Peer Support Mentor/Helper/Professional Home Alliance Coordinator Program Assistants On-Demand Support Specialist	Human Services Worker Crisis Advocate Counselor Assistant Chemical Dependency Counselor I and II Clinical Supervisor Counselor Technician Substance Abuse Counselor I and II Counselor Trainee
Job family ►			
	Alaska Infant Mental Health	Alaska Juvenile Justice	Alaska Long Term Care
Competency set ►	Early Infant/Infant Learning Program (EI/ILP) Competencies	Juvenile Justice Officer Criteria	Long Term Care Adult Abuse Prevention Competencies (Alzheimer's Care Certification Matrix)²⁶ [Policy and Procedure Kills Matrix]²⁷
1. Interpersonal	Family-centered communication	Interpersonal relations Control	(Communication techniques to promote comfort and reduce stress)
2. Assessment	Assessment/evaluation Child development		Adult development and aging Abuse indicators (Etiology of common behaviors)
3. Planning	Individualized Family Service Plan (IFSP)	Treatment plan	(Plan of care) (Dementia care planning)

4. Intervention	Intervention Collaboration/case management Curriculum development and implementation Transition	Safety and security Crisis intervention Treatment/intervention Counseling practices	Intervention/prevention Caregiver education re: stressors/safety planning/de-escalation (Providing a safe, comfortable, dementia friendly environment) (Recognizing changes in health status) (Environmental considerations) (Communication, education, and collaboration with families) (Behavior management and positive solutions model) (Activities of daily living) (Safety) (Palliative care) [Medication management] [Case management]
5. Community Resource and Referral	Intake Community coordination Family and community relationships		[Referrals to community resources] [Outreach]
6. Documentation		Paperwork	[Record keeping and documentation]
7. Professional and Ethical Conduct	Professional responsibilities	JJO Promotional Criteria	Value and ethics Statutory responsibilities: mandatory reporting Participant rights
8. Professional Development	History and philosophy of Early Intervention Career development	Philosophical adaptation	(Comprehension of dementia)
9. Advocacy			
10. Health and Wellness			
11. Cultural Competency			Cultural competence (Spirituality)
12. Quality Improvement			
Unassigned Competency Domains			
TITLES USED	Early Infant Professional Developmental Assistant/ Associate/Specialist Early Intervention Specialist Child Welfare Social Service Aide Child Development Associate Infant Family Associate/ Specialist Infant Mental Health Mentor	Juvenile Justice Officer I Juvenile Justice Officer II	Health Care Attendant In-Home Care Provider Dementia Care Technicians Home Health Aid Elder Care Specialist Assisted Living Aid Activity Coordinator

Job family ►	Alaska Mental Health	Alaskan Children’s Mental Health
Competency set ►	Community Health Aide Program Certification Board (CHAPCG) Standards Alaska Native Tribal Health Consortium Behavioral Health Aide (bold below)	University of Alaska Outcomes and Competencies
Competency “domains” ▼		
1. Interpersonal	Client centered communication Foundational Skills in Client and Community Engagement	Effective verbal and non-verbal communication strategies Safe therapeutic environment and helping relationship
2. Assessment	Client evaluation and assessment Co-occurring disorders Foundational Knowledge to Be Applied in All Activities Routine Contact, Screening, Assessment, and Evaluation	Developmental processes Physical, emotional, and behavioral indicators of placement-induced stress on children Assess risk of violent behavior Functional assessment and analysis of problem behavior Emotional and behavioral manifestations of trauma
3. Planning	Organization and Treatment planning Treatment planning	Treatment planning, monitoring, and modifying Significance of family Social skill development
4. Intervention	Individual, Group, and Family counseling Case management and coordination Medication management Prevention, community education, and community organizing Monitoring treatment plan Crisis management Case Management, Coordination, and Monitoring Treatment Plans Medication Management Counseling Crisis Management	Fetal Alcohol Spectrum Disorder (FASD), trauma, and attachment disorders Learning theory Transition into adulthood Side effects of psychotropic medications Family interaction and participation Teaching skills Motivation systems, limit setting, and consequating strategies De-escalate, defuse anger, and prevent violence Behavior modification, behavior management, and positive behavior supports Intervention strategies that address trauma triggers and challenging behaviors Safe de-escalation of defensive or protective behaviors
5. Community resource and referral	Community resources and referral Prevention, Community Education, and Community Organizing Community Resources and Referral	
6. Documentation	Documentation	Record keeping and documentation
7. Professional and ethical conduct	Professional and ethical responsibilities Foundational Professional Readiness	Treatment environments State laws, federal laws, and codes of ethics governing youth in care HIPPA: federal/state confidentiality laws and regulations Ethical interactions

8. Professional development	Professional readiness and development Supervision, Training, and Professional Development	Analyze causes of institutional and unintentional professional traumatization Develop self-awareness of role in working with traumatized children and the impacts of non-family adults in the lives of those children
9. Advocacy	Prevention, Community Education, and Community Organizing	
10. Health and wellness		
11. Cultural competency	Cultural competence (5 specific domains) Promote mutual respect Foundational Skills in Client and Community Engagement Foundational Knowledge to Be Applied in All Activities	Incorporation of culture and diversity Adaptive treatment environments Cultural aspects of trauma
12. Quality Improvement	Supervision, training, and professional development	Propose a checklist of supervision needs around trauma for student's future employment
Unassigned competency domains		
TITLES USED	Behavioral Health Aid Behavioral Health Practitioner Psychiatric Aid Technician Mental Health Assistant Shelter Worker	Child Residential Specialist Residential Child Care Worker Therapeutic Child Care Worker Therapeutic Intervention Mentors ICWA Assistant/Worker/Advocate Residential Treatment Counselor

SUMMARY AND RECOMMENDATIONS

Summary of Findings

1. Both nationally and in Alaska, there are diverse health and human service sectors that are staffed at the front lines largely by direct support workers. These workers typically have had little if any post-secondary education or formal preparation for their jobs. Yet they carry enormous responsibilities in caring for individuals who have serious and persistent illnesses and disabilities.
2. This direct support workforce is not well-defined or routinely examined as a whole. It was a challenge for the CQSS to identify the relevant sectors of the workforce that should be included in this review project and to identify the relevant job titles within those sectors. It soon became clear that like the nation at large, Alaska's titles were employer-developed, not well defined, and lacked standardization.
3. There are a growing number of well executed efforts within Alaska to develop competencies and credentialing processes. This is driven by recognition of the importance of clarifying essential competencies, building curricula and training programs around these, and developing some process for assessing or attesting to the capability of the individual worker to perform his or her duties. Many of these efforts have faced challenges since competency development and credentialing systems are complex to develop, require considerable resources over a sustained period of time, and can be impeded by the challenge of obtaining consensus on the final products.
4. There exist many resources nationally on competencies and credentialing for health and human services roles. These scattered resources are known principally within a narrow silo of disability or service focus. They vary considerably in terms of level of detail, the rigor with which they were developed, the amount of information available, and their current use and impact. However, an enormous amount of funding and energy has been invested nationally in systematic efforts to develop competencies and credentialing systems by federal and state agencies, foundations, and professional associations. Collectively, the resulting products represent a set of riches that Alaska can draw on as it strives to strengthen its workforce.
5. The crosswalk of competencies revealed that there is considerable commonality among the competency sets that have been developed nationally for different sectors of the health and human service field. While there is variability in the organization and language used to describe the competencies, there are clear and recurring themes about the knowledge, skills, and attitudes that are essential for these diverse jobs. This commonality yields one fundamental conclusion: ***There does exist a set of core competencies that could serve as the foundation for cross-disability competency development in Alaska.***
6. The crosswalk of Alaska competencies revealed that there are a number of different types of direct care competencies being used to enhance the knowledge and skills of direct care workers serving Trust beneficiary groups. These competencies have been designed or applied within the State Health and Social Services Department, higher education, provider organizations, the Alaska Native Tribal Health Consortium (ANTHC), and the Alaska Commission for Behavioral Health Certification (ACBHC). Several were created by Alaska stakeholder committees, but most competencies being applied in Alaska are either a modified or original version of national competencies. Several emerging competency sets are under development and intended for dissemination within the next fiscal year.
7. Currently there is no single competency set that is being applied across settings that serve Trust beneficiaries.
8. Most direct care employees who undergo competency related training are not rewarded with higher wages, benefits, or other incentives.²⁸

9. With the exception of chemical dependency counselor certification, there are currently no active state certification processes for direct care workers serving trust beneficiaries. However, several efforts are currently underway. The ANTHC is working on a certification for co-occurring disorders. The ACBHC is constructing a certification process for behavioral health counselors. In addition, the Direct Support Specialist Occupational Endorsement (DSSOE) program through Prince William Sound Community College, which will serve the adult mental health, developmental disabilities, and long term care job families, is intended to become a State certification in the future.
10. The Alaska Native Tribal Health Consortium has been developing a set of core competencies since 2000 which will be applied to ANTHC Behavioral Health Aide positions. The ANTHC and the ACBHC will certify their behavioral health professionals through separate processes due to the differences in the nature of the work each type of employee will do. However, ACBHC and ANTHC are working together closely to create a system of reciprocity for Behavioral Health Aides certified through the tribal system and Behavioral Health Counselors certified by ACBHC.
11. While the commonalities in competencies across disability or service groups are striking, there are substantial differences as well. The competencies for adult corrections and juvenile justice are most dissimilar to the others reviewed. This is driven by the large focus on control and management of individuals, as opposed to care giving, which characterizes job duties in correctional facilities and inpatient settings. Competency development models, such as the Community Support Skills Standards, have explicitly restricted their focus to community-based positions, given these differences in functional duties. The competencies for caring for infants and young children are also significantly dissimilar from those related to services for adults.
12. There are additional differences in competency sets that are related to population characteristics and the nature of services being delivered. These emerge primarily in the master competency domain labeled “interventions” in the crosswalk. There are many common elements of care giving that involve communication, person-centered assessment and planning, referral, professional conduct and development, and advocacy. But there are inescapable differences in the range of interventions provided, which can range from personal care and nutritional support of a physically disabled individual to crisis intervention with an individual diagnosed with a severe mental illness. The range of knowledge and skills required to intervene with these diverse populations cannot be fully represented in a core set of competencies.
13. Some competency sets were designed to specify the “minimum” level of competence necessary to function in a role, while others were developed using exceptional workers as the data source in order to identify “optimal” performance. The former approach is quite common in credentialing and licensing systems, which function to ensure public safety and must avoid the perils of legal liability that would occur from restricting the practice of those who are minimally qualified. However, there remains a need to strive for excellence in workforce preparation and service delivery. Consumers of healthcare have been vocal about their dissatisfaction with any standards that focus on identifying the lowest level of competence that is acceptable.
14. There has been a striking lack of involvement of persons in recovery and family members in the development of competencies in health and human services. Many of the competency sets were developed in an era when consumer and family involvement *and influence* in quality improvement efforts were unusual. However, their participation and feedback on issues related to workforce competency are long overdue.
15. Credentialing systems in health and human services vary widely. They are non-existent in some sectors and widely employed in others. There has been substantial resistance to credentialing, primarily from employers. However, this appears to be slowly diminishing as the magnitude of workforce problems grow and employers seek new strategies to strengthen the workforce ***and create payer support for wages and benefits that might slow turnover among the workforce***. Despite the absence of rigorously developed evidence for the impact of credentialing, there is anecdotal evidence that credentialing may “raise the bar” for a workforce in the manner desired by the CQSS.

Recommendations

As Phase 1 of the CQSS initiative, the job classifications or “job families” and titles in Alaska that are relevant to this initiative have been identified. At this juncture it is clear from the crosswalk of both national and Alaskan competencies that exist for these jobs that there is considerable commonality in terms of the **core** competencies. It is also clear that disability or population specific initiatives within Alaska could benefit from a more coordinated or integrated approach as most suffer from a lack of adequate resources and staffing to develop and apply robust competency models independently.

Below is outlined a series of additional proposed stages to move this work forward. Phase 2 must precede all others, which could then follow in accord with local priorities and funding availability.

Future Stages - Proposed

Phase 2: Develop the Alaska Core Competency Model

This is a complex and critical task that will involve drawing on existing national and Alaska-based competencies to create and validate a set of core competencies for the identified job classifications. The competencies will be sufficiently detailed to guide curriculum development, training, and the assessment of competence among trainees and employees. This is suggested as the critical next step for the CQSS. More detailed recommendations about this phase are outlined below, following the review of other phases.

Suggested time frame: 9/1/08 – 6/30/09

Phase 3: Develop assessment model and tools to evaluate trainee/employee competence

The capacity to evaluate the knowledge, skills, and attitudes of trainees and employees on the Alaska Core Competencies will be essential if their value is to be realized. Without practical, reliable, and valid methods of assessment, the impact of training or the capacity of employees to perform their duties cannot be determined. Assessment tools are also an essential precursor to a competency-based credentialing approach. It is recommended that the CQSS initiate and manage this process as soon as the Alaska Core Competencies are complete.

Suggested time frame: 7/1/09-3/31/10

Phase 4: Develop standardized curriculum and training modules

With the core competencies identified, it is both possible and critical to develop a standardized curriculum and to strengthen existing curricula used to train this workforce. Training modules built around the core competencies should be developed and made readily available to trainers and educators in Alaska who also would receive continuing education and support regarding the use of “evidence-based teaching methods” to implement the curricula. It is recommended that the Alaska Mental Health Trust Authority work to ensure that responsibility for this agenda be assumed by a consortium of groups and organizations that might include: the University of Alaska system, professional associations, and other training organizations. This agenda might be coordinated through the Training section of the Workforce Development Focus area, but is likely not the purview of the CQSS.

Suggested time frame: 7/1/09 – 6/30/11

Phase 5: Develop credentialing system.

With the competencies identified and assessment methods and tools created, a state-wide credentialing system focused on these competencies could be developed. This would be a voluntary system with levels that range from an entry level “registration” credential to higher level “certification”. For the credentialing system to have impact, efforts must be initiated to promote support of credentialing by employers and payers. Employers must be encouraged to provide the types of work-place based learning opportunities and supervision that qualify an employee for credentialing and give preference to credentialed applicants for positions. Most critically, an increased credential level must directly or indirectly lead to increased compensation and job opportunities. An absence of such incentives will lead to the

credentialing process being viewed as a meaningless burden. Oversight of the development of a credentialing system falls within the charge of the CQSS.

Suggested time frame: 4/01/10 – 3/31/11

Phase 6: Develop specialty competencies

There are competencies unique to each job classification or job “family” (e.g. addiction treatment). Once the core competencies are developed, the specialty competencies for entry level practice in different sectors of the health and human service field should be identified in order to strengthen employee performance and the quality of care provided. The existence of the core competencies should narrow and limit the number of specialty competencies that must be identified and trained, making these tasks easier for each sector. It is likely that much of the specialty training will occur through workplace-based learning. Since this scope of work relates closely to training initiatives, it is recommendation that coordination of these efforts fall within the Training section of the Workforce Development Focus Area, but outside of the CQSS.

Suggested time frame: 7/1/09 – 6/30/11

Developing the Alaska Core Competencies

The review of the competencies and the literature on competency development generated a series of recommended strategies for Phase 2 in which the Alaska Competency Model is developed. These are outlined below:

1. Restrict the focus of the Alaska Core Competency Model to positions involving community-based care. This could be defined to include residential and shelter care positions. However, it would exclude positions related to inpatient and correctional facility services. The focus on “command and control” in these settings generates a competency set that is dissimilar to community-based positions.
2. Utilize existing national competency sets as the primary resource in building the Alaska Core Competency Model. Extensive competency has been completed for numerous disciplines using DACUM processes, expert panels, literature reviews, key informant interviews and surveys. It would be impractical and cost prohibitive for Alaska to conduct original research on all of the job families to build its core competency model from original source data. The publicly available detail in these national models could serve as the source data for Alaska’s model, with the resulting product tailored to Alaska’s unique service and workforce needs.
3. Many of the Alaskan competency models were derived from national competency sets. However, the Alaskan models should be reviewed to identify any unique characteristics that need to be imported into a cross-disability Alaska Core Competency Model.
4. In terms of specific methodology for the competency development, the following steps are proposed:
 - a. Establish a final set of Master Competency Domains by establishing inter-rater reliability of the master domains identified in a preliminary fashion in this review.
 - b. Using multiple raters/judges, place the individual competencies from the national models into the Master Competency Domains.
 - c. Using multiple raters/judges drawn from varied job family sectors, rate each competency on frequency, importance, and criticality.
 - d. Using the findings from these ratings, reduce the competencies within each set to a manageable/practical number.

- e. Using experts and exceptional employee from each job family in Alaska, develop behavioral descriptors for each competency at three levels: Exceptional (expert), Acceptable (minimum), and Unacceptable level. This provides the tools necessary for educational and credentialing programs, which can only test to a *minimum* level of competence, while highlighting an optimal level of competence to which each individual can aspire.
- f. In developing the behavioral descriptors, focus principally on skills. While knowledge and attitudes are extremely important, the behavioral manifestations of these should be identified in the descriptors as behavior or performance constitute the desired workforce outcome.

Endnotes

- ¹ Alaska Department of Labor and Workforce Development, Research and Analysis.
- ² People with mental illnesses, developmental disabilities, chronic alcoholism, Alzheimer's disease and related disorders, and traumatic head injury resulting in permanent brain injury.
- ³ The "Reno Report" can be seen at <http://ruralhealth.hrsa.gov/pub/WicheMH.asp>
- ⁴ For a summary of this work and where funding in the State was focused, please see http://www.wiche.edu/mentalhealth/conference/Alaska_files/frame.htm
- ⁵ Read the plan here: www.annapolis.coalition.org. For background, please go here: http://www.wiche.edu/mentalhealth/conference/AnnapolisCoalition_files/frame.htm
- ⁶ Please see the report here: <http://www.wiche.edu/mentalhealth/conference/MeetingMinutes.asp>
- ⁷ A full description of each Trust Beneficiary Group, as well as Trust activities, can be found at <http://www.mhtrust.org/index.cfm?section=About%20the%20Trust&page=Beneficiaries%20of%20the%20Trust>.
- ⁸ <http://www.noca.org/GeneralInformation/WhatIsCertification/tabid/63/Default.aspx>
- ⁹ <http://www.noca.org/>
- ¹⁰ <http://www.noca.org/NCCAAccreditation/AccreditedCertificationPrograms/tabid/120/Default.aspx>
- ¹¹ <http://www.noca.org/NCCAAccreditation/NCCAMissionandVision/tabid/90/Default.aspx>
- ¹² Read more information about these standards at <http://www.noca.org/portals/0/Standards%20-%20Updated%20December%202007.pdf>
- ¹³ <http://www.nadsp.org/pdf/NADSPCredentialingGuidebook.pdf>
- ¹⁴ <http://www.nfattc.org/uploads/rubrics%20of%20final%20pdf%204-6-01.pdf>
- ¹⁵ <http://www.akcertification.org>
- ¹⁶ <http://www.radact.com/site/>
- ¹⁷ Data was received from Kim Haviland, Chair of the Board of Commissioners for ACBHC.
- ¹⁸ <http://csat.samhsa.gov/publications.aspx>
- ¹⁹ http://www.dshs.state.tx.us/mhprograms/copsd_manual.pdf
- ²⁰ Minkoff, K., and Cline, C. A., (2005). Dual Diagnosis Capability, moving from concept to implementation. *Journal of Dual Diagnosis*, 2, 121-134.
- ²¹ www.nfattc.org/aboutfattc/index.html
- ²² These competencies are property of ANTHC and are not public domain.
- ²³ www.dec/sped.org
- ²⁴ http://www.sherrystock.com/conf2004/aacbismanual6_04.pdf
- ²⁵ Information in parenthesis taken from Chemical Dependency Certification Matrix
- ²⁶ Information in parenthesis taken from Alzheimer's Care Certification Matrix
- ²⁷ Information in brackets taken from Policy and Procedure Skills Matrix
- ²⁸ The tribal regional health organizations are working with their human resources department to create a BHA competency file and an increased level of responsibility with training and higher levels of certification. Many have stated that as BHA's move into higher levels of certification there will be a pay rate increase.
- ²⁹ Extracted from Competency Sets that outlined a major Competency Domain.

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APPENDIX A

NCCA Standards for the Accreditation of Certification Programs

PURPOSE, GOVERNANCE, and RESOURCES

- 1 The purpose of the certification program is to conduct certification activities in a manner that upholds standards for competent practice in a profession, occupation, role, or skill.
- 2 The certification program must be structured and governed in ways that are appropriate for the profession, occupation, role, or skill that ensure autonomy in decision making over essential certification activities.
- 3 The certification board or governing committee of the certification program must include individuals from the certified population, as well as voting representation from at least one consumer or public member. For entities offering more than one certification program, a system must be in place through which all certified populations are represented, with voting rights, on the certification board or governing committee.
- 4 The certification program must have sufficient financial resources to conduct effective and thorough certification and recertification activities.
- 5 The certification program must have sufficient staff, consultants, and other human resources to conduct effective certification and recertification activities.

RESPONSIBILITIES to STAKEHOLDERS

- 6 A certification program must establish, publish, apply, and periodically review key certification policies and procedures concerning existing and prospective certificants, such as those for determining eligibility criteria, application for certification, administering assessment instruments, establishing performance domains, appeals, confidentiality, certification statistics, discipline, and compliance with applicable laws.
- 7 The certification program must publish a description of the assessment instruments used to make certification decisions as well as the research methods used to ensure that the assessment instruments are valid.
- 8 The certification program must award certification only after the knowledge and/or skill of individual applicants have been evaluated and determined to be acceptable.
- 9 The certification program must maintain a list and provide verification of certified individuals.

ASSESSMENT INSTRUMENTS

- 10 The certification program must analyze, define, and publish performance domains and tasks related to the purpose of the credential, and the knowledge and/or skill associated with the performance domains and tasks, and use them to develop specifications for the assessment instruments.
- 11 The certification program must employ assessment instruments that are derived from the job/practice analysis and that are consistent with generally accepted psychometric principles.
- 12 The certification program must set the cut score consistent with the purpose of the credential and the established standard of competence for the profession, occupation, role, or skill.
- 13 The certification program must document the psychometric procedures used to score, interpret, and report assessment results.
- 14 The certification program must ensure that reported scores are sufficiently reliable for the intended purposes of the assessment instruments.
- 15 The certification program must demonstrate that different forms of an assessment instrument assess equivalent content and that candidates are not disadvantaged for taking a form of an assessment instrument that varies in difficulty from another form.
- 16 The certification program must develop and adhere to appropriate, standardized, and secure procedures for the development and administration of the assessment instruments. The fact that such procedures are in force should be published.
- 17 The certification program must establish and document policies and procedures for retaining all information and data required to provide evidence of validity and reliability of the assessment instruments.
- 18 The certification program must establish and apply policies and procedures for secure retention of assessment results and scores of all candidates.

RECERTIFICATION

- 19 The certification program must require periodic recertification and establish, publish, apply, and periodically review policies and procedures for recertification.
 - 20 The certification program must demonstrate that its recertification requirements measure or enhance the continued competence of certificants.
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MAINTAINING ACCREDITATION

- 21 The certification program must demonstrate continued compliance to maintain accreditation.
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APPENDIX B

Alaska Competency “Domains”	Collectively Defined As:	Alaska Job Family
1. Interpersonal	<p>Interpersonal competencies/relations</p> <p>Client-centered communication</p> <p>Communication</p> <p>Family-centered communication</p> <p>Interpersonal relations</p> <p>Control</p> <p>Communication techniques to promote comfort and reduce stress</p> <p>Foundational Skills in Client and Community Engagement</p> <p>Effective verbal and non-verbal communication strategies</p> <p>Safe therapeutic environment and helping relationship</p>	<p>Included:</p> <p>General / Cross-Sector</p> <p>Adult Mental Health</p> <p>Co-Occurring</p> <p>Child Mental Health</p> <p>Child Development</p> <p>Long-Term Care</p> <p>Juvenile Justice</p>
2. Assessment	<p>Clinical evaluation and diagnosis</p> <p>Co-occurring disorders</p> <p>Assessment</p> <p>Understanding addiction</p> <p>Dual diagnoses</p> <p>Assessment/evaluation</p> <p>Child Development</p> <p>Adult development and aging</p> <p>Abuse indicators</p> <p>Etiology of common behaviors</p> <p>Foundational knowledge to be applied in all activities</p> <p>Routine contact, screening, assessment, and evaluation</p> <p>Developmental processes</p> <p>Physical, emotional, and behavioral indicators of placement-induced stress on children</p> <p>Assess risk of violent behavior</p> <p>Functional assessment and analysis of problem behavior</p> <p>Emotional and behavioral manifestations of trauma</p>	<p>Included:</p> <p>General / Cross-Sector</p> <p>Addictions</p> <p>Co-Occurring</p> <p>Child Mental Health</p> <p>Child Development</p> <p>Long-Term Care</p> <p>Juvenile Justice</p>
3. Planning	<p>Treatment/rehabilitation planning</p> <p>Facilitation of services</p> <p>Individualized Family Service Plan</p> <p>Plan of Care</p> <p>Dementia care planning</p> <p>Organization and treatment planning</p> <p>Treatment planning, monitoring, and modifying</p> <p>Significance of family</p> <p>Social skills development</p>	<p>Included:</p> <p>General / Cross-Sector</p> <p>Addictions</p> <p>Co-Occurring</p> <p>Child Mental Health</p> <p>Child Development</p> <p>Long-Term Care</p> <p>Juvenile Justice</p>

4. Intervention

Substance use/mental health treatment and prevention
Individual, group and family counseling
Treatment coordination
Crisis management
Education: client, family, community
Medication management
Community living skills and supports
Vocational, educational, and career support
Crisis prevention and intervention
Treatment /recovery knowledge
Application to practice
Multiple treatment interventions
Safety
Collaboration/case management
Curriculum development and implementation
Transition
Safety and security
Counseling practices
Intervention/prevention
Caregiver education re: stressors/safety planning/de-escalation
Providing a safe, comfortable, dementia-friendly environment
Recognizing changes in health status
Environmental considerations
Communication, education, and collaboration with families
Behavior management and positive solutions model
Activities of daily living
Palliative care
Prevention, community education, and community organizing
Fetal Alcohol Spectrum Disorder (FASD), trauma, and attachment disorders
Learning theory
Transition into adulthood
Side effects of psychotropic medications
Family interaction and participation
Teaching skills
Motivation systems, limit setting, and consequating strategies
De-escalate, defuse anger, and prevent violence
Behavior modification, behavior management, and positive behavior supports
Intervention strategies that address trauma triggers and challenging behaviors
Safe de-escalation of defensive or protective behaviors
Family systems
Co-occurring disorders
Prevention and community development

Included:

ALL

	<ul style="list-style-type: none"> Substance abuse/dependency Behavioral health clinical care Psycho-physiology Motivational interviewing CPR/First Aid 	
5. Community Resource and Referral	<ul style="list-style-type: none"> Intake/screening/referral Community education and organizing Community resources Community and service networking Service coordination Community resources and case management Intake Community coordination Family and community relationships Referrals to community resources Outreach Community resources and referral Prevention, community education, and community organizing 	<p>Included:</p> <ul style="list-style-type: none"> General / Cross-Sector Addictions Adult Mental Health Co-Occurring Child Development Long-Term Care
6. Documentation	<ul style="list-style-type: none"> Charting/records Documentation Paperwork Record keeping and documentation Documentation and quality assurance Behavioral Health technical writing 	<p>Included:</p> <ul style="list-style-type: none"> General / Cross-Sector Addictions Adult Mental Health Co-Occurring Child Mental Health Long-Term Care Juvenile Justice
7. Professional and Ethical Conduct	<ul style="list-style-type: none"> Professional and ethical responsibilities Behavioral healthcare policies and procedures Policies and procedures Organizational participation Principles and practices of supervision JJO Promotional Criteria Values and ethics Statutory responsibilities: mandatory reporting Participant rights Professional and ethical responsibilities/interactions Foundational Professional Readiness Treatment environments State laws, federal laws, and codes of ethics governing youth in care HIPPA: federal/state confidentiality laws and regulations Ethical interactions Ethics and confidentiality 	<p>Included:</p> <p>ALL</p>

8. Professional Development	<ul style="list-style-type: none"> Training Self-assessment Education, training, and self development Professional readiness History and philosophy of Early Intervention Career development Philosophical adaptation Comprehension of dementia Professional readiness and development Supervision, training, and professional development Analyze causes of institutional and unintentional professional traumatization Develop self-awareness of role in working with traumatized children and the impacts of non-family adults in the lives of those children Principles and practices of supervision Behavioral health clinical team building 	Included: ALL
9. Advocacy	<ul style="list-style-type: none"> Comprehensive planning Community collaboration and coordination Advocacy Participant empowerment Prevention, Community Education, and Community Organizing 	Included: General / Cross-Sector Co-Occurring
10. Health and Wellness	<ul style="list-style-type: none"> Recovery, health, wellness, and balance 	Included: Addictions Adult Mental Health
11. Cultural Competency	<ul style="list-style-type: none"> Client expectations Culturally competent treatment team strategies Impact of cultural factors Cultural awareness Knowledge of Alaska Native traditional health and healing Working with diverse populations Spirituality Cultural competence (5 specific domains) Promote mutual respect Foundational Skills in Client and Community Engagement Foundational Knowledge to Be Applied in All Activities Incorporation of culture and diversity Adaptive treatment environments Cultural aspects of trauma Traditional health based practices Case studies with culture based issues 	Included: Addictions Adult Mental Health Co-Occurring Child Mental Health Long-Term Care

12. Quality Improvement

Professional evaluations
Documentation and quality assurance
Supervision, training, and professional development
Propose a checklist of supervision needs around trauma for student's future employment
Case management supervision
Staff development plans

Included:
Addictions
Adult Mental Health
Co-Occurring
Child Mental Health